

DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUDGET PRIORITIES FOR FISCAL YEAR 2004

HEARING
BEFORE THE
COMMITTEE ON THE BUDGET
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ONE HUNDRED EIGHTH CONGRESS
FIRST SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 26, 2003

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**DEPARTMENT OF HEALTH AND HUMAN SERVICES
BUDGET PRIORITIES FOR FISCAL
YEAR 2004**

WEDNESDAY, FEBRUARY 26, 2003

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

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

Members present: Representatives Nussle, Shays, Gutknecht, Ryun, Hastings, Brown, Putnam, Wicker, Hulshof, Tancredo, Vitter, Bonner, Franks, Garrett, Barrett, Diaz-Balart, Hensarling, Brown-Waite, Spratt, Moran, Hooley, Baldwin, Moore, DeLauro, Scott, Capps, Thompson, Baird, Cooper, Emanuel, Davis, Majette, and Kind.

Chairman NUSSLE. This is the full committee hearing on the Department of Health and Human Services budget priorities for fiscal year 2004.

Today we have two very distinguished panels. The first panel is the Secretary of Health and Human Services, the Honorable Tommy G. Thompson, Secretary of Health and Human Services, and the second panel will be Gail Wilensky. Dr. Wilensky is a senior fellow from Project Hope—and Dr. Judith Feder, who is the Dean of Public Policy at Georgetown University. We are honored to have these guests with us today to testify and to give us their advice on a host of issues, but most importantly, the budget for fiscal year 2004.

Mr. Secretary, thank you so much for taking time to spend with us today. This is, as we were just speaking off the record here, I believe, your 41st appearance, as you were saying, before the Congress; and that may be a record, certainly among the current Secretaries. I am not sure it is true with others in previous administrations, but what it says to me is that you are willing to be here, to defend programs, to defend policy, to defend administration, to answer questions, tough questions, at a time when there are not always good, easy answers as you know. But we appreciate that.

The Department of Health and Human Services has a long list of responsibilities, maybe the longest list just about anywhere in the cabinet. The responsibilities are within numerous agencies. There are four specific areas that I believe our committee would like to focus on here today. Certainly bioterrorism, welfare reform, Medicaid reform, and Medicare reform with prescription drugs

would probably be the four big areas that members may want to inquire. I am sure there may be others.

I don't think most people would immediately associate the Department of Health and Human Services with homeland security; at least that was not traditionally an association. But the last 2 years have underscored the critical services that this department provides when it comes to the well-being of our citizens, especially in the event of a bioterrorist attack.

Since September 11, we have become increasingly aware of the possibility of these types of attacks. Health and Human Services is at the forefront of ensuring America that we are ready by overseeing that there exists an appropriate supply and stockpile of vaccines and immunizations, an appropriate number of trained health care providers and first responders, hospitals and facilities that are properly outfitted and equipped, appropriate funding for vaccine research and development, and improved information networks so that key personnel can act appropriately in the event of an emergency.

Another area that I would like to discuss that has had some success over the last several years is welfare reform.

Mr. Secretary, there is probably no one with more working knowledge in this area than you. As the Governor of Wisconsin, you led the effort to bring common-sense reforms to this program that helped put more people back to work and ended decades of government dependence; and we used you as a model and used your expertise and advice as a model for our reform.

Since we passed welfare reform in 1996, the number of families receiving welfare has been reduced by more than half, and child poverty has been cut significantly; and that is a job well done for this Congress, for this administration, for previous administrations, and we need to build upon that. When welfare reform finally passed, there were critics who claimed that it might work well during the current economic boom that we saw at that time, but we were warned that welfare case loads would swell during economic slowdowns. I am pleased to note that, in fact, the reforms did sustain during economic slowdown.

One of the key components of welfare reform—the one that I believe made it such a success—was the flexibility that gave States the ability to implement the program. In a similar fashion, the President's budget proposes to reform the Federal-State Medicaid program.

This proposition, in theory, gives the States greater flexibility to cover some of the 41 million Americans without health insurance. But, Mr. Secretary, we don't have a lot of specifics or details on the Federal-State Medicaid program reforms that are part of this proposal, and Congress eagerly awaits that guidance from the administration.

Similarly, the last issue I want to touch upon is by no means the least in importance. It may be the most important non-Homeland Security, non-Defense issue that we have before us, and although most of the public discussion has focused on prescription drugs, there is an urgent need to fundamentally reform the program of Medicare; or, for that matter, risk that it has become unsustain-

able. Even today, Medicare's dedicated revenue is lower than expenditures for the program as a whole.

The President's budget says that Medicare has a \$13.3-trillion shortfall over the next 75 years. Taken together, Medicare, Social Security and Medicaid eventually will consume all Federal revenue. So therefore, I agree with the warning that the President has in his budget where it says, quote, "Given the financial challenges faced by Medicare in the future, the Congress must be extremely careful that legislative changes not add to the long-term, unfunded promises faced by this program."

I also have a more specific concern with regard to Medicare. My State of Iowa, as you know has the fifth highest population of people over the age of 65 and has the most over the age of 85 of any State. So clearly Medicare is an incredibly important component of our health care system. And we have visited about this many times because I know Wisconsin has shared similar issues and concerns.

Ironically though, while Iowa ranks 6th in terms of providing overall quality, it remains 50th in overall Medicare reimbursement. Medicare simply does not pay its fair share to Iowa or, for that matter, many other States in similar situations. And I will just report to you for the good of the order, that it is not enough, nor is it acceptable, for the director of CMS, Mr. Scully, to just praise our efficiency and tell us that our hospitals are fine using data that is 2 years old; that is just not acceptable. And while we certainly understand he has an enormous amount of expertise in this area, we wish that he would come forward with proposals rather than just faint praise.

Unfair reimbursements rates are causing major problems for recruitment and retention of health care personnel. It is making it tough for health care facilities to make ends meet. If Iowa's health care providers are forced to leave rural and small urban communities the same way it is true in so many other States represented on this committee, other employers will follow suit. It is that simple. If the health care leaves the community, you have no economic development.

So I am pleased that the recent omnibus appropriations bill included some short-term relief, but it was not enough. This needs to be resolved. We have talked about this many times. My concern is that even though I have had a chance to meet with you and Mr. Scully and the President himself about this issue and had a chance to talk about some specifics, we have had the budget proposal with a plugged number of \$400 billion for a few weeks now and still have no icing on the cake, meaning we have none of the details similar to the Medicaid program.

I believe Iowans certainly have waited long enough, and I can tell you that I believe Congress and America have waited long enough. I believe it is time for the administration to come forward and give us the principles of the plan and the outline as soon as possible.

We need to fix this problem now, and we need your leadership and the leadership of the President in order to get it done, as we have seen from recent experiences here in the Congress.

So, Mr. Secretary, I know you have got a snootful of issues that are on your plate, but I also know that you revel in the challenges

that face you and the Department and our country; otherwise, you wouldn't have taken on this task. And so we know that when we make these constructive comments and arguments to you, they are not falling on deaf ears. We have got a partner in someone who wants to work with us.

So, with that, let me turn to Mr. Moran for any comments that he would like to make on behalf of Mr. Spratt. And then I would like to begin with your testimony.

Mr. MORAN. Thank you very much, Chairman Nussle, and we thank the Secretary for being here.

And given the fact that the President was clearly going to appoint a Republican as Secretary of HHS, I think he made an excellent choice in choosing you, Governor Thompson. And I do sympathize with you for having to defend this miserable HHS budget that you are presented with.

There are three reasons I say that. One is the domestic discretionary spending levels. Given the fact that the President feels that we can afford tax cuts of trillions of dollars, the idea that we would be cutting in critical areas, NIH, for example, just doesn't seem to be logical. The National Institutes of Health budget here will erode the progress that NIH has made in recent years and undermine the agency's ability to continue current research efforts and undertake new research efforts, and I am quoting there from a number of people involved with NIH that have been involved in the substantial progress they have made.

In terms of Medicare, that the—excuse me. In terms of prescription drug coverage that the chairman rightfully emphasized, I do think that in the interest of full disclosure, we should make it clear to seniors that they cannot get prescription drug coverage under your approach through their Medicare plan. The plan that is being presented with the price tag that the chairman suggested does, in fact, put them into private health coverage, and I am not sure that Medicare seniors are fully aware of the consequences of this plan.

And the third area that I know you are going to emphasize in your testimony, that I think we want to ask further questions about is with regard to the Medicaid program, because I know as Governor—if you were still Governor of Wisconsin—you would be in the front lines protesting this plan.

I see you nodding there. I think you may be prematurely nodding there, Governor, but I wanted to catch that, make a note on that, that the Governor was nodding affirmatively.

You would be on the front lines protesting this plan because what we are doing is putting this thing under a block grant which, while it may give more leverage to individual Governors, takes away responsibility from the Federal Government for the substance of the plan. But most importantly, it covers your fiscal situation for the first 7 years, but then in the last 3 years, you have to pay it all back.

This is worse than the tax plan that we get under the budget resolution by saying that we are going to repeal the whole tax plan in order to pay for it in the tenth year. You know we are not going to do that, and States can't possibly pay back what we are advancing them for the first 7 years in the last 3 years. Talk about being fiscally irresponsible.

Now, some of them may feel they are going to be out of office then and it is not their problem. But to suggest that we would advance money and then require the States to pay it back when they may well be in even worse fiscal condition doesn't seem to be responsible. I know that you would have been one of the first ones to protest this approach.

I don't want to take a lot of your time because we are going to have a lot of interesting questions to ask, and we are looking forward to your testimony and appreciate you for your leadership, Governor Thompson. Thank you.

Thank you Mr. Chairman.

Chairman NUSSLE. The record will reflect that the Secretary was fidgeting in his seat.

Mr. MORAN. Sounds like you are fudging there, Mr. Chairman.

Chairman NUSSLE. That is OK, Jimmy.

All members, with unanimous consent, may put a statement in the record at this point.

[The prepared statements follow:]

PREPARED STATEMENT OF HON. ADAM H. PUTNAM, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF FLORIDA

Mr. Chairman, I am pleased that we have convened today to receive the fiscal year 2004 budget priorities for the United States Department of Health and Human Services from Secretary Tommy Thompson. I am honored to be here with you, Ranking Member Spratt, and the rest of the committee, to exchange views on the Department of Health and Human Services budget for the coming year. Thank you, Secretary Thompson, for appearing today to discuss the needs of your Department, which is so crucial to the well-being and health of our Nation.

I look forward to hearing your department's plans for addressing the looming Medicare crisis in this country. Together, Congress and the administration must create a fair and responsible Medicare program that has improved benefits for its current customers while remaining a stable, solvent program for the future. Medicare's outmoded benefit does not cover prescription drugs, provide consistent coverage for many preventive treatments, support coordinated management of chronic diseases, or offer catastrophic coverage.

It is imperative that any Medicare reform plans include benefits similar to what our seniors are receiving now, yet also move to modernize them. Seniors are generally pleased with their current benefits but understand the need for a prescription drug benefit. However, we must institute reforms that will ensure a quality Medicare program is available to future generations also. Reforms must create a Medicare that is relevant to future generations. I am eager to hear the President's proposal to modernize Medicare and I am hopeful that we can create a system that will keep all of Medicare's benefits financially secure while also providing our seniors with what is necessary for them to live healthier and improve their quality of life.

I am also concerned with the Department of Health and Humans Services' role in meeting threats to our homeland's security. Americans have access to the best health care system in the world, headed up by the most dedicated professionals from the CDC level right down to the local hospital. We have the finest health system, yet we must continue to reinforce it. I want to be assured that we are improving surveillance techniques, the dissemination of information, and awareness of biological threats such as anthrax, smallpox, botox, bubonic plague, and food safety threats. These are the new threats to our country and they must be addressed.

In the past I have expressed my concerns with foot and mouth disease and mad cow disease as examples of diseases that would have a huge impact on public safety and consumer confidence in our food supply. This has been a concern of mine for a long time, and so I'm appreciative that you are concerned about it too. I am hopeful that you have continued to keep food safety and biological threats a high priority in your department.

Mr. Secretary, I look forward to your testimony and I am sure you will provide all of us with a clear picture of your Department's priorities and required resources necessary to keep America healthy.

Chairman NUSSLE. Mr. Secretary, welcome back to the committee. This is your third time that you have had an opportunity to come before us. We do greatly appreciate that, and we would like to ask you to proceed as you see fit.

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

Secretary THOMPSON. Thank you very much, Mr. Chairman. Thank you so much for your leadership, your dedication; and thank you for your opening remarks on so many issues that are really key to Iowa, to the country and especially to my department; Mr. Spratt in absentia and my current Congressman. Mr. Moran, I live in your district, and I——

Mr. MORAN. Wouldn't you know he is a constituent.

Secretary THOMPSON [continuing]. I would like to point out, Congressman Moran, that if I was still Governor, I would walk all the way from Madison to Washington, DC, to be the first Governor to sign up for my plan, because it is that good; and I hope to get a chance to explain it to you and even convince my temporary Congressman from northern Virginia that it is the right way to go.

And, Mr. Shays and all the other members of this wonderful committee, thank you for giving me this honor to appear in front of you to present the President's fiscal year 2004 budget for the Department of Health and Human Service's that continues to advance the President's goal of ensuring that every American has access to health care.

The President proposes outlays for HHS of \$539 billion; 539 billion represents an increase of \$36.8 billion, or over 7 percent, over fiscal year 2003's enacted amounts, and an increase of more than \$109 billion, or 25 percent, since 2001. The discretionary part of the budget increases \$1.64 billion, or 2.6 percent, to \$65 billion of budget authority. This would be \$60 million higher than the enacted fiscal year 2003 appropriation.

Our most urgent priority is bioterrorism, and I would parenthetically, just at the outset, invite every member of this committee to come over to the Department of Health and Human Services to see our operation, our brand-new communications room, which is state of the art, and I think it will allay a lot of your fears, once you have a chance to go through it and give me an opportunity to explain it to you.

Congressman Shays has been through it, and he would, I think, remark that it is one of the finest communications rooms in the Federal Government. It is an area where we have moved with unprecedented speed, commitment, and determination to prepare our Nation for an attack or a public health crisis since the terrorist attack of September 11.

It is clear that our public health structure is stronger than ever, and getting stronger each and every day as we work with States and local communities to prepare for possible attacks as well as other health crises. Yet there is much work to do, and we remain committed to building our unprecedented efforts to protect the public health.

Our budget would spend \$3.6 billion to further enhance the steps that we have taken since that terrible day including an additional \$1.4 billion in State, local and hospital preparedness. Additionally, President Bush recently announced a new initiative, Project Bio-shield, that would also help prepare the country for a bioterrorism attack.

He would spend roughly \$6 billion over 10 years on new counter-measures. This proposal would speed up research approval of vaccines and treatments and ensure a guaranteed funding source for their purchase, just the latest in our forward-looking efforts to protect our homeland.

While we are preparing the Nation for a bioterrorist attack, we are also working aggressively to strengthen and modernize our two largest health programs, Medicare and Medicaid, popular programs that are badly in need of an update.

As you well know, Mr. Chairman, our Nation's Medicare program needs to be strengthened and needs to be improved in order to fill the gaps in current coverage. The President has proposed numerous principles for Medicare enhancements to ensure that we are providing our seniors with the best possible care. We have also dedicated \$400 billion over the next decade to achieve this very ambitious goal, and we look forward to working closely with Members of Congress and especially this committee to develop and pass a responsible and effective Medicare bill.

The budget proposed a prescription drug benefit that would be available to all beneficiaries, would protect them against high drug expenditures and would provide additional assistance through generous subsidies for low-income beneficiaries to ensure individuals have ready access to pharmaceutical drugs.

Passing Medicare legislation will be a huge task, and improving Medicaid is also very urgent. In fact, Medicaid is growing even more rapidly than Medicare. The Federal portion is \$162 billion this year, and the program is growing at about 9 percent a year. But State Medicaid programs are under tremendous financial pressure and beneficiaries risk losing coverage. Two-thirds of the States have already made reductions or have reductions pending.

The President has proposed a very aggressive plan to preserve coverage, make Medicaid more efficient and provide better health care delivery. We would begin by addressing the immediate fiscal needs of the States. We would meet the 9 percent base growth in the program and then forward-fund by \$3.25 billion for 2004 and \$12.7 billion over 7 years. And the States would not have to pay it back. If Congress adopts this plan, States will be able to build on the successes of the States' Children's Health Insurance Program. I had a chance to discuss this proposal with many Governors on Monday, and their reaction was very positive.

Let me be very clear about two things. First, State participation in this new program would be optional; it would be voluntary. Second, mandatory populations will continue to receive all of their mandatory benefits. The Medicaid entitlement will be unchanged. States will have more flexibility in covering optional populations, which account for a large part of Medicaid spending. They will gain the ability to target special needs populations, such as those suffering from mental illness and HIV/AIDS. And if we do not improve

Medicaid, a million Americans could lose coverage this year, and millions more next year. I look forward to working with this Congress to make sure that that does not happen.

At the same time we expand access to health care, we also want to reduce the number of people who need it, and because so many Americans suffer from preventable diseases, this administration has made prevention a key priority. Our budget proposes a new investment of \$100 million to promote a healthier lifestyle by emphasizing prevention of obesity, diabetes and asthma, something I am absolutely committed to and passionate about.

Turning from health to welfare. Many of you worked on welfare reform in 1996 and we have all known how successful it has been. We will work with Congress this year to reauthorize the program and to strengthen work requirements and support for healthy families. The President's budget would spend \$17.6 billion for 2004 on TANF, and the \$2-billion contingency fund still remains available.

Now is not the time to turn back. We must move forward in helping millions of Americans become self-sufficient. In a continuing effort to improve the lives of children who are at risk of abuse and neglect, we are proposing a child welfare financing option that States can use to improve their child-welfare service systems. We propose to spend nearly \$5 billion for foster care in 2004, a \$90-million increase over the fiscal year 2003 enacted appropriation.

The President has made improving our Nation's health and health care one of his biggest priorities for the year; and by working together, we can make it one of our proudest achievements. I look forward to all the work and I know our discussion this morning will get things rolling.

I thank you, Mr. Chairman, members of this committee, once again for giving me this opportunity to come before you and testify and answer your questions.

[The prepared statement of Secretary Thompson follows:]

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

Good morning Mr. Chairman, Mr. Spratt, and members of the committee. I am honored to be here today to present to you the President's fiscal year 2004 budget for the Department of Health and Human Services (HHS). I am certain you will find that, viewed in its entirety, our budget will help improve the health and safety of our Nation.

The President's fiscal year 2004 budget request continues to support the needs of the American people by strengthening and improving Medicare and Medicaid, enhancing Temporary Assistance for Needy Families (TANF) and Foster Care; strengthening the Child Support Enforcement Program; and furthering the reach of the President's New Freedom Initiative.

The \$539 billion proposed by the President for HHS will enable the Department to continue its important work with our partners at the State and local levels and the newly created Department of Homeland Security. Working together, we will hold fast to our commitment to protect our Nation and ensure the health of all Americans. Many of our programs at HHS provide necessary services that contribute to the war on terrorism and provide us with a more secure future. In this area, I am particularly focused on preparedness at the local level, ensuring the safety of food products, and research on and development of vaccines and other therapies to counter potential bioterrorist attacks.

Our proposal includes a \$37-billion increase over the fiscal year 2003 budget, or about 7.3 percent. The discretionary portion of the HHS budget totals \$65 billion in budget authority, which is an increase of \$1.6 billion, or about 2.6 percent. HHS' mandatory outlays total \$475.9 billion in this budget proposal, an increase of \$32.3 billion, or roughly 7.3 percent.

Your committee will set the framework for achieving many of the administration's most important priorities. I am grateful for the close partnership we have enjoyed in the past, and I look forward to working with you on an aggressive legislative agenda to advance the health and well being of millions of Americans. Today, I would like to highlight for you the key issues in the President's budget.

SUPPORTING THE PRESIDENT'S DISEASE PREVENTION INITIATIVE

One of the most important issues on which we can work together is disease prevention. We all have heard the disturbing news about the prevalence of diabetes, obesity and asthma that could be prevented through simple lifestyle changes. The statistics, I am sure, are as alarming to you as they are to me. For example, the incidence of diabetes and obesity among Americans is up sharply in the past decade, putting millions more Americans at higher risk for heart disease, stroke and other related medical conditions.

Diabetes alone costs the Nation nearly \$100 billion each year in direct medical costs and leads to incalculable indirect economic costs, including disability, missed work and premature death. Medical studies have shown that modest lifestyle changes—such as getting more exercise and losing weight—can reduce an individual's risks for developing these serious health conditions.

For this reason the HHS budget, consistent with the President's Healthier US effort, proposes a coordinated, Department-wide endeavor to promote a healthier lifestyle emphasizing prevention of obesity, diabetes, and asthma. The fiscal year 2004 budget includes a new investment of \$100 million for targeted disease prevention.

The proposed fiscal year 2004 budget for the National Institutes of Health builds upon the doubling of the NIH budget that was completed in fiscal year 2003, providing an increase of \$500 million from the previous year. NIH will be able to increase funds devoted to its research programs by \$1.9 billion, or 7.5 percent. In addition

FIGHTING BIOTERRORISM

As Americans confront the realities of terrorism and hatred around us, it is imperative that the Federal Government be prepared to keep our citizens safe and healthy. HHS's \$3.6 billion bioterrorism budget substantially expands ongoing medical research, maintains State and local preparedness funding, and includes targeted investments to protect our food supply. The President's proposal significantly expands NIH research funding needed to develop vaccines and medicines that will make biologic agents much less effective as weapons. HHS and DHS will be working hand-in-hand to ensure that Americans have emergency access to stockpiles containing effective drugs, vaccines, and other biologics. HHS and the Department of Homeland Security, will spearhead the development of Project Bioshield. This project, which the President recently proposed, will bring together the resources of the United States government in an innovative effort to develop defenses against bioterror before they are ever needed. Project Bioshield will have three (3) major goals:

- Ensure sufficient resources are available to procure the next-generation countermeasures. The administration proposes a permanent, indefinite authority that will: a) provide the government with the flexibility needed to respond to changing threat information and science; b) establish a guaranteed funding source that will allow the government to purchase vaccines and other therapies as soon as experts believe they can be made safe and effective; and c) spur the industry investment needed to produce these countermeasures by providing assurance that if they can produce a needed product, the government can and will purchase it.
- Speed up NIH research and advanced development. Provide more flexible contracting and procurement authorities for critical biodefense work.
- Make promising treatments available more quickly for use in emergencies. Establish a new FDA Emergency Use Authorization for promising medical countermeasures that are under development that provides greater flexibility in emergency situations than the current Investigational New Drug (IND) authority.

IMPROVING THE NATION'S HEALTH

In an effort to improve the Nation's health, the budget includes initiatives to reduce drug-related medical costs and carry out the Best Pharmaceuticals for Children Act. The request for the Food and Drug Administration (FDA) includes \$13 million to increase Americans' access to safe, effective, and less expensive generic drugs. The budget also includes an additional \$30 million in NIH and FDA to expand Federal and private research to improve information for prescribing pharmaceuticals to children.

The HHS budget includes a series of improvements in the financing of childhood vaccines to meet three goals—first, improve vaccine access for children eligible for the Vaccines for Children program, second, restore tetanus-diphtheria booster to the VFC program; and third, build a national stockpile of childhood vaccines. To ensure against future shortages of childhood vaccines, HHS will develop a strategic plan and implement a vendor-managed, 6-month supply of all childhood vaccines by 2006. In addition, legislation will be proposed to improve access to VFC vaccines for children already entitled to them. The budget proposes to expand the number of access points for underinsured children to those whose private insurance does not cover the immunizations by allowing them to receive their VFC vaccines at State and local public health clinics. I also propose to restore the tetanus and diphtheria booster to the VFC program by removing outdated price caps that are so low that vendors will not bid on VFC contracts.

The budget also contains \$100 million to begin working with industry to ensure the Nation has an adequate supply of influenza vaccine in the event of a pandemic. Due to its short shelf life, we cannot stockpile influenza vaccine, and current manufacturing methods could not surge to meet the Nation's needs in a pandemic. Funds will be used for activities to ensure a year-round influenza vaccine production capacity and the development and implementation of rapidly expandable production technologies.

In fiscal year 2003, we are completing a 5-year doubling of the budget of the National Institutes of Health (NIH). This year, we continue that commitment with a budget of \$27.9 billion, a net increase of \$549 million over last year. As a result of one-time projects being funded in fiscal year 2003, and not needing to be continued, NIH funding for research on larger scale projects will increase \$1.9 billion, 7.5 percent, and fund a record number of new and competing research grants.

We are investing \$50 million in a new program at AHRQ to increase investments in hospital information technology to improve patient safety. Of this amount, \$26 million will be used to focus on small and rural hospitals. Proven technologies like computerized physician order entry and automated medication dispensing systems improve the safety and quality of care.

FAITH-BASED AND COMMUNITY INITIATIVES

In support of the President's Faith-Based and Community Initiative, the HHS fiscal year 2004 budget supports programs that promote positive relationships that link faith- and community-based organizations, State and local governments, and Federal partners to develop a shared picture for substance abuse treatment and positive youth development.

We are proposing to establish a new \$200-million drug treatment program. For some individuals, recovery is best assured when it is achieved in a program that recognizes the power of spiritual resources in transforming lives. Under this new program, individuals with a drug or alcohol problem who lack the private resources for treatment will be given the means to secure drug treatment services. The program will give them the ability to choose among a range of effective treatment options, including faith-based and community-based treatment facilities. Another important program that helps some of our most vulnerable children is the Mentoring Children of Prisoners program. We are asking for funds to be increased to \$50 million, which would in turn be made available to faith-based, community-based, State and local governments and tribes, and public organizations for programs that provide supportive one-on-one relationships with caring adults to these children who are more likely to succumb to substance abuse, gang activity, early childbearing and delinquency. This down payment will help approximately 30,000 adolescent children of prisoners receive some guidance, have positive role models, and give them a fighting chance to succeed. In addition, the budget request for the Compassion Capital Fund is \$100 million, an increase of \$65 million above the fiscal year 2003 appropriation. These funds would continue to be used to provide technical assistance to faith- and community-based organizations to expand and emulate model social programs. These are just a few examples of the services that can be provided to those in need under this initiative.

STRENGTHENING AND IMPROVING MEDICARE

As we are all aware, our Nation's Medicare program needs to be strengthened and improved to fill the gaps in current coverage. We remain steadfastly committed to ensuring that America's seniors and individuals with disabilities can keep their current, traditional Medicare. The President has proposed numerous principles for Medicare enhancements to ensure that we are providing our seniors with the best possible care. The budget builds on those principles by dedicating \$400 billion over

10 years to strengthen and improve Medicare, including providing access to subsidized prescription drug coverage, better private options and better insurance protection through a modernized fee-for-service program.

Prescription drug coverage

Ensuring that Medicare beneficiaries have access to needed prescription drugs is a top priority for the President and me. This budget proposes a prescription drug benefit that would be available to all beneficiaries, protect them against high drug expenditures, and would provide additional assistance through generous subsidies for low-income beneficiaries to ensure ready access to needed drugs. The administration's prescription drug plan would offer beneficiaries a choice of plans and would support the continuation of the coverage that many beneficiaries currently receive through employer-sponsored and other private health insurance.

Medicare choices

Medicare+Choice was introduced to provide beneficiaries with additional options for Medicare coverage. Over the past year, the Department has made significant strides in expanding beneficiaries' Medicare+Choice options by approving 33 new preferred provider organizations (PPOs) through a demonstration. However, due to a variety of factors, in many parts of the country, few other new plans have entered the program. More needs to be done to encourage plan participation. We believe that we should move away from administered pricing to set Medicare+Choice rates. The administration believes that Medicare+Choice payments need to be linked to the actual cost of providing care. America's seniors and citizens with disabilities should have access to the same kind of reliable health care options others enjoy and that those choices should be provided through a market-based system in which private plans compete to provide coverage for beneficiaries. Those beneficiaries who select less costly options should be able to keep most of the savings. It is time we give our seniors the choice they have been promised in Medicare.

Modernized fee-for-service

One of the basic tenets of our proposal to strengthen and improve Medicare is that seniors and individuals with disabilities deserve the same range of health care delivery choices as Federal employees enjoy. These choices should reflect the care and service innovations incorporated into today's best health insurance plans. A strengthened and improved Medicare program would rationalize cost-sharing for beneficiaries who need acute care. It would also eliminate cost sharing for preventive benefits and provide catastrophic coverage to protect beneficiaries against the high costs of treating serious illnesses.

Medicare appeals reform

Our budget also includes \$129 million for the strengthening of the Medicare appeals process. The adjudicative function currently performed by the Administrative Law Judges at the Social Security Administration would be transferred to the Centers for Medicare and Medicaid Services (CMS). In addition, the administration proposes several legislative changes to the Medicare appeals process that would give CMS flexibility to improve the appeals system. These changes will enable CMS to respond to beneficiaries' and providers' needs efficiently and effectively.

STRENGTHENING AND IMPROVING MEDICAID AND SCHIP

State health care partnership allotments

Mr. Chairman, as you know, states are confronting serious challenges in running their Medicaid programs. It is crucial that we do something now to stabilize Medicaid programs so we do not allow millions of Americans to go without health care. In the past year, 38 states have reduced services or eligibility and most states are currently considering other benefit or eligibility cutbacks. We want to give states another option. It is our responsibility to work together so that states can get the help they need in managing their health care budgets, while preventing further service and benefit cuts and expanding coverage for low income Americans.

Building on the success of the State Children's Health Insurance Program (SCHIP) and the Health Insurance Flexibility and Accountability (HIFA) demonstrations in increasing coverage while providing flexibility and reducing the administrative burden on States, the administration proposes optional State Health Care Partnership Allotments to help States preserve coverage. Under this proposal, States would have the option of electing to continue the current Medicaid program or to choose partnership allotments. The allotment option provides States an estimated \$12.7 billion in extra funding over 7 years over the expected growth rate in the current Medicaid and SCHIP budgets. If a State elects the allotments, the Federal por-

tion of SCHIP and Medicaid funding would be combined and states would receive two individual allotments: one for long-term care and one for acute care. States would be required to maintain their current levels of spending on Medicaid and SCHIP, but at a lower rate of increase than the increase of the Federal share.

States electing a partnership allotment would have to continue providing current mandatory services for mandatory populations. For optional populations and optional services, the increased flexibility of these allotments will allow each State to innovatively tailor its provision of health benefit packages for its low-income residents. For example, States could provide premium assistance to help families buy employer-based insurance. States could create innovative service delivery models for special needs populations including persons with HIV/AIDS, the mentally ill, and persons with chronic conditions without having to apply for a waiver. Another important part of the new plan would permit States to encourage the use of home and community-based care without needing a waiver, thereby preventing or delaying institutional care. Let me stress that this is an OPTION we are proposing for States.

New Freedom Initiative

One of the administration's priorities is relying more on home and community-based care, rather than institutional care for the elderly and disabled. The New Freedom initiative represents part of the administration's effort to make it easier for Americans with disabilities to be more fully integrated into their communities. Under this initiative, we are committed to promoting the use of at-home and community-based care as an alternative to nursing homes.

It has been shown time and again that home care combines cost effective benefits with increased independence and quality of life for recipients. Because of this, we have proposed that the fiscal year 2004 budget support a 5-year demonstration called "Money Follows the Individual" Rebalancing Demonstration, in which the Federal Government will fully reimburse States for 1 year of Medicaid home and community-based services for individuals who move from institutions into home and community-based care. After this initial year, States will be responsible for matching payments at their usual Medicaid matching rate. The administration will invest \$350 million in fiscal year 2004, and \$1.75 billion over 5 years on this important initiative to help seniors and disabled Americans live in the setting that best supports their needs.

The administration again proposes four demonstration projects as part of the President's New Freedom Initiative. Each promotes home and community-based care as an alternative to institutionalization. Two of the demonstrations are to provide respite services to caregivers of disabled adults and severely disabled children. The third demonstration will offer home and community-based services for children currently residing in psychiatric facilities. The fourth demonstration will test methods to address shortages of community direct-care workers.

Medicaid coverage for spouses of disabled individuals

The budget proposes to give States the option to extend Medicaid coverage for spouses of disabled individuals who return to work and are themselves eligible for Supplemental Security Income benefits. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to the spouse the same Medicaid coverage protection this committee was instrumental in offering to the disabled worker.

Extension of the QI-1 program

Under current law, Medicaid programs pay Medicare Part B Premiums for qualifying individuals (QI-1s), who are defined as Medicare beneficiaries with incomes of 120 percent to 135 percent of poverty and minimal assets. The budget would continue this premium assistance for 5 years.

Transitional Medicaid Assistance (TMA)

TMA provides health coverage for former welfare recipients after they enter the work force. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare related Medicaid eligibility due to earnings from work, and was scheduled to sunset in September 2002. TMA has been extended until June 30, 2003 through the appropriations process. This budget proposal would extend TMA for five more years, costing \$400 million in fiscal year 2004, and \$2.4 billion over 5 years. This program is an important factor in establishing independence for former welfare recipients by providing health care they could not otherwise afford.

We are also proposing modifications to TMA provisions to simplify it and make it work better with private insurance. These provisions include:

- States will be given the option to offer 12 months of continuous care to eligible participants.
- States may waive income-reporting requirements for beneficiaries.
- States that have Medicaid eligibility for children and families with incomes up to 185 percent of poverty may waive their TMA program requirements.
- States have the option of offering TMA recipients "Health Coupons" to purchase private health insurance instead of offering traditional Medicaid benefits.

State Children's Health Insurance Program (SCHIP)

As you know, SCHIP was set up with a funding mechanism that required States to spend their allotments within a 3-year window after which any unused funds would be redistributed among States that had spent all of their allotted funds. These redistributed funds would be available for one additional year, after which any unused funds would be returned to the Treasury. An estimated \$830 million in fiscal year 2000 funds are expected to go back to the Treasury at the end of fiscal year 2003. The administration proposes that States be permitted to spend redistributed fiscal year 2000 funds through the end of fiscal year 2004. Extending the availability of SCHIP allotments would allow states to continue coverage for children who are currently enrolled and continue expanding coverage through HIFA waivers.

Medicaid drug rebate

The current Medicaid Rebate methodology establishes rebates to State Medicaid agencies based in large part on the drug manufacturer's reported best price. The best price component of pharmaceutical rebates requires that the discounts that private sector purchasers are able to negotiate with pharmaceutical manufacturers also be given to Medicaid. It has been claimed that this provides a disincentive for drug manufacturers to give discounts to private sector purchasers. The administration is interested in working with this committee, the House Energy and Commerce Committee and the Finance Committee to explore policy options to address this issue.

EMPOWERING AMERICA'S FAMILIES

Reauthorization of Temporary Assistance for Needy Families (TANF) and the Child Care Development Fund

Building on the considerable success of welfare reform in this great Nation of ours, the President's fiscal year 2004 budget follows the framework proposed in the fiscal year 2003 request which includes the reauthorization of TANF. We applaud passage of H.R. 4 and are committed to working with both the House and the Senate to ensure the legislation moves quickly through the process and is consistent with the President's budget. The President's proposal includes 5 years of funding for the TANF Block Grants to States, Tribes, and Territories; Matching Grants to Territories; and Tribal Work Programs at current levels. In addition, the fiscal year 2004 budget reinstates authority for supplemental population grants at \$319 million each year; restore transfer authority to the Social Service Block Grant of up to 10 percent; as well as funding the \$2 billion Contingency Fund with modified maintenance of effort and reconciliation requirements to make it more accessible for States.

The central focus of the proposal strengthens work requirements while allowing States greater flexibility to define activities that will lead toward self-sufficiency. The Bonus to Reward High Performance States would be redesigned to provide \$100 million a year for bonuses for employment achievement. We propose replacing the bonus to reduce out-of-wedlock birth with a new initiative to fund research, demonstrations, and technical assistance activities primarily targeted to family formation. Our proposal includes \$100 million for matching grants, also focused on building strong families and promoting healthy marriages. In addition, the budget proposes to reauthorize State abstinence education grants for 5 years at \$50 million annually to further assist with reducing the number of out-of-wedlock pregnancies, reducing the spread of STDs, and helping teens make healthy life choices. These proposals demonstrate that this administration is committed to strengthening foundations for our children and supporting programs that will empower persons who have not been able to work, for any number of reasons, to achieve self-sufficiency.

Hand in hand with these efforts, the President's fiscal year 2004 budget also follows the framework established in the fiscal year 2003 budget and requests reauthorization of the Child Care and Developmental Block Grant Act and the Child Care Entitlement to assist States in meeting the critical child care needs of families.

Increasing support for children in foster care

In a continuing effort to improve the lives of children who are at risk of abuse and neglect, this administration is proposing a child welfare financing option that States can use to improve their child welfare service systems. This plan will allow

States to choose a fixed allocation of funds over a 5-year period rather than the current entitlement funding for the Title IV-E Foster Care Program. Participating States will receive their funds in the form of flexible grants which could be used for a wide array of child welfare-related purposes, such as child abuse and neglect prevention, maintenance and administrative payments for foster care, child welfare training, and family support. The flexible funding will allow States to develop innovative plans that can be tailored to meet the needs of their child welfare populations. States that elect this option and experience emergencies affecting their foster care systems may apply for access to additional funding from the TANF contingency fund.

The administration is proposing a nearly \$5 billion budget for Foster Care in fiscal year 2004, an \$89-million increase over last year's request. Not only will these funds support the child welfare program option, but they also will be used to provide payments for maintenance and administrative costs for more than 240,000 children in foster care each month, as well as payments for training and child welfare data systems.

The Adoption Incentives Program has been successful in contributing to the substantial increase in the number of children who are adopted from the public foster care system in recent years. The President's fiscal year 2004 budget request includes reauthorization of this important funding. Additionally, we propose changes to the incentive system to target older children, who despite the overall gains in adoptions constitute an increasing proportion of the children waiting for adoptive families. The President's budget request for the Adoption Incentives Program is \$43 million.

Another important issue we face with foster care is the transition for children out of these programs. Last year, nearly 20,000 children aged out of the foster care system. In order to assist these at-risk young adults, the President is committed to maintaining the Independent Living Program, which provides a variety of services for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21. The President's budget request for the Foster Care Independence Program is \$200 million. This request includes \$60 million to provide participants with up to \$5,000 for college tuition or vocational training to youth who age out of the foster care system.

Additionally, the administration continues its commitment to the Promoting Safe and Stable Families Program by requesting to \$505 million to assist States in coordinating services related to child abuse prevention and family preservation. This important program also helps to promote adoption and provides post-adoption support to families.

Child support enforcement

Related to my commitment to strengthening America's families, I am proud to tell you that our Child Support Enforcement program has made some impressive gains. Child support collections hit a record \$20 billion in fiscal year 2002, serving an estimated 17.1 million child support cases and in fiscal year 2001, over 1.6 million paternities were established or acknowledged.

The President's fiscal year 2004 budget will build on this considerable success. Legislation will be proposed to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. For example, States can better benefit from Federal data systems to freeze and seize assets in multi-state financial institutions and to garnish insurance settlements in order to satisfy past due child support. In addition, gaming winnings will be subject to intercept for past due support. When combined with the opportunities to increase child support outlined in the President's fiscal year 2003 budget (expanded passport denial, offset of certain Social Security benefits, optional pass through of child support to families on TANF, among others) these proposals offer an impressive \$7.5 billion in increased child support payments to families over 10 years. The budget also recognizes that healthy families need more than financial support alone and increases resources for the Access and Visitation Program to support and facilitate non-custodial parents' access to and visitation of their children.

HEAD START

The President's budget includes \$6.8 billion for Head Start. This level will increase enrollment of children in those areas of the country with the greatest unmet need. This budget proposal will continue to focus on school readiness of Head Start programs.

RESPONSIBLE FATHERHOOD AND HEALTHY MARRIAGES

The President's budget also proposes \$20 million for promotion and support of responsible fatherhood and healthy marriage. This funding will promote and support involved, committed, and responsible fatherhood and encourage the formation and stability of healthy marriages.

PRESIDENT'S MANAGEMENT AGENDA

I am committed to improving the management of the Department of Health and Human Services, and I realize that as we work to improve the health and well-being of every American citizen, we also need to improve ourselves. The fiscal year 2004 budget supports the President's Management Agenda and includes cost savings from consolidating administrative functions; organizational layering to speed decision making processes; competitive sourcing; implementation of effective work force planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations. We have also included savings in information technology (IT) which will be realized from ongoing IT consolidation efforts and spending reductions made possible through the streamlining or elimination of lower priority projects. I am also very excited about the IT infrastructure consolidation which should be fully implemented by October, 2003, that will further reduce infrastructure expenditures for several HHS agencies.

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

Mr. Chairman, the budget I bring before you today contains many different elements of a single proposal. What binds these fundamental elements together is the desire to improve the lives of the American people. All of our proposals, from building upon the successes of welfare reform to protecting the Nation against bioterrorism; from increasing access to healthcare, to strengthening Medicare and Medicaid; all these proposals are put forward with the simple goal of ensuring a safe and healthy America. I know this is a goal we all share, and with your support, we are committed to achieving it.

Chairman NUSSLE. Thank you, Mr. Secretary.

Let me begin with the budget proposal for Medicare. The proposal has \$400 billion of new resources over 10 years for Medicare. Is that a net number, meaning is that a number that recognizes that we should make reforms within the base part of the program and that the net amount of Medicare should be no more than \$400 billion over that 10-year period?

Secretary THOMPSON. That is correct.

Chairman NUSSLE. Or is that the new number?

Secretary THOMPSON. The \$400 billion includes the changes that we will be making to Medicare. But the giant share of it is for prescription drugs, Mr. Chairman.

Chairman NUSSLE. The omnibus bill that just passed had a \$54-billion 10-year add-on for—

Secretary THOMPSON. That is not subtracted, which a lot of people want to know about. That is not subtracted; the \$400 billion is over and above that.

Chairman NUSSLE. When the budget was submitted, the \$54-billion doctor reimbursement changes were not contemplated and were not budgeted for in 2004 budget cycle?

Secretary THOMPSON. That is correct.

Chairman NUSSLE. How are we going to pay for that then?

Secretary THOMPSON. We are taking that into the base budget that we have in Medicare, Mr. Chairman. But it is not part of the \$400 billion that the President will be advocating in his Medicare proposal.

Chairman NUSSLE. But then, in point of fact, it is a \$454-billion budget?

Secretary THOMPSON. If you add that to it, yes. But the final details have not been totally determined as of yet.

Chairman NUSSLE. Alright. Well, I guess that is what I am—it's either one or the other. It is either added to the 400, or it is part of a net \$400 billion total at the end of the day. But otherwise, \$54 billion doesn't just, as you know, fall out of the sky; it has got to come from someplace.

Secretary THOMPSON. That is correct, Mr. Chairman, and as of right now, the \$400 billion is for the changes the President is going to make and does not include the \$54 billion, which was in the congressional appropriations bill which was signed last week.

Chairman NUSSLE. Alright. Should that be in that number? Should the 54 be included in the \$400 billion or should it be added on?

Secretary THOMPSON. At this point in time, Mr. Chairman, I cannot answer that question because it is still being discussed.

[The information referred to follows:]

SECRETARY THOMPSON'S RESPONSE TO MR. NUSSLE'S QUESTION REGARDING THE
PRESIDENT'S MEDICARE PROPOSAL

The fiscal year 2004 President's budget requests \$400 billion over 10 years for a prescription drug benefit and Medicare modernization. This remains the highest priority of the administration for fiscal year 2004. Congress took action to add \$54 billion to fix physician payments after our budget was released. We do not anticipate adjusting our fiscal year 2004 President's budget baseline to reflect this change until we do our mid-session review. As always, we are monitoring and assessing congressional actions and changes to the Medicare program made after our budget was submitted to assess whether adjustments are necessary.

Chairman NUSSLE. Alright. Well, we need an answer, because I will tell you right now——

Secretary THOMPSON. I understand that and I can tell you that I am pushing very hard to get an answer to all the questions dealing with Medicare, so I can come back in front of you and other members of this committee and tell you what is going on.

Chairman NUSSLE. Do you have an idea of when we will get answers on Medicare? Because when I met with the President in December, at that point in time there was some discussion that this might happen congruent with the budget.

Secretary THOMPSON. Mr. Chairman, I can assure you that my Department and the White House are working extremely long hours to accomplish a proposal that we can give to Members of Congress very soon. It is not quite ready.

I can assure you that it is very close, and we will be giving you all the details very shortly. I can't give you an exact date because, I have found, in this city timelines slip quite easily. And I don't want to—I have been caught up in this before, and if I give a definite time, I would like to be able to honor that; and since I can't tell you that it is going to be on a particular date, all I can tell you is, it is very imminent.

Chairman NUSSLE. Well, let me report back to you about our timeline. We have to have a budget completed by April 15, and it requires us to be in markup here in this committee and on the floor within the next 3 weeks.

Secretary THOMPSON. I understand that, Mr. Chairman. And all I can tell you is, I am pushing extremely hard to make your job easier by getting you the details very quickly.

[The information referred to follows:]

SECRETARY THOMPSON'S REPLY TO MR. NUSSLE'S QUESTION REGARDING PHYSICIAN
UPDATE RULE

The fiscal year 2004 President's budget assumes that the 2003 Physician Update Rule would have been implemented March 1, 2003. That rule would have decreased the physician fee schedule by 4.4 percent. The baseline reflected the current law at the time. The Consolidated Appropriations Resolution, 2003 (CAR) was not enacted until February 20, 2003, after the budget had been released. While the current law budget baseline cannot reflect anticipated changes in the law, even if it could, there was no way to know what the final provisions of CAR would be. The impact of the physician payment adjustment enacted in the CAR will be reflected in this summer's mid-session review baseline.

Chairman NUSSLE. Well—and part of my job is to help make your job easy too by providing the resources to make sure that we can get these things done. But we to get the details on this.

In your testimony on page 4, you say that under Medicare+Choice, “We believe that we should move away from administered pricing to set Medicare+Choice rates” and “the administration believes that Medicare+Choice payments need to be linked to the actual cost of providing care.”

What would you say about the areas where Medicare+Choice is no longer available, such as many areas of Wisconsin and all of Iowa?

Secretary THOMPSON. As you know, when Medicare+Choice started, it grew quite rapidly, and got up to almost 18 percent of the population. Then there was a decision made by Congress, I think in 1998, in which they were going to reduce the payments in those areas where the HMOs were operating and put a higher premium in those areas where they were not operating.

It did not work, and as a result of that, it has not been able to continue to grow. In fact, it has slipped from 18 percent down to about 11 percent of the population. And what we are trying to do is put it on a financially solvent footing so that it will have the opportunity to continue to grow. The seniors that are in it like it, and if they have the opportunity, they will make that choice. But we have to make sure that companies are able to continue to furnish the product, namely the Medicare coverage.

Chairman NUSSLE. Well, I don't usually do this, but I am going to make the announcement right now. I am not voting for Medicare+Choice unless or until I understand how it is going to be in your part of Wisconsin and my part of Iowa, and I mean now.

It is not going to be enough to come forward with another fill-in-the-blank stopgap kind of Medicare+Choice proposal that we blindly assume is going to do the job, when it never has in our areas. We are done with it. And I mean, I—you know, I have blindly voted for a number of these proposals on the blind faith that, in fact, the marketplace will work and that we will be able to provide these kinds of opportunities for seniors, but I am announcing to you right now, I am done and I am on the authorizing committee and that is one vote.

Now—and I am not threatening. I want to work to get this thing done right, but I will tell you that based on the track record, you don't have one vote right now unless I see how it is exactly going to apply to my next door neighbor across the street in Manchester, IA, and whether or not she is going to have coverage under a

Medicare+Choice plan or whether her reimbursement rates to her doctor or her hospital are going to be commensurate with their ability to stay in business and keep their doors open, period. Done.

I don't have any more room to negotiate on this. And I hate to say it that way, but it has lasted too long.

Secretary THOMPSON. I appreciate your comments. But let me just respond by telling you that the Medicare+Choice is an HMO, among other things. I have been in just about all the meetings and I want to be able to tell you, and tell all the members of this committee the President's plan is not going to force seniors into Medicare+Choice or into HMOs. It is going to be a different concept. And it will be based on the Federal Employees Health Benefit Program, which is in all areas of Iowa, which is in all areas of Wisconsin, which is in all areas of Alaska, whether you are a janitor in a Federal building, a warden or an FBI agent, every single Federal employee has had the benefit of the Federal Employees Health Benefit Plan. It is a competitive market, and we are looking at that procedure.

It is not the Medicare+Choice that you are talking about, Mr. Chairman, and I want you to know that. There is nothing in the President's proposal that is going to force—and I want to restate and to restate this once more, there is nothing in the President's plan that will force the senior into an HMO plan.

Chairman NUSSLE. Well, pardon me if I went off on a tangent then, but since we don't know what the President's plan is, you can pardon us for maybe not quite understanding what is in the plan.

Secretary THOMPSON. I understand that, and it is my responsibility to get that proposal to you as soon as possible, and I will endeavor to make sure that happens as quickly as the President makes the final decisions.

Chairman NUSSLE. I appreciate it.

And I yield now to Mr. Moran.

Mr. MORAN. Thank you very much, Chairman Nussle. And I am going to follow up on your line of questioning because I would agree with you.

Whereas the Secretary says that this is going to be comparable to FEHBP, I suspect you are going to be putting people into PPOs if not HMOs. But it seems to me that if this is going to be viable of both, substantively, policy-wise as well as political, it ought to be as good as what the members provide for themselves. The President wants——

Secretary THOMPSON. I agree.

Mr. MORAN. You agree. OK, I am glad we will begin from that assumption.

The President wants seniors to pay a \$275 deductible each year; most Members of Congress pay no deduction for prescription drugs. The President wants seniors to pay 50 percent coinsurance for the first \$3,000 worth of medicines; most Members of Congress pay 25 percent. The President wants seniors to have a gap in coverage where they pay 100 percent of costs when their need is between \$3,000 and approximately \$7,000 for drugs; most Members of Congress have no gaps in prescription drug coverage.

So if those are the criteria, I think we need to bear that in mind, because we can't sell a plan that is considerably worse for our con-

stituents than it is for ourselves. And most of us are under this FEHBP plan.

Under the President's proposal, as we understand it, seniors would spend \$5,500 of their own money each year on medicines and would get help with only 20 percent of their drug costs under the President's plan. Our Congressional Budget Office estimates that Medicare beneficiaries will spend more than \$1.8 trillion on prescription drugs between 2004 and 2013. Even if every dollar of the President's proposal went toward prescription drug coverage, and it doesn't because you have got three other areas of expenditures included there, so it looks like it is only about \$300 billion for—specifically for prescription drug coverage. But even if it were \$400 billion, the plan would only cover 22 percent of beneficiaries' medication needs.

Now, that's Medicare. With my time, I want to get back to Medicaid because you said something about crawling from Wisconsin.

Secretary THOMPSON. Not crawling. Walking.

Mr. MORAN. Not crawling. Walking. OK, I don't want to exaggerate. You would walk from Wisconsin to Washington in favor of this plan. But apparently your sentiments have changed since April 14, 1997, Governor Thompson, where you signed onto a letter to President Clinton, where you said, "We adamantly oppose a cap on Federal Medicaid spending in any form."

Now, this block grant is a cap on Medicaid. Well, that is the way you interpreted it when you were one of the leaders of the National Governors Association and signed onto this letter, because that is what block grants are all about. It is a method of capping entitlement programs.

And I am sure you are familiar with this letter of April 14, 1997, so I won't go into great detail on it. But I refer people to it if they question where the Governors are likely to stand.

Those are our major concerns: Medicare, Medicaid and then some of this discretionary spending.

You know, we can't understand how we can have \$1.3 trillion in tax cuts and yet some of the cuts that are in discretionary programs for the disadvantaged.

You know, here, this budget proposal would mean that at least 36,000 seniors would be cut from Meals on Wheels in this program. I can go down a half a dozen other programs that are in this budget. It just seems to be misplaced priorities.

So that is where we have our problems. It is Medicare, it is the Medicaid block grant, and it is the very substantial reductions in discretionary programs. There is not a lot of money for each of these individual programs, but as the President has said in any number of quotes, it means a great deal in the lives of people in need.

So I am not going to ask any questions. My colleagues are going to do that. But, again, I hope you have the answers to their questions.

Thank you, Mr. Secretary.

Secretary THOMPSON. Mr. Chairman, can I please respond?

Chairman NUSSLE. Yes.

Secretary THOMPSON. Congressman Moran, first off on Medicare, I will be more than happy to sit down with you and go through the

plan as soon as all the decisions are made; as I indicated to the chairman, I will be more than happy to do that. I would like to work with you and come up with a Medicare plan that you could support on a bipartisan basis.

Medicaid: I was one of the leaders when I signed that letter. Do you know what President Clinton was trying to do? He was trying to cap Medicaid on a per capita basis and take \$8 billion out of the system. That is completely contrary to the program that I am advancing.

Let me explain. We are not capping the program on a per capita basis. In fact, the mandatory coverages are not capped; they are the same as the current Medicaid program.

The optional programs, which States now have the opportunity to drop, are dropping in record numbers—36 States last year, and 42 States have got pending drops this year of over a million individuals under the current Medicaid law; the only thing that States and legislators can do is to drop whole populations. They cannot redefine the program and keep the coverage and keep the Federal dollars. The Medicaid proposal I am advancing allows them the flexibility to do that.

The second thing is, it advances \$12.7 billion over 7 years so that States are going to get an additional \$3.25 billion this year, so they can set up their own programs and use flexibility in order to accomplish what you want to accomplish. What I want to accomplish is to keep individuals covered under the Medicaid system.

The third thing is, under the current law there are three provisions in which States have to advance payments each year; they make these determinations in September and October. Each year the base budget for the States' portion of Medicaid has three factors which they have to put into consideration to determine what their next year's payment is going to be. It is based upon population increases within your State and utilization and indexing of medical costs in a particular State.

Under the proposal we are advancing from the Department, the first two, the population increases and the utilization, are not going to be factors anymore. So it will only be based on the third factor; the indexing of the medical costs. Last year those increases were \$12.7 billion. So, if you pass this particular program, States would only be paying approximately \$4 billion. Therefore our net savings is over \$8 billion of State contributions in order to get the same Federal match.

So the States are going to pay less, get more money up front, which they will not have to pay back; and they will have complete flexibility to design the program so more people can be covered.

Medicaid is growing at a rate of 9 percent a year for 10 years, and so 9 percent for 10 years is the line that we have to budget for. And for the first 7 years, States that voluntarily take this program will be above that line, and only in the 8th, 9th and 10th years will they go below the line. But they will still get increases; instead of 9 percent, it will be about 6 percent. But for the first 7 years, they will have complete flexibility, will not have to pay that money back, and the mandatory coverages will be the same.

So it is not a block grant because it continues to rise. There is no block grant because the population increases, the mandatory

population increases, the money increases, and so do the responsibilities and the accountability put on by the Federal Government.

Mr. MORAN. Thank you, Mr. Secretary. President Clinton's intent was exactly the same amount of money. And I know his intent was to achieve the same savings, but we haven't compared it in total. But I do think there is a lot of commonality to the plan that you rejected in the past.

But I appreciate your explanation. Thank you, Mr. Secretary.

Chairman NUSSLE. Mr. Gutknecht.

Mr. GUTKNECHT. Thank you, Mr. Chairman.

Mr. Secretary, Governor, I will try not to be as tough on you as some of my colleagues here, but I think you can understand there is a good deal of frustration. And as a former Governor, part of the frustration we are feeling on this committee is, we are having unlimited demands right now on a very limited budget, and frankly, as I mentioned to several of the other Secretaries, you know, we have had debate about economic theory and supply side economics and tax cuts.

I tend to be a supply-sider. I tend to believe that during soft economic times it is a good idea to allow Americans to keep more of their own money. But I have to say, first and foremost, that is a theory, and this is a fact. The fact is that government will be paid; it will either be paid for now by us, or it will be paid for in the future by our children, with interest. And as a former Governor, I know that early in your governorship of Wisconsin you were very effective—probably made the most effective use of the veto of any Governor I have ever seen. And if I recall, it wasn't so that you could add more spending to what the legislature was passing. It was to cut spending.

The dilemma here is that even with the President's budget as he has submitted it, we are looking at very, very large deficits, and not only this year, but for several years to come. One of the problems that the Governors are having, and I am sure you have talked to Governors and probably your successor—I met with our Governor, our new Governor, a few weeks ago and he told me that roughly a third of his problem that he is having to confront in the State of Minnesota in terms of his budget deficit is the cost of health care. My concern is, and I share some of the concern that the chairman mentioned, is that we are just going to nibble around this thing and not really deal with it. Because my real concern is, as a country, I don't know—and I represent—I mean, the biggest employer in my district is one of the finest health care institutions in the world, and so we are very interested in making certain that every American has access to top-quality health care. No question about that.

But can we afford, as a nation, to have a system that is somewhere near 14 percent of gross domestic product for overall health care? It seems to me that we have got to get serious about real reform, and we can't just be shifting around dollars. And I think, in some respects, Mr. Moran is correct. It seems to me that we have got to come up with a system that is sauce for the goose and sauce for the gander; I think it has got to be fair to everybody. And the problem, it seems to me, that we have is we have set up various levels of health care delivery.

We take care of seniors one way, we take care of Federal employees another way, State employees another way; and I do think that ultimately it is drawing down our economic growth rate.

I have met with a lot of business people in my district. I have talked to big business people, small business people. I have talked to two of them in particular I will mention. One said that part of the reason he is not hiring more people today is that his cost for health care per employee is about \$550 per month. He is in a very competitive marketplace, and he said, "I simply can't afford to bring more people on because of the high cost of health care."

I talked to another individual last week, and he employs 134 people. This year his health care costs were going to go up 50 percent—50 percent. So what he did was he dropped the health care insurance for all of his employees. He simply gives them an additional \$550 per month to buy their own insurance.

And I guess I want to encourage you to look not only at what we are doing and what you are recommending, but I think we are going to have to look completely outside of the box. And I guess I had a bit of an epiphany when I was over in Taiwan a month ago. Their costs for health care in Taiwan—and I am not saying it is the model, but I think it is an example—where they are spending 5 percent of their gross domestic product. We are spending almost 14 percent. I am not sure how long we can afford a health care system in this country that is consuming that much of our GDP.

We want to work with you. And we wish you all the luck, you are one of the toughest Secretaries in this Cabinet. If anybody can do it, you can do it. We want to help you.

Secretary THOMPSON. Congressman, thank you for that open-ended question. I appreciate everything you have said, and I would like to respond point by point. First, it is 14.8 percent of GDP, and if we don't make a change within the next 15 years, it will be 18 percent of GDP.

As for the second thing you talked about, the Mayo Clinic—it is a fantastic place. In fact, I had one of the chairmen of Mayo Clinic in charge of my regulatory reform, another cost driver. He came in with 250 changes with his commission, and held five hearings across America. We have already made 35 of those changes, such as eliminating paperwork, and streamlining efficiencies.

The third thing you mentioned was your Governor, Tim Pawlenty from Minnesota. His biggest driver is Medicaid. This proposal, the Medicaid proposal, will be a godsend to the State of Minnesota. It will lower his payments by two-thirds that he has to pay in on the increases of that amount he would have to pay. I don't know what Minnesota's share is, but I can tell you, he would appreciate that.

It would give him flexibility so that he could develop a Medicaid program in which he could use different programs and different benefits for southern Minnesota, central Minnesota, and northern Minnesota. This is something he cannot do under the Medicaid law. It would advance payments so that he would be able to get additional money right now over the next 7 years to set up a new system.

We would require him to split the population into acute as well as long-term care and, therefore, we would be able to develop new

ways to keep seniors out of institutions and use the flexibility to do it.

The Medicaid proposal that I am advancing is way out of the box, and I would strongly urge you to strongly consider it. Medicare I cannot talk about except in general terms right now because the final details have not been made.

You talked about thinking outside the box. Let me tell you what has to be done if we want to do this on a bipartisan basis. The first thing we have to do is pass a Medicaid proposal; we have to pass what I think is the best idea. It is based upon the very successful TANF and SCHIP programs. It would help every State that voluntarily goes into it.

Third, we have to pass a very good uninsured proposal. I have got great ideas that I think that you would like to see in which we could actually pay for it, but—it would cause some angst, but it would deal with, and get a lot of the uninsured covered.

The fourth thing and the biggest driver—and this is one thing that Congress has got to address—is preventative health. We spend \$155 billion a year on tobacco-related illnesses; 400,000 people die. We spend \$117 billion a year on obesity-related illnesses, and 300,000 people die. We spend \$100 billion on diabetes, and 200,000 people die. Seventeen million people have diabetes; 16 million are prediabetic and if we do nothing in the next 5 years, there will be 33 million people that have diabetes.

Ninety-some million people in America have chronic illnesses. You can usually stop the chronic illnesses by exercising, watching your diet and quitting smoking.

If we are willing to take on those three things, it would be the biggest driver of reducing costs across America. And when you add those three things, \$115 billion on tobacco, \$117 billion on obesity and a \$100 billion on diabetes, you are at over \$300 billion, and we are only spending \$260 billion a year on Medicare. So, this is where you are going to have an impact.

Mr. GUTKNECHT. Thank you.

Chairman NUSSLE. Mr. Spratt.

Secretary THOMPSON. I get a little emotional about that. I am sorry.

Mr. SPRATT. Mr. Secretary, I was not here to welcome you when you came, and I apologize.

Secretary THOMPSON. I am so happy you weren't, but I am glad you are here now.

Mr. SPRATT. I appreciate, as always, your forthright testimony. I don't have any questions at this point, but thank you for coming.

Secretary THOMPSON. Thank you very much for being here.

Chairman NUSSLE. Ms. Hooley.

Ms. HOOLEY. Yes. Thank you.

And thank you for being here. It is always nice to have a Governor who has been in that spot before and understands what the States are talking about. Again, I thank you for being here.

Medicaid—I am going to talk about two things, Medicaid and Medicare. Medicaid is one of the fastest rising costs in the State budget. In Oregon, Medicaid covers about 450,000 people; that has been increasing by 10 percent a year. Currently, Oregon is in a tough financial situation, not unlike a lot of States, but we are the

number one unemployment State. We have cut days off our school year, we have made huge cuts to public safety, we are laying off State troopers and we are making State cuts to Medicaid.

We have a projected \$400 million budget shortfall in Medicaid alone, and we have already cut prescription drug benefits, alcohol and drug treatment, those things that are preventative—mental health benefits for many Medicaid recipients. And we have had people come and talk to us: You know, they are getting kicked out of nursing homes, they have got \$1,000 a month drug payments that they can't make.

As we look at that \$12.7 billion for participating States to encourage them to restructure their Medicaid—and I know you know this about Oregon—this is not what we need. We won't receive much of this money because we restructured our Medicaid program 10 years ago with the Oregon health plan. And it has been one of the most successful Medicaid programs in the country. We need money to fund Medicaid, not money to change it.

While reduced revenues are placing severe strains on many State budgets and could limit Medicaid at a time when additional coverage and spending is most needed, the Federal Government's share of the cost will only increase a fraction of a percent for 2004. Increasing the Federal Medicaid assistance percentage just by 2.45 would provide Oregon with an additional \$1.7 million over the next 18 months, something we desperately need.

How are you going to—how do you address Oregon's needs when we desperately need assistance and would not benefit from the \$12 billion program that you are talking about, because we have already changed and restructured our program?

Are you going to give us a special dispensation?

Secretary THOMPSON. First off, the reason you were able to change is through the waiver process.

Ms. HOOLEY. I know that.

Secretary THOMPSON. And the reason that Oregon has been successful is, they have used the waivers which I have granted, as you know.

Ms. HOOLEY. I do. I understand that. Thank you.

Secretary THOMPSON. Several of the waivers do it.

This plan is based upon TANF, it is based upon the SCHIP, and it is based upon the waivers that I have advanced since I have been Secretary. In fact, I have advanced 2,500 SCHIP plans, waivers and Medicaid State plan amendments. Oregon has received several of them to redo their plan. But Oregon still has several problems. It still is restricted under the current Medicaid law.

Let me explain. Oregon has urban areas, it has rural areas. I spend a lot of time in Oregon, so I know the State, and you have got the mountains on the east, versus the plains and the ocean on the west coast.

Ms. HOOLEY. Right.

Secretary THOMPSON. And so you have different things.

But you cannot, under the current Medicaid law, even with your options, have any kind of differentiations as far as benefits or as co-pays or as being able to use the SCHIP money.

Oregon was not able to use all its SCHIP money. It had to send some back because it is SCHIP money. Under this proposal, Oregon

gets to keep all of its SCHIP money and is able to use it. That is point No. 1.

The second point, the \$12.8 billion, the \$3.2 billion this year would give Oregon an additional 2-percent increase on the Federal match. Oregon, if it voluntarily went into the program, would get another 1 percent of the Federal match by paying less into it. So instead of your 2.45-percent increase on the Federal match that you are asking for, if Oregon went into this program voluntarily, which I am sure they will, they will get a 3-percent increase on their Federal match.

That is the dollars that they need in order to make this program work. That is why you should be enthusiastically supporting this program and be one of the prime sponsors for it.

Secretary THOMPSON. This program is one of the most helpful programs for Oregon and New Mexico and Tennessee, States run by Democratic Governors. And each one of those individual Democratic Governors know that.

Ms. HOOLEY. Let me ask you a second question. I want to follow up on our Chair's question about Medicare. And again, we were very efficient in how we dealt with health care in our State, and then a long time ago when the formula came up for Medicare, we got the short end of the stick like many other States did. You have got seniors—the same program, everybody pays into this program, and yet you have got seniors in some States reaping the benefits of—they have prescription drug benefits, they have eye care, they have hearing care, and we have—our State is under-reimbursed. We have doctors leaving the system. They will not take any Medicare patients. They will not take any more Medicare patients. And are we ever going to get to a solution to this problem where it should be equal across the United States?

And I don't begrudge anyone any benefits they receive, but it seems to me if you have a program that is a national program, that it should treat people equally, and this program doesn't. Do you see a solution at the end of the rainbow?

Secretary THOMPSON. I see lots of solutions. I am extremely optimistic. I think if we have the will, Congresswoman, we have the opportunity to change Medicare for the best. There are some very inequitable provisions in it. Medicare needs a complete review by Congress and by the administration, and if we had the political will to do that, we could change it.

Just to give you some ideas, there is something in the law that requires different payments for urban hospitals versus rural hospitals. It is a 1.5-percent difference. That could be changed. That could be uniform. There are MSAs in Iowa; there are 12 different areas in Iowa that have different hospital assessment areas in order to determine the formula and only one formula area for doctors. Now, that could be changed, and so that would be a uniform thing based upon a different kind of a formula.

There has to be the will to make these kind of statutory changes legislatively. We can give you a whole list of them, but as long as the government is the driving force for all medical costs, and it is based upon reimbursement formulas that have been built up since 1965 to the present, you have to really change it or change the model so that you have competition from the Federal Employees

Health Benefit Program in order to benefit the kind of changes necessary to have a national system. And it can be done. It is going to require some bipartisan support to do that, but ideas are out there. If we sat down across the table, we could certainly, I am confident, come up with a solution and come up with a much better proposal that would treat more citizens more equitably. Whether or not we get rid of all the inequities, I can't promise you that, but we could reduce them.

Ms. HOOLEY. I would like to get a little closer.

Secretary THOMPSON. So would I.

Ms. HOOLEY. And happy to work on that. It seems to me such an unfair situation in this country.

Secretary THOMPSON. I hope you would want to work with me on the Medicaid system, because I know that the proposal I am advancing would be tremendously helpful to Oregon.

Chairman NUSSLE. Mr. Ryun.

Mr. Hulshof.

Mr. Garrett.

Mr. GARRETT. I always appreciate coming to these meetings because the chairman often—I know he digs through this material more than I do and throws out little tidbits that strike me. And then in his opening comments when he stated that I guess in the not too distant future that if we take Medicare and Medicaid and Social Security and combined that, that will be consuming the entire Federal spending it just gives you pause to think that is where we are going with it.

I also appreciate that in the time that I have been here as the freshman, to hear the folks, we have been able to have experts such as you come before us and to hear questions a lot harder than mine, because I sure don't have the answer to this either, but I look forward to, with this administration, putting forward something that we can work with that will at least lead us down the road the right way.

One of the numbers that I remember the chairman mentioned at one of the meetings that we had previously was talking about how Medicare spending is going just as it is right now, and as I understand your initial comments with \$400 billion is essentially—and the way I look at it and the way you are saying is for prescription drugs primarily, that addition to the program after we complete any cost savings from the reform in the proposal that you will be presenting to us—but the numbers that I have seen before is that Medicare spending is about \$269 billion, and it is projected to nearly double in the next 5 years, and by 2013—and I know you are not going to spend the \$400 billion evenly, but even if we were to spend it out over a 10-year period of time, it averages out to \$40 billion per year. So if you didn't do anything, you would be seeing a \$25-billion average increase in the Medicare problem, which is part of the problem in essentially going in debt totally.

But we are taking that \$25 billion figure and adding on top of it, if I am understanding it correctly, another \$40 billion on average, which is, I don't know, around a 165-percent increase. And nothing that I have seen so far says that that is going to reverse the overall trend of what the chairman was saying at the outset, that eventually we are going to see Medicare, Social Security, and

Medicaid consuming everything. We may be slowing the pitch of the chart on the graph a little bit, and in some ways maybe we are—by the reform, but by adding the prescription drugs and the \$400 billion to it, actually we are throwing that red line up even further, aren't we?

Secretary THOMPSON. Absolutely. You can't add a benefit of prescription drugs, which is going up at 13 to 15 percent a year, without having that trend line increase. It is impossible. So the only way to compensate for that is to make some kind of changes in the basic system in order to make it more efficient, and that is what the President and the administration are trying to do.

What I have told a lot of people is that this is the dessert. Everybody wants prescription drug coverage, and everybody supports prescription drug coverage, Republicans and Democrats and Independents. And the seniors need it, there is no question about it. But if we don't make some structural changes to the model, to the delivery system, this Congress, I don't think, will ever come back until it is a crisis situation.

That is why we need to make the changes with a prescription drug program so that we can try and put it on a better financial footing, but it will not go back to where it is right now. Prescription drugs is an expensive add-on, and it is going to be more expensive in the future with prescription drugs added on, even with the changes that we are advocating.

Mr. GARRETT. I will close in the numbers I know this House passed before I was here, the additional program in their bill, that was a \$13.3-trillion increase. The Senate Democrats had their own version, but theirs would have increased to a \$20-trillion increase. I appreciate this is an add-on. With the overall budget question, how in the world do we add that on today until we can confirm that we are going to overall bring the line down by the cost savings? And until we—because even though what you are saying is, well, do the reforms, we will save a little money or maybe a lot of money through the reforms, but we are going to add on the prescription and not add benefits.

One of my constituents said to me, how can we be doing this and adding it on, providing the benefit to the seniors today if my grandkids are going to be ending up being the ones paying for the seniors' health benefits?

Secretary THOMPSON. It is not a one-for-one situation. The changes that will be advocated will not bring it into line. This is going to require some real heavy lifting by Members of the Congress and the administration. But the first thing is not to exacerbate the situation so badly that we can't get back there. And just adding on prescription drugs without any kind of corrections is just, to me, not acceptable, because all you are doing is driving up the cost, and there will be no driving force for anybody to get back.

The driving force for people to look at Medicare right now is prescription drug coverage, and so it is important for us to take a look at the model, the delivery system, so that we can make some changes now and hopefully other changes in the future to make it something that is going to be around for your children and grandchildren and great grandchildren in the future.

Chairman NUSSLE. Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Secretary Thompson, thank you for your testimony this morning. As a former Governor, we have had a chance to work together before, and I want to thank you for being here.

I want to follow some of the line of questioning regarding Medicaid. Those of us who have been following this have seen more generalities, and in your previous testimony in response to previous questions we are getting a little bit more of a first glimpse of some of the details behind the proposal. I want to, first of all, make sure that my understanding of the big picture is correct, and then probe a little more on the details, especially as you note on your testimony, prepared testimony, that the States are facing incredible budget crises, that many have—in the last year 38 have reduced services or eligibility, and most are considering further benefit and service and eligibility cutbacks this year.

As I understand it, overall States could decide not to join in the flexibility program and operate their Medicaid programs without any sort of additional relief from the Federal Government. And certainly as the States are progressing with budget crises, this could resolve in deep Medicaid cuts for the States. In the alternative they could receive funding or these advances, \$12.7 billion over 7 years, but only if they agreed to convert much of their Medicaid program, and we are going to dispute the terminology, but into a block grant or some new structure. And this would be capped, as I understand it, according to a fixed formula and would not automatically rise as the current formula does to meet increases in need perhaps due to a recession, or a rise in the number of families in poverty in a given State, or the costs of health care in a given State. Also, then there is this provision in the final 3 years of the 10-year plan of paying back the additional money.

I have several concerns as I understand that outline, if I understand it correctly. I also want to draw your attention—I suspect you are already aware not of the activities of the National Governors Association in 1997, but this year they posed, as I understand it, a significant number of questions to tease out the details of this program. We have been given copies of their communication of earlier this month. Those are precisely the questions I am eager to get at, questions concerning the mandatory core, you know, what happens for the remaining mandatory populations with FMAP; and does it go away, is it reduced; financing; our questions, like are the utilization in populations' projected increases based on the national average or on the individual States' averages? Just a wide variety of questions.

I would ask as you answer the National Governors Association and get those details that you provide them to my office, and, I suspect other members of the Budget Committee would be very interested to hear those details so that we can scrutinize this more carefully. And I would ask your timeline on that.

And lastly, and I will give you the floor to tackle some of these, I want to just make a little bit of note about the governance of these programs as States opt in, if they do.

We know that in the Medicaid program we have used the States as laboratories. The waiver programs have permitted the States over the last several years to engage in all sorts of experimentation

with limited controls at the Federal level, but these have predominantly been transactions between the executive branch of the Federal Government and the executive branch of the State governments. As a former Governor, I know this is probably attractive; but as a lifetime legislator, I know that I am concerned about the legislative oversight. A vast amount of experimentation is taking place with very little guidance from the Congress or from the respective State legislatures, and, in that same contrast, to other arenas in which we have done State experimentations. Wisconsin's welfare experience would be an example.

So I would like to hear your comments also on the governance issue and accountability to the people of States through their legislators.

Secretary THOMPSON. Well, thank you, Congresswoman Baldwin, and it is always a pleasure to see you. And let me just answer every one of your points.

A lot of people don't understand Medicaid. First off, this is not a block grant. A block grant by definition is level funding. TANF is a block grant. It is \$16.8 billion a year for 5 years. Medicaid has a trend line. It is growing at the rate of 9 percent a year. We have to budget for 10 years. So, we take a look at the figures and the computation that States send us in September and October each year, and we make an actuarial judgment, and our actuarial judgment is that Medicaid is going up 9 percent. Next year, or this year in September, October, based upon cost accounting and other things, we may adjust that figure to 10 percent because we think that is probably where it is going to go.

So, Medicaid has got a trend line. The Federal Government funds that trend line, and it is always going up. So you can just draw a trend line increasing at 9 percent a year and that is the Medicaid budget which will continue to increase.

Second, there are mandatory populations, and there are optional populations. One-third of the Medicaid population is optional population; two-thirds is mandatory. Two-thirds of the cost of Medicaid are the optional benefits added on by Governors and legislators. So you have one-third of the population, two-thirds of the cost on optional populations.

Governors and State legislators right now are dropping those optional populations because they either have to drop it or continue to fund it. There is no middle ground. They can't change the mix. They can't increase copayments. They can't change from geographic locations from Madison to Superior. It has got to be uniform. So the only choice State Governors have, and legislators, is to drop it, and they have dropped over a million people last year, and this year there will be 42 States making further cuts into it.

I am trying to change the program so that they can change that mix and give them the opportunity to be able to differentiate between Madison and Superior, maybe add some copayments and keep the Federal dollars in Madison and in the Medicaid system and keep those people covered. You should like that, and I know you will if you listen to my explanation.

The third thing is, each year the States have got to make a computation. Wisconsin pays 42 percent in the Medicaid budget. The Federal Government pays 58 percent. We get a pretty good deal in

Wisconsin. We get 58 percent. But the Governor and the legislature have to increase that 42 percent each year based upon three factors: What is the population increase in Wisconsin? What is going to be the utilization? And what is the indexed inflation of medical cost? So those three factors each year have to be added on to the State's base of 42 percent.

We are saying under this new proposal that States would voluntarily have the opportunity to join if they want to; that we will forgive them not having to make payments on population increases or on utilization, only on the inflation index. So that means the State legislature, in order to get the 58 percent, will be paying less, which means that the percent increase will go up by the Federal Government just by the terms because States will pay in less, which will mean the percentage for Wisconsin will go down. The inflation index increase will go up for the Federal Government mathematically.

The fourth thing is that gives the Governor and the legislature this money to spend and the ability to use it. Also under this program, the SCHIP program, the disproportionate share for hospitals, the administration, and Medicaid, which now are four checks sent out quarterly on a draw-down by the States, will be two checks. They will be able to go to the State in two checks, one for acute care and one for long-term care and prevention. Because the long-term care and prevention States and Federal Government have really never really looked at, and what I think, that is going to be the increased cost in the future. I would like to see the Federal Government use this long-term care opportunity to be able to find ways to keep more people in their own homes, and they will have that flexibility to do so under the new model.

Then you said they have to pay it back. Wrong. They don't have to pay it back. If the States would take it, if Wisconsin would take it, instead of getting 9 percent, they would get 12 percent the first year, then above the trend line. Do you follow me? The trend line is 9 percent, they get 12 percent, then they get 11, then 10 percent, then 11 percent. They would always be up above the 9 percent for the 7 years. But then in the 8th year they would drop below the 9 percent, but still get an increase of, say, 6 percent, not have to pay any of this money back. They would still get an increase of 6 percent, 7 percent, and 8 percent for the last 3 years. They would still be getting an increase, but they would have the use of the money, the flexibility for adopting new systems and new ways to be able to accomplish that.

And then on top of that, SCHIP is also a capped program. I don't know if you know that. SCHIP is a capped program. And SCHIP each year, if the States don't use it, has to be sent back after 3 years. Under this program, this would be on top of the Medicaid program. And for those States like Oregon who have a system that can't use the SCHIP money, and it goes back into the Federal Government and gets redistributed, Oregon would be able to use that money for helping low-income families. And so it is a wonderful thing for Oregon, it is a wonderful thing for Wisconsin, it is a wonderful thing for every State.

And then you asked about oversight. I want you to know that, yes, I have been aggressive. When I was Governor, Wisconsin re-

ceived more waivers and we still have more waivers outstanding than any other State. I was very innovative, as you know, and I used the waiver process under the Clinton administration, under the first Bush and under the Reagan administration to get waivers to try things new. BadgerCare was one of my programs; family care, senior care, and welfare all were waiver programs that I used the Federal dollars in the Federal system to set up. And since I have been Secretary, I have granted more waivers than all previous Secretaries combined. And I am not shy about it, I am not bashful about it. I have to make sure they are budget-neutral.

But under the waiver program that I have utilized with the States—and the Democrats and Republican Governors all have proclaimed that this is fantastic because they are able to set up new systems, we have been able to expand the system so that under the waivers that I have granted, 2.2 million more Americans today are covered by Medicaid and by Medicare; 6.7 million more Americans have increased benefits. And I am using the waiver proposal, the TANF proposal and the SCHIP proposal to come up with a new streamlined, modern Medicaid proposal that will be bigger and better than TANF, and all you have to do is learn the details, and I am confident, knowing your intelligence and your willingness to help people that need health coverage, that you will be one of my most enthusiastic backers and supporters for it.

Ms. BALDWIN. One quick follow up on that detail.

Chairman NUSSLE. The gentlelady's time has expired, and the question consumed three more answers' worth of time.

So Mr. Hensarling.

Mr. HENSARLING. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for your testimony today.

Before coming to Congress, I was in private business for 10 years, which to me is all about going out and figuring out the goods and services people want and then producing them at the lowest price, which has produced the great American dream. However, we have a huge amount of our medical dollars that are spent in this country run through the government.

One of the things I saw a number of months ago on the national press was a report that Medicare was spending five times as much on the same wheelchair as the VA did. Now, I know often the media doesn't quite get it right, but I do know in the fiscal year 2003 budget that the President's budget included competitive bidding for durable medical equipment, and I am under the impression that this budget does not include that proposal. If that is correct, why wouldn't you want to have competitive bidding for this?

Secretary THOMPSON. We do want it.

Mr. HENSARLING. OK. Is my information incorrect? Your proposal does include competitive bidding?

Secretary THOMPSON. Competitive bidding is going to be in the new Medicare proposal, sir.

Mr. HENSARLING. OK.

Secretary THOMPSON. It is absolutely—yes.

And another thing is I was hoping that Congress would change the contracting provisions that the House passed last year, which are arcane and as expensive as anything that we want. If you want to do something to help me a great deal to lower the Medicare costs

and make it more efficient and more uniform, as several people have asked, change the contracting provisions as well.

Mr. HENSARLING. What else might be on your laundry list, since I am a firm believer that government can act smarter and still be able to deliver greater health care services without necessarily taking more money away from the American taxpayer? What else might be on your laundry list for Congress?

Secretary THOMPSON. Thank you. I have been waiting for that question. Thank you.

I would like to find you or anybody else who would like to sponsor a very progressive proposal for the uninsured. I can give you the details. I would like to have you sponsor a proposal for preventative health on diabetes and asthma and obesity, which would be the biggest savings.

I would like to change the contracting provisions. Right now we are required to get recommendations from State medical societies and hospitals in order to enter into a contract for our contract carriers and our financial intermediaries. And we have to do this, and we can't consolidate them, and we can't require accountability. Can you imagine that? If you change that, it would be great.

The fourth thing I would like you to do is I would like you to take some of the fraud and abuse money and set up a quality improvement. I have got the details. I need somebody to sponsor it, you know, take that money and be able to put in a mini Hill-Burton law.

What is your name?

Mr. HENSARLING. Hensarling.

Secretary THOMPSON. Mr. Hensarling, let us make it the Hensarling proposal, OK?

Mr. HENSARLING. If anybody could spell it.

Secretary THOMPSON. H-E-N-S-A-R-L-I-N-G. Alright. And put that money in and be able to use that money as a match grant for hospitals and clinics to be able to tap into to come up with uniform new technological devices. It would reduce mistakes, improve efficiencies. We could develop almost a paperless system, which would drive down the cost. And then on top of that do something on the medical liability system, and we would reduce the cost of health care tremendously.

And I have got ideas, and I have got legislation and programs. I just can't introduce them.

Mr. HENSARLING. Thank you. As my time is running out here, could you give us a little more detail of the savings that could be derived from a meaningful medical liability reform?

Secretary THOMPSON. That could be billions of dollars. Total cost to the Federal Government right now is about \$28 billion. But that is just the cost that the Federal Government pays in liability judgments. That doesn't take into consideration the defensive medicine, which is hard to quantify. But if you want to, we can try and quantify it, but the actual amount is about 20 to \$28 billion that we can actually itemize.

Mr. HENSARLING. Thank you, Mr. Secretary.

Chairman NUSSLE. Mrs. Capps.

Mrs. CAPPS. Secretary Thompson, welcome. I want to ask you about an issue we have discussed many times in the past. In fact,

a couple weeks ago at Energy and Commerce Committee I brought up the topic of the nurse shortage. Nurses are critical to everyday health care as well as our Nation's efforts to prepare for terrorism and bioterrorism, and clearly the current shortage compromises these efforts. We have to keep in mind that currently some 19,000 nurses in the work force today are also in the Armed Forces Reserves. As they are being called up, our public health system becomes even more compromised. And I know you and I agree, and we have talked about the seriousness of this issue.

I was very pleased to read in your fiscal year 2004 budget in brief document, wonderful language talking about the nurse shortage. You know I agree with it, and that is why we worked so hard to pass legislation last year, signed into law, addressing the growing nurse shortage. It is really a crisis. The Congress followed up on this in the omnibus appropriations bill that the President signed, increasing nurse funding for 2003 by \$20 million over 2002. But this budget now only asks for \$98 million for these very same programs, \$15 million below the 2003 levels, in the face of a crisis in health care because of a nurse shortage.

Is the administration—I would like an explicit answer, if you would—going to revise its request, or are you going to support a cut in the budget for nursing in 2004?

Secretary THOMPSON. Congresswoman, you know how passionate I am with you on this, and I have put together a budget based upon the figures that are given me. I tried to put more money into nurses. As you know, I always do. The document speaks for itself. I wish we had more, but we don't. There is an additional \$21 million in the work force diversity that is assisting nurses that is not included in that. I tried to stretch as much as I possibly could.

Mrs. CAPPS. Again I ask, could the administration revise this budget?

Secretary THOMPSON. I doubt very much the administration will.

Mrs. CAPPS. Then we are going to see areas continue to suffer, rural areas like Jim Nussle's in Iowa and many rural parts of my district, and urban centers where advanced practice nurses are really delivering primary health care. That piece of the budget was cut in order to put a few more dollars—robbing Peter to pay Paul, actually—into basic nursing. But the overall cut is certainly going to fly in the face of our bioterrorism preparedness. Who is going to give the vaccines if we ever need them?

Secretary THOMPSON. First, I want to work with you on this and work with Congress. And if we can find some more dollars, I am certain that the administration would be happy to sign it into law.

Secondly, I hope you come over and see what we are doing as far as dividing up the country in order to make sure that bioterrorism is taken care of with nurses, doctors, and morticians. If you have the opportunity, I would invite you to come over, and I think I would allay a lot of the concerns and a lot of the fears you have as far as bioterrorism is concerned.

Mrs. CAPPS. Well, it is one thing to see things on paper, but it is another thing to be in the communities that all of us are in every day and know that hospital wards are closed because of a lack of nurses; that when emergency staff gather—front line, first-line responders—that the pieces that are often in very short supply are

the people to administer bioterrorism remedies and preventive mechanisms.

We are talking about a few million dollars here in a very large budget, and I strongly ask you to reconsider the amount that has been allocated.

Secretary THOMPSON. I want to be your partner in this, as you know, and I have talked to you many times about it, and I also want you to help us try and recruit more young people to go into nursing.

We also have to do something about getting more of the senior nurses or more advanced educated nurses to go into teaching, because that is the bottleneck we have right now in our nursing colleges.

Mrs. CAPPS. And that is exactly where these few million dollars we are talking about would be plugged right in. The need is so clearly there. I know you and I agree, and you know I am going to work very hard to increase the allocation in this budget in this very area, and we—I know that many of our communities are going to be right behind us in saying this is a crying need right now. It is not that high-cost of an item. It will stretch our resources just in the very areas that we need right at this time.

Secretary THOMPSON. You are a champion, and I salute you, and I thank you for your leadership.

Mrs. CAPPS. And I will work with you. We are going to make—we are going to do something about this budget.

Secretary THOMPSON. Alright.

Mrs. CAPPS. I yield back the balance of my time.

Chairman NUSSLE. Thank you.

Mr. Bonner.

Mr. BONNER. Thank you, Mr. Chairman.

Mr. Secretary, thank you very much for being here. You talked in answering some of the questions about the number of waivers you have granted since you have been Secretary. I would like to say thank you. On February 10, your Department granted a waiver for 30 Alabamans, and especially a young man by the name of Nick Dupree, to be able to stay at home receiving the care that they deserve without having to be forced into a nursing home. So thank you very much for that waiver in particular.

Secretary THOMPSON. Thank you very much, Congressman. I appreciate that.

Mr. BONNER. You made a point in answering one of the questions about increased costs associated with tobacco-related illnesses. I have had a number of phone calls from my constituents over the last few days about a rumor afloat that suggests there is a possible \$2-a-pack increase in the Federal cigarette excise tax being contemplated by your Department. This would raise that tax from 39 cents to \$2.39 a pack. I don't smoke. I have never smoked. But it is a legal product that is grown in this country. And so can you tell me, is this a proposal that you or that your Department is contemplating?

Secretary THOMPSON. I can tell you we are not contemplating. This administration does not raise taxes.

Mr. BONNER. Thank you.

The second question that is of real concern——

Secretary THOMPSON. Saying that, I still think it would be nice to have some money set aside. I haven't found a way to get it yet, but I am looking for a fund to use for smokers to be able to quit. Seventy percent of the smokers that are now smoking would like to quit, and I would like to be able to help them.

Mr. BONNER. Mr. Secretary, as you are aware, current Medicare hospital reimbursement policy takes into account the area wage index. This is something that, in my view, has long outlived its purpose with regard to areas such as the area that I represent in Alabama. It is hard for me to go back home and meet with my hospitals and doctors and nurses and give them an answer about why they are being reimbursed at a lower rate in Mobile, AL, than their counterparts in Biloxi, MS, or Pensacola, FL, which are just 60 miles away. Does this budget address this inequity?

Secretary THOMPSON. No.

Mr. BONNER. Would the administration be willing to take this on as a priority?

Secretary THOMPSON. The Congress has got to take that on, because if you change one, Congressman, you take away from another. If you change the wage indexing, you take away from hospitals in Pennsylvania and New York and New Jersey for Alabama, Wisconsin, and Iowa. Now, coming from Wisconsin and Alabama, and Chairman Nussle, we may think that is a good deal. But Congress has got to make that decision as to how to deal with it.

And I would like to point out, and especially for the chairman's sake, that last year the actuaries wanted to raise the wage differentiation from 71 percent of the reimbursement formula to 72 percent, which would have exacerbated the situation. I said no. We kept it at 71 percent.

But when I was Governor, I tried to sue the Federal Government on this point. So I know what you are talking about. We have made certain improvements, but it is something that all of us collectively have got to sit down and work on.

Mr. BONNER. My last question, Mr. Secretary, is that the home health industry has recently undergone a reduction in the reimbursement levels from Medicare, and this has had a chilling effect in terms of the services provided, especially to seniors, in my district and throughout the country. And so a question is does the administration have a plan, or would the administration be willing to work on a plan, to ensure the viability of home health care as we move forward into fiscal year 2004?

Secretary THOMPSON. Yes. Of course we would. We are there to serve you. The Balanced Budget Amendment, which is a congressional law, in 1998 made that decision. It was not the Department.

But, yes, I am. I would love to work with you on it. I would love to work with you on tobacco smoking, love to work with you on preventative health care, love to work with Mr. Hensarling on a lot of my ideas, and I would love to have some of you introduce them, because I think they are great ideas. All we have got to do is get some people to introduce them and get them passed.

Mr. BONNER. We may try to get the Hensarling-Bonner bill on quality.

Secretary THOMPSON. I would like that very much, and I would like to work with you on it, and I will give you the ideas, and then

you can change it any way you want to and introduce it, and I will help you get it passed.

Mr. BONNER. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Chairman NUSSLE. Thank you.

Mr. Emanuel.

Ms. Majette.

Ms. MAJETTE. Thank you, Mr. Chairman.

Good morning, Mr. Secretary.

Secretary THOMPSON. Good morning. How are you, Congresswoman?

Ms. MAJETTE. I am fine. Thank you.

I represent the Fourth District of Georgia, and the CDC, the Center for Disease Control and Prevention, has its headquarters in my district. And I would just like to take this opportunity to thank you for your management of that branch of your Department.

Secretary THOMPSON. It is a great branch.

Ms. MAJETTE. Mr. Secretary, I have recently had the privilege of visiting the CDC headquarters, and I certainly was very impressed with your staff's expertise and their dedication. This branch of your Department is a vital link in the war on terrorism, as you well know, and I believe that I speak for all Americans when I say that I am proud of the work that the scientists and public health experts perform on our behalf.

At this time when Americans are told to be concerned about the use of chemical weapons by rogue nations and are legitimately worried about chemical and biological attacks in our own cities, we know that preparing for these attacks is even more important than before. So I applaud your leadership of the CDC through this preparatory phase of its growth as we prepare to protect our citizens. The CDC is engaged in a very important facility building master plan, and within this plan the CDC will be able to enhance the exchange of information between public health professionals and allow them to better inform the public, which, as you know, is a vital mission. Also, as part of that plan the CDC will be much more effective at addressing the public health education and the disease prevention components about which you spoke with such passion earlier this morning, particularly in the areas of diabetes and asthma and obesity.

So I would encourage you, Mr. Secretary, to make the rapid completion of these construction projects one of your priorities, as we don't know how soon these facilities might be needed to protect Americans from the unknown, as well as being able to continue to move forward on the public health and public education front.

The second point I would like to make, and here is really where my question comes in, is with regard to Medicaid and SCHIP. Obviously those programs provide insurance not just for potential workers, but also for their families and what I would like to focus on now, our children. SCHIP currently covers more than 5 million children nationwide. In Georgia the program is called PeachCare. In Georgia, PeachCare provides more than 50,000 children with health care coverage. Now, as I understand the budget, the proposed solution, Federal funding for PeachCare would be rolled into part of the grant that the States would use to cover Medicaid re-

cipients' benefits. And, of course, you have talked about the flexibility implied by this system, but the potential effect it could have on the number of uninsured children cannot be ignored.

What solution would you propose to deal with the very real possibility that, under this plan, States might run out of money in their grant and be forced to cut SCHIP rather than some of the other mandatory beneficiaries?

Secretary THOMPSON. Congresswoman, they can do that right now. That is the SCHIP proposal. They can drop, they can add. And so that doesn't change.

And second, Georgia could elect to join or not join. The Medicaid proposal is a completely voluntary program.

Third, the new changes would require the same amount of children to be covered, plus you would not be able to drop in order to get the SCHIP money, you would not be able to drop it. It would allow the State of Georgia to be able to take some of the SCHIP dollars and help low-income working families get health coverage as well, provided there aren't any other further children eligible to get that money. Georgia would be able to have the discretion first to either join the program or not join the program, but could use that SCHIP money to help working families.

This is what I did in Wisconsin. I was the first State to do this, called BadgerCare, and I found that if you allow the parent or parents to join up with their children, you get more children to go into the program. And that is what Georgia could do with this new, improvised, flexible Medicaid system. I am confident that you would have more kids covered under this change than under the current law.

Ms. MAJETTE. Thank you.

Mr. SHAYS [presiding]. Thank you, Mr. Secretary. We are going to go to Trent Franks, and then Brian Baird would follow.

Mr. FRANKS. Thank you, Mr. Chairman, and thank you Secretary Thompson. A lot of us have followed you over the years and just seen your innovative personality and attitude be kind of an inspiration to a lot of the folks that want to try to look at new ways to systemically change things.

Secretary THOMPSON. Thank you.

Mr. FRANKS. And you know Mr. Secretary, I think that all of us on this panel, Democrat and Republican alike, have essentially in this particular area the same goals, and that is to try to afford all Americans the very best health care that they can have at the least cost while still maintaining their dignity to direct their own lives as much as possible. And yet you have very succinctly put forth the other side of the ledger, which is this whole preventative area, and I think that is vitally, vitally important, and it just would change the actuary completely if we could follow your line of logic there.

Having said that, in order to produce the best health care possible at the least cost, if we glance over our shoulder and look back, we see the highway of history, as it were, is indeed littered with the wreckage of socialism. And it is free enterprise and innovation that have brought revolution to a lot of areas. I mean, just recently we have seen Federal Express bring revolution to the post office. We have seen the breaking up of a telephone monopoly 20 years ago completely bring revolution to the entire industry where we

have seen a profound decrease in the actual cost and, when you index it for inflation, enormous decrease. And yet with our medical costs we see no end in sight in terms of the escalation.

And one of the things that I found very fascinating in the proposal here was the President's proposal to have a health tax credit, a refundable tax credit for low-income and moderate-income individuals that are not covered by insurance. And I am just wondering, has your Department—or would it be wise, considering the actuaries that we face, for us to look at that more broadly and ask ourselves what do we spend per person enrolled in Medicare and Medicaid, and ask ourselves if indeed this money were made available to them in the form of a government draft or a refundable tax credit could be assigned to private insurance, where would we be? What could they buy? And would it indeed be possible to create the same revolution in health care that we did in these other industries that I mentioned?

Secretary THOMPSON. Thank you so very much, Congressman. Let me take your question and expand on the answer if I may.

If you really want to get at health care costs, we have got to have a Medicare prescription proposal, because that helps the States as well because it funds the dual-eligibles' prescription drugs. The Medicaid proposal that I am advancing is completely innovative, it is completely new, and it changes the system and allows the entrepreneurship of Governors and legislators to develop a whole new medical system in their States. That is why Democrats and Republicans alike should really like this proposal. Most Democrat Governors have taken advantage of the waivers that already do what I am suggesting we do in the new Medicaid law, and I know Republicans have as well.

The third thing, let us take the President's tax credit proposal. I think what we should do is expand it so that we would require every State to put all of the uninsured into a class. So for the State—I believe it is Arizona—I don't know how many uninsured there are in Arizona, but let us say you have 2 million people in Arizona that are not insured. The Governor would put them all in a class of the uninsured and would be able to negotiate. Could you imagine how many companies would like to bid on 2 million people? And you have some very healthy individuals in that uninsured population. The categories of the uninsured are usually young, healthy people that are not making enough money or starting out and don't think they are ever going to get sick. So it is a good class, and it should be quite competitive. There are some other people that can't get a job and have got some other problems that just can't get insurance. But overall, the class would be very competitive if you had that big of a buying category.

So if you had the buying category for the uninsured, and then allowed the State or the individual to go down to the IRS office, get the number from the IRS office which would equate to cash, \$1,000 for a single, \$3,000 for a family to buy a family plan, you could conceivably move millions of people from being uninsured to insured, and it would lessen the cost of health delivery because those individuals go to the emergency ward because they wait until they get sick. But if they got insurance, you could also then put in, which I would like to see, disease management or preventative

health, and you would save megabucks. It would work, it would solve the uninsured, and it would also improve the quality of health in America.

Mr. FRANKS. Thank you, Mr. Secretary. My time has expired.

Mr. SHAYS. Thank you. I was probably not paying attention to the clock. I am sorry, folks.

What we are going to do is we are going to go to Brian Baird and then Rosa DeLauro.

Mr. BAIRD. I thank the chairman and thank the Secretary for your—I found your testimony refreshing and interesting. I would like if your staff could give me a copy of the proposal you just described for dealing with uninsured. I would welcome that.

Secretary THOMPSON. Thank you. It is in my head, but I will write it down for you.

[The information referred to follows:]

PROVIDE INDIVIDUAL TAX SUPPORTS FOR HEALTH INSURANCE COSTS

Offering health credits. The President's budget also proposes \$89 billion in new health credits to make private health insurance more affordable for Americans who do not have employer-subsidized insurance. As part of the Department of Treasury budget proposal, eligible families with two or more children and incomes under \$25,000 could receive up to \$3,000 in credits to cover as much as 90 percent of the costs of purchasing health insurance. The credit phases out at \$60,000 for families. Eligible individuals earning up to \$15,000 annually would receive up to a \$1,000 tax credit. For individuals, the credit phases out at \$30,000. The credits are refundable, so their value does not depend on taxes owed. Beginning in July 2005, advance credits will be available allowing individuals to directly reduce their monthly premium payments. The health credits could also be used in privately sponsored health insurance purchasing groups. This proposal is expected to provide coverage for Americans who would otherwise be uninsured for one or more months, and will help many more working low- and moderate-income families who currently purchase private health insurance with little or no government help.

Mr. BAIRD. Alright. Let me throw out a few things and then let you choose how to answer them in the 5-minute time in the interest of everybody else.

First of all, I want to associate my comments with that of Chairman Nussle. Washington State, as you know, is quite disadvantaged relative to other States in Medicare compensation, and the fundamental principle to me is everybody pays into the Medicare system at the same rate, everybody should receive the same benefits regardless who they are. And if I may, and I don't mean this to sound critical, but you have been, I think, constructive and shared that you have a number of ideas to fix a number of problems and invited Mr. Hensarling and others to join you on fixing those problems. I will offer to you that I will be happy to work with you to fix this problem, and if you have some ideas for how we can do so, I would appreciate it. So don't just leave it to the Congress. You are the Secretary, and we will work with you on this, but this is, I would say, the number one priority for many of our States in health care.

So secondly, I want to associate myself with Lois Capps' comments on loans. I just came back from a tour of several community colleges, and they are very concerned. It is not your Department, but it affects this issue of nursing supply. I didn't mean loans, I meant vocational—Carl Perkins vocational programs.

The Carl Perkins cuts proposed will substantially adversely impact our ability to train nurses, and I hope you will work with your

colleague, Mr. Paige, and others and the administration to fully fund those vocational funds for nurses.

Finally, let me ask as a former practicing clinical psychologist, I am interested in mental health issues as you see them, and where you see that going from here, and how we can address the growing mental health needs and reduction in services for folks who need mental health. And thank you for your comments.

Secretary THOMPSON. Thank you, Congressman.

The first one on the uninsured, I would love to sit down with you. I have got some and I will put out some of my ideas in writing and send them to you, and if you want me to come up to your office, or you can come down, and I would like you to come down and see the communication room. I keep saying that because I think you would find it very fascinating and exciting, and allay a lot of your fears, which hopefully will allay a lot of your constituent fears about how well we can respond to a bioterrorism, chemical, or radiological attack.

And secondly, in regards to the Carl Perkins, you will have to work with my colleague. I am confident he will want to work with you. Nursing is very important to all of us, and Congresswoman Capps has taken the leadership role, and I commend her every time I get a chance to see her on that, as well as several other people. Billy Tauzin was another great leader in this thing. And I think we can work something out.

In regards to the SAMHSA budget, we have put in \$200 million for a new State voucher program that hopefully is going to allow the States to set up accountability and responsibility, and allow for more money to get out to faith-based communities as well as other individuals in the community to offer mental health services. We are also putting in an additional \$16 million for mental health services, \$9 million for children's mental health services, and \$7 million for projects for assistance with transition from homelessness. And we are putting in a lot of—I think it is \$50 million in a new program to counsel children of prisoners, which has some mental health association, as you well know.

Mr. BAIRD. How do those increases correspond to inflationary levels? Will that allow us to maintain current levels of spending?

Secretary THOMPSON. It increases them quite a bit.

Mr. BAIRD. Over inflation?

Secretary THOMPSON. Much, much higher. Probably the biggest increases in this program ever. In fact, the voucher program is brand new.

Mr. BAIRD. Let me, if I may—

Secretary THOMPSON. And as you know, the President has come out in favor of equal parity of mental health and believes very strongly in that.

Mr. BAIRD. I would strongly endorse that and was going to ask you that very next question. I would very strongly endorse that and appreciate your commitment to that.

Secretary THOMPSON. I was in favor of that when I was Governor, but I never quite got the legislature to go along with that.

Mr. BAIRD. I will work with you on that one, too.

On the SAMHSA front, one of the concerns that you may be interested in looking into this, I don't know enough, but I hear from

folks that dual-diagnosis patients, i.e., patients who have substance abuse problems and mental health problems. The funding streams are tied up in bureaucracy occasionally, so that if you are trying to treat a patient who is, say, dealing with affective disorder and has an alcohol problem, which is very common, you are restricted. And some of your reform efforts might look at that, and I would also be happy to work with you on that.

Secretary THOMPSON. You know, Congressman, the best thing you could do for me is to point out exactly where it is. If you have got prime examples, I love ideas, and I love to find out where something is wrong in my Department, because it doesn't take me long to get it fixed. I tell people if they believe in the status quo, I don't want them on my team. And if they are not living on the edge, they are taking up too much space. So I want individuals that are willing to make changes.

Mr. BAIRD. Thank you.

Mr. SHAYS. Thank the gentleman.

We will go to Doc Hastings and then to Rosa DeLauro.

Mr. HASTINGS. Thank you, Mr. Chairman.

And, Mr. Secretary, welcome to the committee.

Secretary THOMPSON. It is always a pleasure. How are you, my friend?

Mr. HASTINGS. I am doing well. Thank you.

I do want to, however, associate myself with the remarks of my colleague from Washington and the chairman, because as was mentioned, Washington is one of those States that is under-reimbursed by the formula on Medicare. And I have had examples where providers have come in, and, you know, you have heard all the horror stories. So I look forward to seeing your proposal. And I hope there is a lot of choice in there because it—

Secretary THOMPSON. Congressman, the truth of the matter is we have to work together on this, because it just can't be something from the administration.

Mr. HASTINGS. I understand that, but you have to put the proposal down, and we have to respond to that. So it always has been amazing to me the idea that when you turn 65, you can't make a decision; it boggles my mind, and that shouldn't be so.

Mr. SHAYS. A little more personal now, isn't it?

Mr. HASTINGS. Well, it is. Yeah. A little ways to go there.

But one thing I want to talk about. You mentioned Medicaid. You spent a lot of time on Medicaid. You may have responded to this when I was gone, but—and you also tied Medicaid reform with SCHIP. In Washington State, our legislature passed a plan prior to SCHIP that covered funding up to 200 percent.

Secretary THOMPSON. You can't use your SCHIP money. This one would allow you to use it.

Mr. HASTINGS. That is exactly my question. The flexibility that you are talking about—

Secretary THOMPSON. Absolutely.

Mr. HASTINGS [continuing]. As it applies to Washington State would allow that to be used.

Secretary THOMPSON. Absolutely, Doc. There are four States, Washington, New Hampshire, New Mexico, and Vermont, that can't use their SCHIP money because their legislature went out

first and passed it, and they have been discriminated against because they can't use it. What they do is they have to send it back in, and then it is sent out on an apportionment basis to other States. So Washington's SCHIP money is not going to Washington; it is going to all the other States around the country.

This proposal would allow you to use your SCHIP money. For instance, it would allow you not only for children, but it would allow for low-income working parents of those children to sign up for health insurance as well and have the Federal Government pay 70 percent of it. It is a wonderful program. As I told Congressman Moran, I would have walked to Washington from Wisconsin to get this deal.

Mr. HASTINGS. Washington, DC.

Secretary THOMPSON. To Washington, DC, and I think the Governor of Washington would like the same. I am working with Governor Locke, and he sees the merits of it. I am confident that unless it becomes a partisan issue, he will strongly support it.

Mr. HASTINGS. Well, thank you very much, Mr. Secretary, for that clarification, because I felt that Washington fell under that, and I just wanted to get it on the record that that is precisely what you are proposing to take care of those States that are ahead of the curve, so to speak. So I appreciate very much your response to that.

Secretary THOMPSON. Thank you very much.

Mr. HASTINGS. Thank you.

Mr. SHAYS. My colleague from Connecticut, Rosa DeLauro.

Ms. DELAURO. I want to thank the Chair, and welcome, Mr. Secretary. It is a pleasure to see you today.

Secretary THOMPSON. It is always a pleasure to see you, as you know.

Ms. DELAURO. Thank you. And I look forward to your coming before Labor/HHS to have an opportunity for additional questions.

The first is, I think, a different change, although I didn't hear all the questions. I want to address the issue of child care and TANF. In 2002, and this is a quote from you, Mr. Secretary, that was absolutely right then, and it is absolutely right now, "I can tell you from my experience as Governor of Wisconsin, access to child care assistance can make a critical difference in helping low-income families find and retain jobs."

We know that that is the case, given what today is all about. And yet, in the President's budget, it flat funds the child care and development block grant. It has 4.89 or \$4.78 millions—

Secretary THOMPSON. It has \$4.89 million.

Ms. DELAURO [continuing]. Over the next 5 years. The fund currently serves only about one in seven eligible children.

Let me take the State of Connecticut; 4,000 families are on a waiting list for child care. The waiting list in Connecticut opened in August, 2002; and we know that States have directed substantial shares of TANF funds to child care in recent years. But, even with this, the child care is only reaching a very small proportion of those children who are eligible.

Now we have got some changes in the new welfare reform legislation. And I—we talk about welfare reform having worked and, you know, tout the success of that, but we also want change. We

want to say, let's move from a 30-hour work week to a 40-hour work week; and I am not disputing that. But if I am going to go to work for 40 hours, rather than 30 hours, what in God's name am I going to do with my kids? I haven't been able to take care of them in those 30 hours, and now I have got 40 hours. Where do I go and what do I do when this backs a law in?

I don't understand the rationale for freezing child-care funding in the budget. I am not even going to talk about education and training not being part of what we are talking about. Good Lord, if we could all get educated and trained in the same way, then maybe we could do away with the welfare system and so forth. But let's leave that for Labor-HHS. Let's just focus in on the child care.

I just think if we are now going to say to States, you are now going to have to deal with this, let's keep in mind you are not able to deal with it now. But now you have got to deal with this because we are going to move from 30 to 40. You handle it.

What happens with this current commitment that we have to lower-income workers? The States are going to have to do this. I mean, this is unfunded mandate. I don't think we can just slip that by and say it is not.

Now the fact of the matter is, what kind of analysis—and I applaud the work that you do in your shop. What kind of analysis has HHS done to determine whether this welfare plan is feasible? The current—my State of Connecticut—my colleague from Connecticut will address this issue. We are in a tough spot in the budget in the State of Connecticut. Most States are this way. How are they going to handle these, this new requirement? What has your shop done to analyze this to find out if the fiscal condition of the States is going to allow them for dealing and handling with these new requirements?

Secretary THOMPSON. Thank you very much, and thank you for your passion. You know, I really like your passion; and I would like to have a chance to discuss things with you, because we get along.

Ms. DELAURO. We do.

Secretary THOMPSON. Several things I want to point out.

First off, the amount of money is not flat funded. If you look, the number of children has been reduced in the last 5 years, but the \$4.8 billion was set. So you have half as many children today as you did back in 1997 when you passed the first TANF bill.

Secondly, the number of hours is not only work hours. Work hours go from 20 to 24. The additional 4 and a half hours is for education, taking care of your children, allowing parents to be involved in PTA, going down to monitor your children in class, and being with your children. That would qualify for the 4 and a half hours.

The third thing is the House bill increased the child support money by an additional \$3 billion—\$1 billion in mandatory, \$2 billion in discretionary. So there is an additional \$3 billion in the over 5 years in the House bill that passed.

This is something that most people don't understand—under the existing TANF law, there is a provision that prevents States from using any excess money for child care. They have to use it on benefits. Right now there are \$2.5 billion—\$2.5 billion of unused TANF money out in the States that could go for child care; and some of

that money is in Connecticut. If the TANF bill as we propose passes that is money that could go for child care, education and transportation instead of for benefits. So there is an additional \$2.5 billion that is locked up because of the restrictions under the current TANF law which will be changed in the new TANF law.

Ms. DELAURO. Is that money fungible? Can it be used anywhere or does it have to be used just on—

Secretary THOMPSON. Just benefits. It all can be used under the current laws just for cash benefits, and that is why it is not being used. Therefore, if the new TANF law goes through, that money could be used for child care as well, Congresswoman.

Ms. DELAURO. Just a quick point. I know that the number of kids may have gone down, but I think that you are looking at the TANF caseloads. With all due respect, Mr. Secretary, I believe that there are loads of kids out there who are eligible who we now cannot accommodate in any way. It is still my fear that we are not going to be able to accommodate them, and there are going to be more because more people are becoming unemployed in today's economy.

Secretary THOMPSON. But the caseload is still declining. The view shows that the decline has been through September, and that was a report that was put out by my Department I think last week. That is through September through the fiscal year.

I don't have new numbers for the next quarter. You may have more modern numbers than the Department does. I don't think you do, but ours show that there has been a decrease of an additional three and a half percent in past year and among single parents, 6 percent. So we are still working on that.

But, you know, this thing has got a long ways to go. But I hope that the Senate will pass it, and hopefully we can continue to work to improve it.

Ms. DELAURO. Thank you, Mr. Secretary. I thank the Chair.

The CHAIRMAN. Ms. Brown-Waite.

Ms. BROWN-WAITE. Thank you, Mr. Chairman.

Mr. Secretary, I represent a district in Florida just north of Tampa, a very heavy retiree population. Medicare+Choice is a very successful program in the counties where it is offered. The problem is that we don't have it in all of the counties and the reason being the reimbursement level.

Secretary THOMPSON. You are right.

Ms. BROWN-WAITE. Is it accurate that previously there has only been a 2-percent increase in Medicare+Choice reimbursement, even though their costs have gone up 8 percent?

Secretary THOMPSON. You are absolutely correct.

Ms. BROWN-WAITE. Well, Mr. Secretary, then it just seems to me as if we are on a road of making sure that Medicare+Choice is available in fewer and fewer areas.

Secretary THOMPSON. You are absolutely correct.

Ms. BROWN-WAITE. What is the reimbursement that is planned for this budget that we have before us? What is the reimbursement increase?

Secretary THOMPSON. A lot higher as it was last year. But Congress didn't pass it.

Ms. BROWN-WAITE. What is a lot higher? What is the percentage that is in your budget?

Secretary THOMPSON. I will be able to tell you that very soon, but it is a lot higher.

Ms. BROWN-WAITE. A couple of other questions, Mr. Chairman, if I may continue.

Secretary THOMPSON. Yes, you know, I agree with you. I mean, we are starving the problem as a result of us going down. We have got to put some more money into it if we want to make the program successful, and the seniors that do have Medicare+Choice like it.

Ms. BROWN-WAITE. The seniors who do have it do like it, but I have counties where Medicare+Choice has pulled out because of inadequate reimbursement.

Secretary THOMPSON. And you are right.

Ms. BROWN-WAITE. The—

Secretary THOMPSON. Congress made the decision in 1998 that they were going to try and get it to expand faster into rural areas, so they decreased the amount of reimbursement. That was a conscious decision by Congress, which reduced the reimbursement to 2 percent and then even some years lower than that from 1998 up until the present. Until last year we tried to increase it to 6.5 percent. And Congress came back with 2 percent. So we have tried in the administration to raise it, and as a result it was a failed decision.

I mean, I am not being critical. Probably Congress thought they were doing the right thing, but they made the wrong decision by starving a growing program in urban areas in order to try and force it to go into rural areas by giving more money to rural areas, and then nobody showed up.

Ms. BROWN-WAITE. My next question concerns the cost of the prescription drug program. In the budget that has been proposed, it is a \$400 billion amount for the prescription drug program. Previously, the amount was \$190 billion that was proposed last year. Help me to understand why the substantial increase in the amount.

Secretary THOMPSON. The increase is because Congress as much as told us that if we didn't come in with an amount that was going to be close to what they were working on that the proposal would be a nonstarter.

Secondly, we want this proposal to pass.

Third, we are making some meaningful changes which are going to require more dollars be put into it.

And, fourth, we want to get something out there that has a much better probability to get fast action, which needs to be done. I am fearful that if it waits till next year it is going to get tied up in presidential politics, and once again we will fail to get a Medicare proposal passed.

Ms. BROWN-WAITE. The last question that I have for you concerns reimbursement to physicians. In Florida, because of the aging population, up to 85 percent of the patient caseload are Medicare recipients. The doctors had cuts, substantial cuts, and when your income goes down because of cuts and your expenses because of medical malpractice go up, I have physicians who are specialty

physicians who are moving out of the area. Now the States and the Federal Government hopefully will do something with tort reform. But what about the reimbursement rate for physicians? You know, 85 percent of your caseload in my district for the doctors that I have spoken to are Medicare. So they can't offset that with private pay.

Secretary THOMPSON. I am happy to report, with the work of the Congress and the most recent appropriation proposal which was signed into law by the President, we have been able to adjust upwards from a 4.4-percent reduction for doctors to a 1.6-percent increase, which will be published on Friday of this week. So on Saturday, March 1, doctors will, instead of getting a cut, get a 1.6-percent increase.

Ms. BROWN-WAITE. What is in the budget for the 2003–2004—any increase?

Secretary THOMPSON. That is going to have to be decided by Congress, Congresswoman.

Ms. BROWN-WAITE. Thank you.

Chairman NUSSLE. Thank you.

Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Mr. Chairman, before I begin my questions, I noticed on the schedule that the hearing for the education part of the budget had evaporated. That is a very important part of the budget, and I was wondering if we could get—if the Secretary can make it, if we could hear from somebody from the administration that can explain to us what is happening to education funding.

Chairman NUSSLE. I thank the gentleman. If you would yield, the OMB Director did cover that in his testimony; and it was our hope to be able to get Secretary Paige. We had him scheduled for tomorrow, but there was a scheduling conflict together with our defense hearing. I had to make a judgment call, and defense took a priority at this moment in time because we had the opportunity to have the Secretary.

Having said that, I would be happy to work to try to include an education hearing. That is—we have done that in years past. It was no intent to do anything but just to make sure we accommodate all of the different, various schedules.

Mr. SCOTT. I would hope that we could do that before the mark up, Mr. Chairman, so it would be a meaningful hearing. I thank you for your cooperation.

Mr. Secretary, it is good to see you again.

Secretary THOMPSON. It is always a pleasure, Congressman.

Mr. SCOTT. You mentioned diabetes, and I was wondering if you were familiar with the research that is going on in the Eastern Virginia Medical School.

Secretary THOMPSON. Where?

Mr. SCOTT. Eastern Virginia Medical School. If not, I would like to get you about a one-page summary of some of that very exciting research.

Secretary THOMPSON. Please do. I speak about diabetes all over the country, and any information that might further enhance my ability to speak on it, I would appreciate.

Mr. SCOTT. Thank you.

The Medicaid option, I am not sure I completely follow it. But my question would be, as I understand, it is a option—you don't have to take it?

Secretary THOMPSON. That is right. It is voluntary.

Mr. SCOTT. And if you don't take it the rules don't change?

Secretary THOMPSON. The rules don't change.

Mr. SCOTT. If you switch and figure out it was a bad idea, can you switch back to the old system?

Secretary THOMPSON. No.

Mr. SCOTT. OK. Low-income heating assistance. It is my information that heating costs per gallon have gone up 30 to 50 percent. That is before we go to war and might get more than that. The LIHEAP budget, as I understand it, goes up 20 percent from last year, but even funded from the year before that. How is that going to work for people getting—buying the same number of—are they going to buy fewer gallons, be able to buy fewer gallons of heating fuel, or will fewer people be eligible for coverage?

Secretary THOMPSON. That question has not been asked. I haven't looked into it, Congressman. But I certainly will and get an answer back to you.

I can tell you that the Congress took out discretionary money of \$100 million and put it into the base funding so the LIHEAP money is going to be at \$1.8 billion this year, in fiscal year 2003; and that is approximately \$200 million more than it was this year.

[The information referred to follows:]

LOW-INCOME HEATING ASSISTANCE

While heating oil prices have spiked recently, we are moving into the time period when oil use and purchases decline. The Department of Energy expects this to be a temporary price increase. You asked how price and funding changes would affect the amount of fuel LIHEAP buys for each household, and the number of households served. Since LIHEAP is a block grant, States make those decisions. This year, I was concerned with higher-than-expected fuel oil prices; that is why a significant portion of the contingency funds I released January 24 were directed to States based on their dependence on fuel oil. My fiscal year 2004 budget request includes \$300 million in contingency funding to address unanticipated needs such as those due to bad weather or abnormally high prices.

Mr. SCOTT. This year was a cut from the year before, as I understand it.

Secretary THOMPSON. No, it was in discretionary money which was not all used, Congressman.

Mr. SCOTT. OK.

Secretary THOMPSON. This is going to be a mandatory fund so it will all be sent out, \$1.8 billion, which will be more money than it was this year.

Mr. SCOTT. Mr. Secretary, the last time——

Secretary THOMPSON. I just have been corrected. It is the \$200 million that was added to the 1.8, so it will be \$2 billion next year in 2004. It is going to be 1.8 in 2003 and \$2 billion in 2004.

Mr. SCOTT. OK. And it was \$2 billion in 2002.

Secretary THOMPSON. It was 1.6 in 2002. It is 1.8 in the fiscal year we are in, 2003; and it will be \$2 billion, additional \$200 million, for fiscal year 2004, Congressman.

Mr. SCOTT. Mr. Secretary, the last time I was asking you questions, I asked you about discrimination.

Secretary THOMPSON. Yes, I know you did.

Mr. SCOTT. And you said at that time that discrimination with Federal money was wrong, period.

Secretary THOMPSON. Yes.

Mr. SCOTT. Trent Lott said that if Strom Thurmond had been elected we wouldn't have had all these problems over all these years. Can you explain to me what problems the 1965 executive order has caused which prohibits discrimination in Federal contracts?

Secretary THOMPSON. I don't know what Trent Lott has got to do with that. Are you talking about the faith-based initiative?

Mr. SCOTT. Yes, if the faith-based organization is hiring a truck driver, an accountant, a typist or a custodian, they can tell them, no, we don't hire your kind. You are in the wrong religion under the President's executive order.

My question was——

Secretary THOMPSON. Nothing in the faith-based initiative, Congressman, promotes or encourages hiring discrimination. It doesn't take away any freedom that they currently have.

Mr. SCOTT. Mr. Secretary, before the President's executive order, you could not tell somebody that they couldn't be hired solely because of their religion with Federal money. After the executive order, you could tell somebody—you can practice all the bigotry you want and tell somebody, no, you don't—you can't get hired because of your religion. If it is an all-white church, you can manufacture an all-white work force. You couldn't do that before the President's executive order just a few weeks ago, isn't that right?

Secretary THOMPSON. It does not discriminate against people on race or sex.

Mr. SCOTT. If it is an all-white church, you can hire an all-white work force.

Secretary THOMPSON. It allows religions to hire people from that religion.

Mr. SCOTT. Or exclude religions. You can consider religion when you hire. In other words, we don't hire your kind. You are in the wrong religion.

Secretary THOMPSON. You can consider religion when you hire, yes.

Mr. SCOTT. Is that a problem?

Secretary THOMPSON. I certainly hope not.

Mr. SCOTT. I mean, before the executive order, you couldn't do that.

Secretary THOMPSON. But it doesn't allow you to discriminate on race or sex.

Mr. SCOTT. Just religion.

Secretary THOMPSON. Just religion.

Mr. SCOTT. Is that a good idea?

Secretary THOMPSON. Yes, I believe it is.

Mr. SCOTT. That is not what you said last time we talked.

Secretary THOMPSON. I said last time that we should not use Federal dollars for discrimination based upon race or sex. I believe that the President has made a decision that money should get to faith-based groups wherever possible, where they have not had the opportunity in the past. And the executive order, as you pointed

out, allows religious organizations to look at religion in hiring, but not based upon race or sex.

Chairman NUSSLE. Thank you.

Mr. Davis.

Mr. DAVIS. Thank you, Mr. Chairman; and, Mr. Secretary, good afternoon to you.

Secretary THOMPSON. Good afternoon.

Mr. DAVIS. Let me ask you about a comment that you have made in a few press conferences and I think you made in response to Mr. Gutknecht's questions earlier. That is, the degree of flexibility that States would have to make certain geographic changes in the way that they administer the Medicaid program. You were stating that one of the virtues of the program was that Minnesota, for example, or, in my case, Alabama could recognize some of the differences and costs and needs between a central part of the State, a southern part of the State. Give me some—let me come at it this way.

Secretary THOMPSON. OK.

Mr. DAVIS. What kind of reassurance can you give people who are living in certain rural areas or in certain isolated parts of States that they won't get caught in that calculus that States are trying to perform? It seems that one aspect of flexibility under your program is that it would give States some capacity to shift resources away from certain high-need areas. If that assumption is not right, tell me why it is not right.

Secretary THOMPSON. It is not right. Let me tell you why.

The current law requires every class to be treated uniformly. These are optional programs. The State only has two choices. Continue the program as is, or drop the program for the optional population. And if it is in central Alabama—you represent Alabama—

Mr. DAVIS. Alabama, that is right.

Secretary THOMPSON [continuing]. Central Alabama, I would think your constituents would like to have a third choice, instead of either. Because Alabama has got financial troubles and they are going to cut back some of their program, I would like to think that most people in your constituency would say, I would like to have a third option. Maybe reconfigure the benefits and allow the Federal dollars to continue and allow the program to continue.

The States don't have that option under the existing law. The States would have that under the new proposal.

The fourth option would be that the State would not have to do it. It is completely voluntary for the State.

And, the State would pay less and get more Federal dollars.

I think all of those things would argue for you to support it.

Mr. DAVIS. Let me come at it this way, Mr. Secretary. Let's say—

Secretary THOMPSON. Did I answer your question?

Mr. DAVIS. To some degree. To the degree you didn't, I will follow up on it right now.

Would the States have the flexibility if they opted into this program to say, for example, there is a particular part of our State where we think that the problem of children having dental care is not as acute as some other part of the State so, therefore, in this part of the State we are going to cut back on funds for dental care for children. Is that a hypothetical under your proposal?

Secretary THOMPSON. I can't imagine any State legislature ever allowing that to pass. Can you?

Mr. DAVIS. Well, coming from Alabama I have seen things like that happen in my State, so it is—we haven't had a Governor like you, unfortunately.

Secretary THOMPSON. Congressman, you would have to pass that particular law in the legislature, and I can't imagine in modern day that would ever happen.

Mr. DAVIS. But there is nothing in the proposal, nothing in the regulations that would constrain the States' abilities from doing that.

Secretary THOMPSON. Unless it is the mandatory population. All the rights and all the responsibilities and all the protections are there, but the State now could drop the whole class, and that would be much worse.

Mr. DAVIS. Let me shift—

Secretary THOMPSON. You would have to take dental away from the whole class, but you would still allow for basic benefits, which is a tremendous benefit for the States instead of dropping it. Because the problem is, under the existing law, 38 States have dropped optional programs this past year. A million people have already been dropped. Next year, 42 States are going to cut back even further; and more people are going to be dropped. I want to give these States the option to keep those Federal dollars coming in and give them the option to keep these programs alive.

Mr. DAVIS. Let me cut you off for one second so I can sneak one more question here. Let me turn to Head Start, which I don't think we have covered today.

Let me anecdotally report to you that in my district a number of people are very concerned about the changes in Head Start; and certainly, as Governor, you have had a fair amount of experience with the program.

Secretary THOMPSON. Very much so.

Mr. DAVIS. In the time that you were Governor of Wisconsin did you find the Head Start program to be less than effective and, if so, did you speak out on that? Did you make attempts to change it as Governor?

And the final part of that, Mr. Secretary, give me some sense when right now most statistics indicate that children are performing at a better level educationally coming through Head Start than children who don't go through Head Start at the same socioeconomic level, given the fact that those educational benefits are being conferred, why shift the program from HHS to Education at all?

Secretary THOMPSON. I am not going to answer the last part of it, but I will answer everything else.

Mr. DAVIS. Can I have a point of order on that, Mr. Chair?

Secretary THOMPSON. While the program is in the Department of Health and Human Services I am going to do everything I possibly can to make it the best program possible.

Secondly, I did not, when I was Governor, get involved in Head Start because I had no ability to. I would have liked to. I think Head Start is an excellent program. But I would like to be able to take my pre-education dollars from my early childhood programs

that I put in when I was Governor for early childhood, be able to use the opportunity to integrate them in with Head Start and make an even better program. Under the current law, I can't do that.

Under the changes that are being advocated, it would allow Governors to be able to work with the Head Start people and be able to use the pre-education dollars from the State, if the State has any, to work with Head Start to improve the overall program, which is completely voluntary and would require the sign-off of both the Secretary of Health and Human Services and the Secretary of Education.

Mr. DAVIS. OK. Thank you, Mr. Chairman.

Chairman NUSSLE. Thank you.

Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here.

If we were to look back at this hearing 5, 10 years from now and a historian judged it, a big-picture presentation would seem to me to be something like States have deficits and those deficits are being used, basically, and Medicaid, as we know it—and let's not prejudge that issue—Medicaid needs a lot of changes and you have been, you know, great in granting flexibility to States. It also seems like Federal deficits are being used to end Medicare and perhaps Social Security as we know it. And to me, it is important for us to be aware of the magnitude of the changes at the time they are being made.

Because, so far at least, you haven't issued a press release to this effect, yet the cumulative weight of the proposals is even attracting the attention of folks like Robert Pear and Robin Toner at the New York Times in their February 24 article where they start hinting that this isn't son of Bush or son of Reagan. This may be son of Barry Goldwater sort of level of changes. So that the public can understand them, to me, truth in budgeting is a good idea, government transparency is a good idea, and if these changes need to be made, let's be open and forthright with the American people about making such changes.

So what would your response be? Are these changes of these magnitudes? Are you going to be speaking at banquets 10 years from now saying that you ended Medicaid as we knew it in the year 2003 or Medicare or Social Security as we knew it?

Secretary THOMPSON. No. Thank you for the question. I think 5 years, 10 years from now people are going to look back at this and say this was—if we do our job, that this was the most constructive Congress that made the most positive changes to allow programs to continue to grow better, with more quality and better health care than ever before. And if we don't do that, Medicare, Medicaid and Social Security—let's forget about Social Security, that is not here. Let's talk about Medicare and Medicaid. That if we don't make those changes we are in a world of hurt.

Last year, a million people were dropped from Medicaid. This year, an additional 2 million people are going to be dropped. With the Medicaid proposal that I am advancing, it takes the best of the work ability of TANF and of SCHIP and of the mandatory popu-

lations in Medicaid and allows it to continue to grow and expand. And I think you should support it, Congressman, with enthusiasm.

Mr. COOPER. To put it in language that corporate America could understand, are you shifting these programs from defined benefit plans to defined contribution plans?

Secretary THOMPSON. No, I am not.

Mr. COOPER. Are you shifting away from the concept of social insurance?

Secretary THOMPSON. Absolutely not. We are expanding social insurance, Congressman, because I think those States that would have my option on Medicaid would not have eliminated a million people. They would have been able to reconfigure it so a good share of those million would have been able to stay in the system, which I think you would support, and I know I do.

Mr. COOPER. Well, it seems easy to support in the short run. But 3 years hence aren't Governors going to be coming back and saying, hey, we are going to have to pay back all this money you allowed us to receive now. And many States traditionally have been unwilling to support their poor. Wisconsin is different. You may be a social model for the rest of the Nation. But Tennessee is not at all like Wisconsin.

Secretary THOMPSON. But, Congressman, you didn't hear me. You don't pay the money back. You don't pay the money back. I don't know, you must have been out of the room. Medicaid is growing at the rate of 9 percent a year. So the trend line nationally is 9 percent. For the first 7 years, the States that voluntarily go into this would be above that trend line, at 10, 11, 12 percent. The trend line continues and the mandatory population continues, no matter what, the same as the existing law.

Mr. COOPER. But two-thirds of the program is optional.

Secretary THOMPSON. One-third of the population and two-thirds of the benefits are optional, which is two-thirds. But in the 8th year you would go below 9 percent. You would still be getting an increase, but you would drop maybe down to 6 percent. Not a pay-back of 7 percent or 8 percent, depending upon the trend line, because each year we have to reconfigure the trend line.

Mr. COOPER. After you are Secretary, Governors may have a different view of the plan. But I hope you are building something that will last for the future.

I admire so much of your record of innovation. You are an accomplished public servant. But these changes need to be clearly explained to the American people so they can have—

Secretary THOMPSON. I want to explain them to you first so you understand so you can explain them to your constituents. I am confident that this is a bigger change, a more important change for more people than the TANF proposal, and it will be more accepted, and 10 years from now you will be one of the individuals out there saying we did the right thing. We changed it, and we saved it, and it is going forward. And I am confident you will make that decision.

Mr. COOPER. Like with TANF which ended welfare as we knew it, we will be ending Medicaid as we know it.

Secretary THOMPSON. No, we will not, because it is not a block grant.

Mr. COOPER. I am not talking about block grants. I am just talking about such a fundamental transformation of the program. We end it as we know it. That was the phrase used with welfare.

Secretary THOMPSON. But it is not ending it as we know it. It allows it to grow and to continue. It allows the mandatory population to get all of its protection. It isn't that big of a change because the States are already dropping these optional programs and optional populations. They have no choice. This proposal allows them to reconfigure it, maybe increase co-pays, maybe drop one of the benefits instead of the whole class, maybe reduce one of the benefits, but allow more people to be in.

Let me give you an example. The State of Utah's Medicaid plan was so rich that it was higher than what the Governor and State legislature and the State employees had. They asked for a waiver to reduce the Medicaid health insurance plan to equate and be able to be purchased with the State employees plan. So they reduced the Medicaid plan down to what the State employees and the State legislature had and were able to expand it so 25,000 more people could come into it. That is the kind of innovation that we are looking for.

Mr. COOPER. I know that I have strained the patience of the Chair. Thank you.

Chairman NUSSLE. Not the impatience of the Chair, it is just there are other members who want to inquire. Mr. Emanuel.

Mr. EMANUEL. Thank you, Mr. Chairman.

Mr. Secretary, I want to thank you for your comments about chronic illnesses that go on in this country, as a son of a pediatrician and the son of a nurse. But the lecture you gave us all on tobacco I would recommend be given to other audiences, and to the general public as well.

Secretary THOMPSON. I hope I wasn't lecturing to you.

Mr. EMANUEL. No, felt good. Don't worry about it. I am the father of three little children. They often lecture me.

My point is, on the comments about tobacco, those comments need to be broadened not only by the Secretary of Health but also by the President as well as the people who overwhelmingly support your party, the Republican party. So I have no problems with it.

I am glad to hear your comments. I agree with those comments as somebody who, for over 20 years; I swim a mile three times a week; and bike 12 miles twice a week. I believe good health is the best preventive medicine. So I appreciate your comments.

To your offer on the uninsured, my father is retired from his pediatric practice 4 years. He dedicates 1 day a week, doing exactly SCHIP program for the City of—Health Department of Chicago. As I said, it is good for the kids, it is good for my dad, and it is great for my parents' marriage now that he is retired. So I believe in it, and I would take you up on your offer and anybody you want to send over to my office to meet and talk about your plan for the uninsured.

In Illinois, the SCHIP program is known as KidCare. It is something I was intimately involved in negotiating when I worked in the White House, and I advocated to expand it to family care. I think one of the craziest things to do is have kids in there whose parents work full time without health care. The kids are getting

medical care, and the parents are sitting in the waiting room without a doctor.

Secretary THOMPSON. You know what State was the first one?

Mr. EMANUEL. Iowa and Illinois. But you only cover up to 33 percent.

Secretary THOMPSON. No, Wisconsin was.

Mr. EMANUEL. Well, the second one was Illinois.

Secretary THOMPSON. Wisconsin was so far out in front of Illinois, like they always are, that—

Mr. EMANUEL. You are a real clean State, too. We always know that. We just had our elections in Chicago, and about 30,000 of your citizens voted, so we thank you, also.

Secretary THOMPSON. My—I better not say it.

Mr. EMANUEL. I think they are going to shut the microphones on both of us soon. Some part of this hearing has been somewhat of a rendezvous for you as a Governor. Some people talk about your record as Governor and ask you questions about it; and the truth is, you did very well as a Governor under those rotten rules you had and—you did very well as a Governor. You were a model on welfare and on health care and all the constricting rules. Somehow you did very well.

So I would like to note that, although those changes—and I am for reforms and changes, as somebody who worked in both the SCHIP program and on welfare reform for the President. That rotten, confining system allowed good Governors like you to succeed.

Second is, on welfare, you made some comments earlier about the welfare plan, and we kind of moved on to health care. And I believe firmly in welfare reform. I worked on passing it. I think it was the right thing to do. Because what we did is we basically eliminated the speed bumps folks face through child care, health care, transportation assistance, minimum wage and the EITC to move from dependency to independence. And the best thing we did is for those children whose parents now go to work. They are tied into the culture of work. So, rather than looking on the inside into the main value system in our country, they are part of the main value system; and that is something we can't measure yet that will pay off for generations to come.

Unfortunately, not putting the resources—there was a big poll done by the Joyce Foundation which showed that recipients who were successful, that moved, needed more dependable, reliable child care and health care; and, unfortunately, what is in this budget doesn't allow them to do that. Now you can say the goal is 70 percent. Without the resources there, you can't achieve that. I believe in this, and I think all of us who worked on this want to see this succeed. Setting an arbitrary goal is the right thing to do. But without the resources it is one of the most mean-spirited things you can do.

To the issue on block grants and flexibility—and I know a little about spin. I practiced it a little while. The problem here is that you have confused people that somehow block grants and flexibility mean the same thing. They are not the same thing. Block grants are a method of financing, and flexibility is a matter of administration.

You have the power as the Secretary of HHS, as you have said, giving more waivers to give that flexibility. Block grants is a matter of financing. As you have explained with your 11, 12, 9 and 6, in fact, financing does go down; and you are giving Governors a Hobson's choice. Get money now, and leave your colleagues in the future in a straitjacket.

I would be interested in any reforms, but the one reform I am very interested in as it relates to SCHIP—and I want to make sure that I understand what you are asking because I think as I read it—I could be wrong. I am positive of that, that I probably am wrong—and it has bipartisan support here in Congress and that is add flexibility to the SCHIP program by reallocating expiring funds back to States to protect the SCHIP coverage. About 800,000 children with coverage would be threatened under current policy.

The administration itself advocated a similar proposal last year, and I haven't heard recently you advocate that, unless it is part of what you are talking about now. That, basically, allows States to keep the money from previous years to roll into the next year and States that succeed would also get more money. So you would be actually rewarding success in moving those children whose parents work full time into the health care system. Is that part of the program you are talking about?

Secretary THOMPSON. No.

Mr. EMANUEL. Did I go over or was it right on the line?

Chairman NUSSLE. Right on the line.

Mr. EMANUEL. I tell you I hope you don't give that gavel to my kids.

Secretary THOMPSON. Congressman, first, it was nice meeting you last night. A mutual friend of ours speaks very highly of you, and he told me that I had to get a chance to talk to you. But there are several things you mentioned.

First, on tobacco, I speak about it, I am passionate about it, and I am glad you are as well.

Secondly, I have the whole Department of Health and Human Services on a diet, including myself. I give out walking meters and make sure everybody tries to walk 10,000 steps a day so that they stay in good health. Because I say, if we are going to be Department of Health, we have got to lead by example.

Third, I am very glad that you convinced your President, Bill Clinton, to sign the welfare bill after he vetoed it twice.

Mr. EMANUEL. They were different welfare bills.

Secretary THOMPSON. Well, he still vetoed it twice; and I am very glad you weighed in on that.

Fourth, in regards to welfare, it is not mean-spirited. In this particular proposal, half of the population, half of the children are no longer on the program. Also, the Congress increased the support by \$3 billion for child support.

You cannot do welfare on the cheap. You have got to be able to furnish for health care. You have got to furnish for transportation and training, and you have got to also provide for child support.

When I was a Governor I came to Congress and testified on that, and I said you are not going to save money on welfare. Because if you are going to get people to move from welfare to independence you are going to have to put more money into those four areas. I

am happy to report that when I was Governor I took all the children off the waiting list and everybody had child care in the State of Wisconsin that applied for it. One of the few States that did that.

Five, in regards to SCHIP, you are talking about the fact that, in the current Federal law, a State has an allotment for 3 years and after 3 years the money is forfeited back to the Federal Government if it is not used and then it is redistributed throughout the country. Several States, such as the States of Washington, Oregon, Tennessee and New Mexico, cannot use their SCHIP money, so they never get the benefit of it. This new proposal will allow them to use their money to allow for working families to get the same coverage as their children.

I am very happy that you support that, because this a concept that I came up with in Wisconsin called BadgerCare, that you can't expect the families to take the children in if they need health insurance. You get more children covered if you allow their parents to be covered, and this is going to be allowed in the new proposal.

I disagree with you on the block grant. Block grants means level funding like a block grant is for TANF, \$16.8 billion a year.

The Medicaid proposal continues to grow at 9 percent; and, as you know from your experience in the White House, we have to reconfigure that trend line each year. Next year, it may be 10 percent. Next year, it may be 11 percent. But we also are not holding Governors to a different responsibility. They are completely voluntary. If they want to go into the new system, they can—if they don't—

I am confident once I get a chance to explain it to you you will be supportive of it. I am confident that once I get a chance to explain it to all the Governors, get the details out there, 90 percent of the Governors will sign up for it. Because it is the right thing to do. It gives them the flexibility and the opportunity to get advanced funding.

We are also going to set up a clearinghouse in the Department of Health and Human Services; and we are going to take the best practices of States around the country, whether it be Wisconsin, Illinois, California. We are going to be the clearinghouse, and we are going to send those out to the Governors and say this is what is working in long-term care. If you use this program and take all the waivers and decide what is doing the best out there and encourage Governors to use the best practices in order to make sure that Medicaid is there.

Right now, Governors don't have any choices. They either continue the program as it now exists or drop it, and that is what is happening out there, as you well know. One million people were dropped from medical assistance last year, probably 2 million this year, because they don't have the third choice. The proposal that I am advancing gives them that third choice, allows them to reconfigure it, allows them to maintain the program, allows them to keep the Federal dollars coming into the health care delivery system, which is a winner for everybody. That is what I would hope you would do.

The SCHIP proposal you are talking about, the \$2.7 billion versus the \$900 million, the President's budget last year suggested

to Congress that all that money should go back, and should not revert to the Treasury. It didn't pass last year. This year, he took \$900 million and said, this money should stay with the States; and, two, \$1.8 billion should go back to the Treasury. But that is not part of the medical assistance proposal that I am advancing.

Chairman NUSSLE. Mr. Shays.

Mr. SHAYS. Mr. Secretary, I have enjoyed the fine questions that are being thrown at you and your excellent answers. I get a chance to see a lot of people respond to difficult questions, and you have purported yourself, I think, extremely well.

You are a very sincere person. I love your passion. I also love your honesty. And I was thinking being Secretary is not like being Governor. But you have, I think, a tremendous opportunity to do a lot of good in your position as Secretary and especially in your past experience as being such an innovative Governor. I just hope you stay on as Secretary, and as long as George Bush is President, because we will be very fortunate if that is the case.

I would like to—

Secretary THOMPSON. That was the nicest thing anybody has said to me. Thank you very much, Congressman.

Mr. SHAYS. Well, it is from the heart; and I think others would have said that as well.

I want to talk about Health Resources and Services Administration, and I want to talk about community health centers. I am beginning to feel that this country, one way or the other, is going to have to address the 41 or 43, whichever it is, million Americans who don't have health insurance. Because, in the end, they get it. They just get it in distorted ways. As your document has pointed out, those who don't have health care are more likely to be in a hospital when they don't need to be.

What I would like to ask you about is the amount of intensity the administration feels for continuing what I hope and expect was a doubling of community-based health care clinics I think in 5 years. My sense is, in general terms, that we are going to go from 10 million to 20 million; and I also have the expectation that about half of the folks in health care clinics don't have insurance. So I make an assumption that, of the so-called 43 million Americans who don't have insurance, 5 million presently are covered by health care clinics, so really do have health care and that, when we double it from 10 to 20, another 5 of the 10 don't have health care and will benefit. I want to know if I am thinking soundly about this, or whether you can enlighten me as to whether that is—

Secretary THOMPSON. No, you are absolutely correct, Congressman. I can't say off the top of my head if your figures are exact, but they are very close, if not right on the money. In fiscal year 2004, we will be serving 13.75 million Americans. We are up to 13.75 million, and at the end of this year we should be at 3,700 community health clinics across America. They do a wonderful job; and I am so happy that you are supporting them, Congressman.

Mr. SHAYS. So the administration, though, intends to move forward and pursue the doubling in the next 5 years, is that correct?

Secretary THOMPSON. That is correct. We are working on that glide path.

Mr. SHAYS. Thank you.

Secretary THOMPSON. We want to get to 20 million. We are at about 14.

Mr. SHAYS. I saw three blank faces when you turned to them, like why are you looking at me? OK. Well, a job well done. Keep it up.

Secretary THOMPSON. Thank you very much. Once again, Congressman, thanks for coming over. Congressman Nussle, I would like to reinstitute my invitation to all of you to come over and see the command center. I think Congressman Shays would tell you it is worth the trip.

Mr. SHAYS. It is worth the trip. I would also compliment you on your fine words on Representative Capps, because she is a star.

Secretary THOMPSON. She is a delight.

Chairman NUSSLE. Mr. Secretary, before you go, we spent an enormous amount of time today talking about Medicare and Medicaid. For those of us that watched public television last night and the presentation, the Nova report on a dirty bomb as an example of some of the things that might go on, I think it would be poor of us to leave—allow to you leave today without at least giving you the opportunity to expand a little bit our testimony with regard to bioterrorism. I mean, certainly smallpox gets most of the attention. But I feel bad that we have spent so much time on Medicare and Medicaid that we haven't given you a little bit more time to expand on that subject.

It is mostly an open-ended question about the strategies. Are you satisfied with what you are doing and seeing and the funding is mostly my question.

Secretary THOMPSON. I thank you so much for giving me this opportunity, because this is another one of my passions.

First off, the Congress gave us \$1.1 billion last year, signed into law by the President on January 10. We sent out 20 percent of the money by February 1, which was 21 days later, which is probably the fastest it has ever happened before.

We requested the States to come back with a comprehensive plan, what they would do with the money, by April 15. Most States complied, much to the chagrin of a lot of the critics who said it couldn't be done. We sent out the balance of the money by June 1; and now the States have got this wonderful plan that they have submitted to NIH, to FDA, to CDC and to the Secretary's Office.

We have sent the money out to expand the communications so that we will have 90 percent of the health departments hooked up to our Health Alert Network. We are expanding the surge capacity so every region in America now has to have a capacity of an additional 500 beds this year, a thousand next year and 1,500 the following year. We are setting up 122 cities that are in the metropolitan civic awareness. We are educating the first responders.

My concern is that the States have only authorized and have only drawn down 17 percent of the Federal dollars. They might be committed, but only 17 percent of the money has been spent so far, and we have an additional \$1.1 billion to send out again this year for them to continue. So I have talked to the Governors, told them that they have to take a look at this thing and find out.

We are coordinating with the mayors and with the first responders, and we have also expanded our laboratory networks up to over

200 so that we are hooked up on laboratories. We are increasing the security. And, we are requesting an additional \$1.5 billion for fiscal year 2004, of which \$518 million will go for hospitals for expanding their surge capacities and so on.

We have got \$780 million this year being used on bioterrorism research at NIH. We are looking at the six most prevalent agents that we are the most concerned about—smallpox, anthrax, botulinum toxin, which I am the most concerned about because it affects food. If we went into closed session, I would like to really talk to you about botulinum toxin because I am very concerned about it. The fourth one is the fever viruses, Ebola; the fifth is plague; and the sixth is tularemia.

I am happy to report that NIH has come up with a vaccine on Ebola, which is one of the hemorrhagic fever viruses. We are going into human trials within the next couple of months. It looks very promising.

We also then set up a bioshield plan which I would like to get into in more detail. This is a program which is a permanent indefinite appropriation, which has probably never been utilized much, if at all, before. It is \$5.6 billion over 5 years. What this would require is Secretary of Homeland Security, Tom Ridge, to declare an emergency. I would have to certify that there is a counteragent out there that can be produced, that it cannot be produced or is not being produced currently commercially and that we can use the dollars in order to do that.

We would take these two certifications to the President. He has to make the final determination; and if he makes the final determination, and if you pass bioshield, then we would get the money to go out and procure the particular money, the services to do that.

This is something that is going to add to our thing. So if there is an imminent danger of smallpox we would be able then to go out and to try and recreate more vaccine or better vaccines. We are on the cutting edge. We were just issued two contracts today for a new smallpox vaccine, one from Canvas Baxter and another from a Copenhagen, Denmark firm. This is one that is called MVA, which is less potent than our current smallpox vaccine, and we think we could give it to immune deficient people without causing any adverse consequences.

We are also developing a new anthrax RPA, which wouldn't require six shots but only three shots and could be manufactured much faster and cheaper and better than the current anthrax that has only got one exclusive distributor ship, namely BioPort, and all the anthrax is being purchased by the Department of Defense.

We are close on Ebola, and we are trying to develop a new antidote for botulinum toxin. That is classified information so I cannot talk about that.

We have expanded our pharmaceutical supply so we have 600 tons of pharmaceutical supplies in 12 strategic locations. We have set up plants now in which we can distribute 50 tons of medical supplies to any city in America within 7 hours. It requires nine semi truckloads or one KC-135 to do so.

We have split the country into 10 regions; and we have got 8,000 medical personnel—doctors, nurses, morticians, and veterinarians—ready to go, divided up. We have DMED-1 teams which have 2,800

individuals. This is level ones distributed within 10 regions, and we put three on alert at all times. Right now, we put them on alert just to see if there are any problems so that we could be able to utilize them.

We have had to send mortuary teams up to Rhode Island this past weekend because of the fire up there, and they came back with rave reviews of what they have done.

We have sent mortuary teams down to Texas to identify the body parts from Columbia.

We sent some medical teams and some mortuary teams over to Guam because of the typhoon which we, through the new communication room that we have been able to develop, can use to monitor food poisoning, and weather, as well as explosions.

So we have divided that up and I think the Department of Health and Human Services is very well equipped to respond to a radiological, biological, or a chemical kind of an incident. We could not prevent it, but we can respond very quickly, and I would love to have you come over and see our operation, Congressman.

Chairman NUSSLE. I appreciate you eating into your own time because I know you have to go to the Senate to talk about that.

But I—you know, all the Medicare and Medicaid and all these other programs combined can't do a thing if something like this happens, as we learned. So I appreciate you spending the moment just talking about it.

Secretary THOMPSON. Thanks for giving me that opportunity.

Chairman NUSSLE. Thank you, Mr. Secretary, for your testimony. We look forward to working with you on all of these programs and policies as we move forward, and we appreciate your return visit to the Budget Committee and wish you good luck and Godspeed in tackling these issues.

Secretary THOMPSON. Thank you very much.

Chairman NUSSLE. Thank you.

The next panel of witnesses for today's hearing we will invite forward. While they are coming forward, let me introduce them. We have today Dr. Gail Wilensky, who is making a return visit to the Budget Committee witness table, as well as Dr. Judith Feder, who is also making a return visit. Both of these professionals are familiar—are probably more familiar with the government health care policies as maybe anybody who is not currently in the administration or involved specifically with the Health and Human Services Department from various activities.

I was just reviewing both of your biographies prior to inviting you forward, and it is amazing all of the things that you have been involved in and worked on. So we very much appreciate your time in coming here today and visiting with us. It doesn't mean that you either agree or disagree with us all the time. That is a different issue. But we do know of your professionalism and your interest, and we appreciate your time today.

What I will do is I will ask both of you to testify, and then if we have any questions we can ask them of either one of you.

STATEMENTS OF GAIL R. WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE; AND JUDITH FEDER, PROFESSOR AND DEAN OF PUBLIC POLICY, GEORGETOWN UNIVERSITY

Chairman NUSSLE. We will start with Dr. Wilensky. And we appreciate you coming back to the committee, Gail. Thank you. Thank you very much.

STATEMENT OF GAIL R. WILENSKY

Ms. WILENSKY. Mr. Chairman and members of the committee, thank you for inviting me to appear before you.

I would like to have my testimony entered into the record and to use my few minutes to speak about some of the issues that have been raised about Medicare and Medicaid.

First, let me comment on the administration's proposals for Medicare and prescription drugs and the need for reforming Medicare and also their proposal to provide some optional Medicaid and SCHIP funding and flexibility as well as the rationale for these changes. In my testimony, I am going to draw on my experiences as the administrator of the Health Care Financing Administration and have also chaired MedPac for its first 4 years.

As you know, the administration is proposing to spend a substantial amount of money, \$400 billion, to reform and modernize Medicare. The specifics of the long-term Medicare reform have not yet been submitted. The framework and the principles have been articulated as following the Federal employees health care plan. That is a program that I participated in during the 10 or 12 years that I was a Federal employee and which each of you has also participated. It has many attractive aspects, most importantly that it allows people substantial choice in identifying the health care plans that will best meet their needs.

I know Mr. Nussle and others on this committee have raised questions that relate to variations in Medicare spending. It is a serious issue that I wish the Congress would address. The Congress addressed it in only one very small way and in some ways unhelpfully in the 1997 Balanced Budget Act when it changed only the payments for the Medicare+Choice program but left the driver of the differential payments in Medicare+Choice, that is the substantial variations in spending that occurs throughout the Medicare fee-for-service program, to continue on as is. It is an issue that ultimately the Congress and administration will need to address if it is an issue that they want to resolve.

Medicare solvency and financial pressure will continue. We have 78 million baby boomers who are going to start to retire at the end of this decade. It will continue to place pressure not only on Part A but on Part B, which is mostly funded by general revenues.

The current benefit structure, as has been noted by many, is unfair. It has people paying in at a comparable rate but receiving very different benefits depending on where they live in the country. It is inadequate, doesn't include catastrophic care and also doesn't include, of course, outpatient prescription drugs.

The administrative structure is excessively complicated. Last year, just in time for your hearing, the GAO had issued a very good report that you had requested about how contractors provide to

physicians and noted that in a large majority of times the information was inadequate, incomplete, and sometimes just wrong.

Payment issues are starting to raise questions of access. You have had some discussion about what happened to physicians which would have been an issue this year. It will be an issue next year unless you change the way physician payments are set. So, while Medicare has many positive attributes, it also has some serious issues.

Having said that, I believe a stand-alone drug benefit without making changes to Medicare that go to some of these other issues is imprudent because of the financial issues out in the future and because we know that we will substantially underestimate the cost of any new benefit if history is any guide.

It is not, however, too soon to start designing and implementing a reformed Medicare program; and if the Congress is able and willing to do that, now would be all the better. Building the infrastructure will take time. Future seniors need to know the program that they will face, and future seniors will be very different from the existing senior population, particularly the women who will have had more education and more time in the labor force and more income.

Just a word about Medicaid, if I may. You have heard that the administration is proposing to provide substantially greater flexibility to the optional benefits and the optional populations, leaving the mandatory population and mandatory benefits as they are. As best I can tell, it is fundamentally taking the same amount of flexibility that is currently available through the waiver process and giving that flexibility more directly to the States in order to try to help them respond in what is a very fiscally constrained period.

Medicaid is ultimately the most flexible Federal program that exists, but it requires the waiver process which is costly and sometimes cumbersome.

There is, however, an additional issue that I would like to raise as a former HCFA administrator and that is the Federal Government ought to be worried about what is otherwise likely to happen to Federal spending under Medicaid with the kind of fiscal pressure that the States are feeling. We have seen in previous periods of fiscal pressure on States that they have shown great creativity in ways to increase spending only at the Federal level and not at the State level. In the early 1990s this was done through provider taxes and voluntary donations. It was followed by intergovernmental revenue and disproportionate share spending.

There are currently disputes going on with regard to upper payment limits as a way to try to increase Federal spending. The problem is that these are inappropriate ways for the Federal Government to make additional monies available to the States. It is unfair. Who gets the money is not a function of the need of the State but rather of the aggressiveness of the State, and it is being made without the explicit decision of the Congress. The specifics of the formula and the details of the program that the administration wants to propose are very important. You need to assess them carefully. But the rationale that they are providing is a sound one, and I would urge you not to dismiss it.

Thank you.

Chairman NUSSLE. Thank you.

[The prepared statement of Gail Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW,
PROJECT HOPE

Mr. Chairman and members of the Budget Committee: Thank you for inviting me to appear before you. My name is Gail Wilensky. I am a senior fellow at Project HOPE, an international health education foundation and I am also co-Chair of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. I have previously served as the administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experiences directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses the administration's proposals for Medicare and prescription drug coverage, the need for reforming Medicare, the administration's proposal to provide optional Medicaid and SCHIP funding and flexibility and the rationale for these changes to Medicaid.

THE ADMINISTRATION'S MEDICARE PROPOSALS

The administration has proposed to modernize and reform Medicare with a program that will include \$400 billion in net additional spending. Although the details are not yet available, the principles for strengthening and improving Medicare are part of the budget. The reformed Medicare program would include an improved traditional fee-for-service plan and more varied health insurance options, so that ultimately Medicare would look more like the Federal Employees Health Benefits Program (FEHBP). Some of the important principles underlying the reform include giving all seniors the option of a subsidized drug benefit, providing better coverage for preventive care, allowing seniors to keep traditional Medicare, providing better options to traditional Medicare, strengthening the program's financial security and streamlining Medicare's regulations and administrative procedures.

The administration is also proposing a variety of strategies to improve Medicare in the short term including changes to the pricing of the Medicare+Choice program, changing the reimbursement for outpatient drugs, providing better information of the quality of care delivered in hospitals and nursing homes and improving the appeals process for beneficiaries and providers.

THE NEED TO REFORM MEDICARE

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors have access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. These include complaints of inadequate benefits from the beneficiaries, concerns of long-term financial solvency by legislators and criticisms from the provider community of inadequate payments and excessive administrative complexity.

Part of the motivation for Medicare reform has clearly been financial. The financial challenges to Medicare are well known and are documented annually in the Medicare Trustees Report made public each spring. Medicare is currently spending about \$250 billion for 39-million aged and disabled Americans and spending on Medicare is expected to grow at a rate of about 7 percent per year for the next decade. This rate is substantially faster than the rate of economic growth and than the growth in Federal revenues.

The long-term outlook for Medicare is primarily driven by demographics. The changing demographics associated with the retirement of 78 million baby boomers between the years of 2010 and 2030, the expected longevity of the boomers, and the relatively smaller cohorts from the baby bust generation means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline. The strong economy of the last decade and the slow growth in Medicare expenditures for fiscal year 1998-2000 has provided more years of solvency than was initially projected, but even so, Part A of the Trust Fund, which is financed by a portion of the wage tax, is expected to face cash flow deficits as soon as 2016.

As important as issues of Part A solvency are, however, the frequent focus on Part A as a reflection of Medicare's fiscal health is unhelpful and misleading. Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially faster than Part A and much faster than the economy as a whole. This means

that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling for Part B expenditures will mean fewer dollars available to support other government programs.

However, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960s. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made as well as other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

The most publicized problem of Medicare is its outdated benefit package. Unlike almost any other health plan that would be purchased today, Medicare effectively has no outpatient prescription drug coverage and no protection against very large medical bills. As a result, most seniors have supplemented traditional Medicare although some have opted-out of traditional Medicare by choosing a Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has important consequences for seniors and for the Medicare program. For many seniors, it has meant substantial additional costs. The supplemental plans also mean additional costs for Medicare. By filling in Medicare's cost-sharing requirements, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increasing Medicare's costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. The large variations in spending for Medicare mean there are substantial cross-subsidies from people living in low medical cost states and states with conservative practice styles to people living in higher medical cost states and states with aggressive practice styles. The Congress and the public are aware of these differences because of the differences in premiums paid to Medicare+Choice plans but seem unaware that the differences in spending in traditional Medicare is now even greater than the variation in Medicare+Choice premiums.

Finally, the provider community has been complaining bitterly about payment inadequacies as well as administrative complexities associated with Medicare. Particular concern has been raised about reduced payments to physicians and whether access to care for seniors is in danger of being jeopardized. Payment rates to physicians were reduced by more than 5 percent for fiscal year 2002 and would have been reduced by an additional 4.4 percent next month, had it not been for the action recently taken by the Congress. Even so, payments are expected to decline next year if additional changes aren't made to the way physician payments are calculated. Reductions in payments for nursing homes and home health care have also raised issues of future compromises in care although to date there has not been evidence to suggest access to care has become a problem for seniors. Information on quality is being made accessible where available and the administration is making the availability of additional quality measures for home care and nursing homes a major priority.

Provider complaints about administrative complexities have been almost as great as their complaints about the levels of payment. Although none of these are new issues, providers have been increasingly vocal about these concerns. Among the many complaints that have been raised-uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment across contractors seems to be at the top of most lists.

In a report released last year, the General Accounting Office (GAO) verified the validity of many of the complaints. Among their findings: information given to physicians by carriers is often difficult to use, out of date, inaccurate and incomplete. The carriers provided toll-free provider assistance and web-based information but only 15 percent of the test calls were complete and only 20 percent of the sites had all the information required. CMS was also criticized for having too few standards for the carriers and for providing too little oversight.

PRESCRIPTION DRUG COVERAGE AND MEDICARE REFORM

Although I believe it is important to pass a reformed Medicare program soon and that a reformed Medicare package should include outpatient prescription drug coverage, I believe just adding this benefit to the Medicare program that now exists

is not the place to start the reform process. The most obvious reason is that there are a series of problems that need to be addressed in order to modernize Medicare to accommodate the needs of the retiring baby boomers and to be viable for the 21st Century. To introduce a benefit addition that would substantially increase the spending of a program that is already financially fragile relative to its future needs without addressing these other issues of reform is a bad idea.

The principles articulated by the President are consistent with the FEHBP model and also the work of the Bipartisan Commission for the Long Term Reform of Medicare. I personally support reform modeled after the FEHBP where the government's payments on behalf of an individual would not vary with the type of plan that is selected. I believe this type of structure would produce a more financially stable and viable program. It would also provide incentives for seniors to choose efficient health plans and/or providers and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I recognize that the FEHBP is controversial with some in Congress, particularly because of the difficulties the Medicare+Choice program has been having. It is important to understand, however, that many of the problems of the Medicare+Choice program reflect the decision by the Congress to encourage the expansion of plans in underserved areas by limiting the increase for plans with most of the enrollees to 2 percent per year, even though their costs were increasing at a rate that was several times that amount. In addition, Medicare+Choice plans have faced additional regulatory burdens as well as substantial uncertainties about future changes in regulation. Combined, these factors have helped transform what had been a vibrant, rapidly growing sector into a stagnant and troubled one.

A second reason not to add a drug benefit without further reforms to Medicare is the difficulty of correctly estimating the cost of any new, additional benefit. Our past history in this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972, for example, was underestimated by several-fold. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of two and one-half between the time it was initially proposed and the time it was repealed.

These issues taken together reinforce my belief that adding a prescription drug benefit to traditional Medicare without further modernizing the program is unwise. A better strategy would be to agree on the design of a reformed Medicare program and to begin to implement changes now. At a minimum, it is likely to take at least 2 years to produce the regulations needed to build the infrastructure needed for a reformed Medicare program.

As we contemplate a Medicare program for the 21st Century, it is also important to understand that the people who will be reaching 65 over the next decade as well as the baby boomers have had very different experiences compared to today's seniors. Most of them have had health plans involving some form of managed care, many of them have had at least some experience choosing among health plans, most have had more education than their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems and if we start soon, with different expectations.

THE ADMINISTRATION'S MEDICAID PROPOSALS

The administration's proposal for Medicaid distinguishes between mandatory populations and mandatory benefits on the one hand and optional populations and optional benefits on the other. Mandatory benefits for mandatory groups are kept as they are under current law, but substantial new flexibility is provided for the optional populations and optional benefits. In addition, increased funding of \$12.7 billion is provided over the first 7 years although the program is to be budget neutral over 10 years. Much of the flexibility that is currently available through the waiver process would be provided directly to the states under the administration's proposal. There are also specific incentives for supporting individuals with disabilities who are currently institutionalized that could be served in home or community-based settings.

Although the specifics of the programs have not yet been presented in detail, the proposal discusses the use of an acute care health insurance allotment and a long-term care and community services allotment. The amounts in each would be based on spending in 2002 with level of effort requirements imposed on the states.

THE RATIONALE FOR PROVIDING MORE FLEXIBILITY TO MEDICAID

States are experiencing severe fiscal pressure from their Medicaid programs. These pressures are coming from three different directions. First, many states proactively increased spending on Medicaid during the 1990s by expanding the populations covered, the benefits offered and the rates paid to providers. Second, State revenue declined substantially more than initially anticipated in 2001 and 2002. Third, the counter-cyclical nature of Medicaid has produced some additional expansion in the Medicaid rolls. The administration is proposing to provide some of the flexibility that has been previously available to the states through the waiver process directly to the states to increase their ability to cope with these additional fiscal pressures. It should be noted that this increased flexibility is being proposed only for the optional populations and benefits and not for the mandatory populations or benefits.

The expectation is that the flexibility being proposed will allow states to make the best use possible of their Medicaid funds in an era of unusually constrained resources. As in the case of SCHIP, states would be able to work more directly with private insurers and provide premium support for recipients enrolled in private plans. States would be able to tailor their programs to meet the needs of individuals throughout the State in ways that are not easily possible under current Medicaid rules, such as with the "State-wideness" requirement. This is not fundamentally new flexibility that is being offered the states since the waiver process provided what was essentially a fully flexible program but rather a less hassled and costly way to achieve a similar flexibility.

There is an additional reason for the Federal Government to provide greater flexibility to the states in return for more total control over Federal monies for optional populations and benefits. States in previous periods of fiscal pressure have shown great creativity in developing ways to increase Medicaid spending using only increased Federal dollars. Provider taxes and voluntary donation strategies in the early 1990s, disputes over disproportionate share spending and intergovernmental revenue transfers later in the decade and current debates about upper payment limits are among the examples that come to mind. These are inappropriate ways for the Federal Government to make additional monies available to the state. The outcomes of these strategies do not represent the results of explicit decisions by the Congress to change the relative shares of Federal to State dollars in Medicaid and the amount of money a State receives is not determined by its own spending on Medicaid nor on the basis of its own fiscal need.

The general direction of the Medicaid policy changes announced by the administration makes sense. The specifics of the formula and the details of the program will be important determinants of the impact of the proposed change on the states and on the populations that have been traditionally served by the Medicaid program. They should be assessed carefully.

Chairman NUSSLE. Dr. Feder, welcome.

STATEMENT OF JUDITH FEDER

Ms. FEDER. Thank you, Mr. Chairman. I appreciate being before you and members of the committee.

I am glad to have this opportunity to speak today on the impact of the President's 2004 budget on both Medicare and Medicaid. I would appreciate your accepting my remarks in full for the record.

What I want to do right now is make some brief points with respect to the proposals on both programs. I have two key points.

First, the fiscal support this budget offers for both Medicare and Medicaid is far too limited to meet program and beneficiaries' needs.

Second, even the limited support that is offered is offered at too great a price: that is, abandonment of Federal fiscal guarantees that make today's Medicare and Medicaid so successful. These proposals would simply do more harm than good.

Let me elaborate, first for Medicare, then for Medicaid.

The administration proposes to allocate most of \$400 billion over 10 years for a prescription drug benefit. Measured against the costs of prescription drugs, despite the size of this sum, these dollars are too limited to support adequate protection. The Congressional Budget Office estimates the next 10 years of drug costs for Medicare beneficiaries at \$1.8 trillion, and \$400 billion covers only a small portion of that expense, exposing beneficiaries to a benefit with substantial cost sharing and actual holes in protection.

The administration likes to compare its proposals to the Federal Employees Health Benefit Plan, which provides Members of Congress and others, including myself, with a comprehensive drug benefit. Estimates indicate, however, that a comprehensive benefit like the FEHBP's—which the Secretary advocated today, saying that Medicare beneficiaries ought to have the benefits Members of Congress have—would cost about twice what the administration has proposed. Not only is the benefit inadequate in general, the administration would provide it only to beneficiaries who agree to trade in their Medicare for enrollment in a private health insurance plan.

You have to ask why the administration would want to replace Medicare with private health insurance. Is it because private insurance is more secure or reliable than Medicare? Experience with private insurance for the working age population and with Medicare+Choice for Medicare beneficiaries tells us that the answer is no.

Is it because private insurance is needed to expand choice for Medicare beneficiaries? Medicare beneficiaries already have the most meaningful choice—choice of doctors, hospitals and other providers. And surveys show that Medicare beneficiaries are more satisfied with their coverage and less likely to face access problems than younger people with employer-sponsored insurance.

Is it because private insurance would cost less than Medicare now or over time? Medicare+Choice plans want more money for Medicare. They are not saving Medicare money. And, historically, Medicare costs have risen more slowly than private insurance, including the Federal Employees Health Benefit Plan, not faster. The only way private insurance can likely spend less than Medicare is to provide beneficiaries less service.

The fact that the administration ignores the statutory commitment of general revenues to Medicare financing now and in the future and grossly exaggerates Medicare's long-term fiscal problems reinforces this concern. Privatizing Medicare won't secure protections for beneficiaries. It will undermine them.

Turning to Medicaid, the administration's proposals are remarkably similar in form. The dollars are too limited, and they are offered at a price that would undermine the current program.

First, the money. The administration offered States \$3.25 billion in 2004, \$12.7 billion over 10 years. These dollars do little to address the deficits States are facing today, estimated at 70 to \$85 billion in State fiscal year 2003. Plus, after 7 years, what the Secretary described as forward funding would be offset by a cut below that baseline that the Secretary was talking about, a cut in Federal funds precisely when the baby boom generation begins to turn age 65 and are likely to need help from this vital program.

Second, States would receive this so-called aid only if they agreed to give up guaranteed Federal matching payments that vary with service costs. This is the key issue about current funding versus a block grant. Today, Federal funds to States flow with the number of people who are eligible and the actual cost of the care they receive. The administration would replace these guaranteed matching payments with capped Federal funds, caps perhaps based on an unexplained trend line, but caps, predetermined allotments, nevertheless.

Why would the administration do this? Will it encourage flexible expansion of services, for example, for the uninsured or for the provision of long-term care at home rather than in nursing homes? Despite the administration's claims, the answer is no.

Capped funds, even based on projections, are not as responsive to beneficiary needs as current arrangements. They do not allow for variation in need across States or unanticipated need within States or across the Nation. Think simply of a new medication for AIDS that can dramatically alter the cost to States of Medicaid services. And no flexibility in delivery can offset the increases in the numbers of people in need, especially among the elderly and disabled, or in the cost of services like prescription drugs and long-term care—to a significant extent optional services for optional populations—that States will inevitably face.

Will capping funds save money? The only money it will save, if services are delivered, is Federal money. Capping funds doesn't eliminate costs. It shifts them. That is, it limits Federal dollars and leaves States, their providers, and their beneficiaries high and dry.

With capped funds, flexibility is nothing more than a euphemism for cost shifting to States or arbitrary cuts in protection that the Secretary seemed to prefer to better support for State programs. Such arbitrary cuts include waiting lists for enrollees, now prohibited under Medicaid law; substituting first-come, first-served service for uniform eligibility rules; changing the mix of benefits, which means favoring some parts of States over others, despite quite similar health care needs; charging even the poorest beneficiaries out-of-pocket payments; and limiting access to optional populations or services that include nursing home care, home care, prescription drugs and other services vital to vulnerable populations.

Whether optional or mandatory, all beneficiaries subject to capped funds are at risk of reduced coverage as well as a loss of standards designed currently to assure timely access to quality care. And allowing States to pay in less to support the program—as the Secretary emphasized several times, referring to the three factors that might be used to project spending but basing maintenance of effort only on one of those factors, the cost of care—would allow States to pull out money at beneficiaries expense.

In his most recent State of the Union address, President Bush described Medicare, and I quote, “as the binding commitment of a caring Nation,” unquote. The same language applies to Medicaid. A strong Medicare prescription drug benefit, along with fiscal prudence, rather than substantial tax cuts, is needed to secure our binding commitment to Medicare. Enhanced and guaranteed Federal matching payments are needed to secure our binding commitment to Medicaid.

In his 2004 budget, the President abandons rather than secures these commitments. A caring Nation should reject these proposals.

Thank you, Mr. Chairman.

Chairman NUSSLE. Thank you, Dr. Feder.

Appreciate both of your testimony here today.

[The prepared statement of Judith Feder follows:]

PREPARED STATEMENT OF JUDITH FEDER, PROFESSOR AND DEAN OF PUBLIC POLICY,
GEORGETOWN UNIVERSITY

Chairman Nussle, Congressman Spratt and members of the committee, I appreciate the opportunity to comment today on the administration's 2004 budget proposals regarding Medicare and Medicaid. The administration describes its proposals as strengthening the ability of these vital programs to serve elderly, disabled and low income beneficiaries. In fact, however, the administration proposals threaten rather than strengthen Medicare and Medicaid. Not only do these proposals offer too little fiscal support to meet program needs. They also make even this modest support contingent upon the abandonment of the Federal fiscal guarantees that secure access to care for all eligible beneficiaries. Specifically, the administration proposes to replace Medicare with private insurance and to replace Medicaid's guaranteed Federal matching payments with capped Federal funds. Such policies would severely weaken both programs and their ability to serve the people who count on them.

Let me explain first for Medicare, then for Medicaid.

IMPACT OF ADMINISTRATION'S 2004 BUDGET ON MEDICARE

Although details are sketchy, it appears that the President's 2004 budget proposes to make available (most of) \$400 billion over 10 years to support prescription drug coverage, but only for beneficiaries who leave the current Medicare program and enroll in private insurance plans for all of their health care. These plans would also offer enrollees a different cost-sharing structure for benefits than Medicare currently provides.

Rather than strengthening Medicare, this proposal provides too little benefit at too great a cost: First, it falls far short of the administration's promise to assure all Medicare beneficiaries the protection against prescription drug costs they so sorely need. The proposed financing for prescription drug coverage does not come close to what is necessary to provide all beneficiaries adequate protection. At the same time, its thinly veiled "bribe" to beneficiaries to leave Medicare for private insurance actually forces beneficiaries to choose between their need for a drug benefit and their need for Medicare's guarantee of dependable, affordable health insurance protection. Despite the urgency of beneficiaries' need for prescription drug protection, the administration's price—structural reforms that would undermine Medicare's greatest strengths—are simply not worth it.

Inadequacy of the proposed benefit. Over the next 10 years, the Congressional Budget Office estimates that prescription drug costs for Medicare beneficiaries will cost \$1.8 trillion. The proposed \$400 billion finances only a slim portion of these costs—leaving beneficiaries to face substantial out-of-pocket expenses in terms of deductibles, co-insurance, and holes without any coverage at all. This benefit does not come close to the protection Members of Congress (and I, as the wife of a Federal retiree) have through the Federal Employees Health Benefit Plan (FEHBP). Indeed, estimates indicate that a comprehensive prescription drug benefit would cost about twice the budget's \$400 billion allocation.

I know that this committee is well aware of the fiscal challenges facing the Nation. But providing adequate financing for prescription drugs is more a question of priorities than fiscal ability. For the administration to propose such insufficient investment in prescription drug coverage alongside a proposal for a \$674 billion tax cut raises serious questions about their priorities.

Inadequacy of private insurance. The administration's proposal to tie the availability of a prescription drug benefit, adequate or otherwise, to enrollment in private insurance plans forces beneficiaries to make an untenable choice: gain a drug benefit but lose Medicare's guaranteed access to care.

Longstanding experience with private insurance reveals that it does not offer the dependable protection that Medicare guarantees. Medicare is an enormously successful program because it brings together the healthy and the sick, the better off and the less well-off in a single insurance arrangement, pooling risks to insure that all beneficiaries—regardless of income or health status, are guaranteed financial

protection against the costs of medical care. It is universal—covering virtually all people eligible—and enables beneficiaries to obtain services from the doctors, hospitals and other providers they choose.

Private insurance cannot compete with Medicare's performance. Over 30 years ago, Medicare was enacted because private insurance failed to reach nearly half the elderly population. Today, private insurance outside the workplace for the under age 65 population is plagued with "selection problems"—making affordable coverage available for people only when they are healthy and denying or restricting benefits to people when they are sick. And inside the workplace, the 1990s' shift to manage care reveals that health plans have relied far more on barriers to access than on efficient care management to control their costs. Rather than offering beneficiaries a broader set of choices, health plans may limit the doctors or hospitals that plan members can use or require them to pay extra to use the providers they want. Indeed, Karen Davis and her colleagues at the Commonwealth Fund find that despite better health status and lower need for care among privately insured employees under age 65, they report less confidence in getting care when needed and higher incidence of access problem than do Medicare beneficiaries.

The Medicare program also has experience with reliance on private health insurance—through Medicare+Choice—that is decidedly disappointing. Plans that beneficiaries join in 1 year are out of business the next. Benefits that beneficiaries count on 1 year are reduced the next. And plans have never found it profitable to serve many parts of the country—especially rural areas. It appears that it is insurers who gain choice under these arrangements—not Medicare beneficiaries.

Nor is reliance on private insurance likely to save money. Medicare+Choice plans are asking for higher payments from Medicare, not costing Medicare less. Contrary to claims made by proponents of private insurance for Medicare, the current Medicare program is as good and often better than the private sector in controlling its costs. In the past 5 years, Medicare's average growth in spending per beneficiary was lower than both the private sector and FEHBP. And, according to Marilyn Moon of the Urban Institute, over the last 30 years, Medicare spending per beneficiary has grown at a rate of over 1 percentage point less than private health insurance—a cumulative savings of about 41 percent relative to what costs would have been through private insurance. The facts are that private insurers cannot best Medicare in terms of value for the dollar in the purchase of services.

The only way private insurance plans can likely spend less than Medicare is to provide less service. Indeed, previous proposals to rely on private insurers to provide prescription drug coverage to Medicare beneficiaries have sought savings precisely by allowing private insurers to limit beneficiaries' access to a full range of prescription drugs. Reliance on private insurance plans for the full range of Medicare benefits—as the administration proposes—would put affordable access to doctors and hospitals at similar risk. The risk to beneficiaries becomes even greater if the shift to private plans transforms Medicare from a program that guarantees the financing of service costs to a program that guarantees the financing of only a share of a private insurance premium. The latter would represent an explicit transfer of financial risk for overall health costs from the Medicare program to elderly and disabled beneficiaries.

MEDICARE'S FUTURE

The administration's enthusiasm for shifting Medicare beneficiaries to private insurance is particularly suspect when it comes to Medicare's fiscal future. With the aging of the baby boom generation, the proportion of the population served by Medicare will grow from 14 percent today to 22 percent in 2030. Along with likely continued increases in health care costs—not just for Medicare but for the Nation as a whole—the demands on the program will be substantial. As just described, reliance on private insurance cannot finance increased demands through greater efficiency. Indeed, the only way that privatization can address Medicare's future fiscal problems is if it shifts costs to beneficiaries, ending Medicare's guarantee to assure affordable access to mainstream medical care.

Not only is the administration promoting privatization as a false "solution" to future fiscal problems; it is exaggerating their scope and squandering the resources needed to address them. The President's budget reports a \$13.3-trillion "shortfall" in Medicare over the next 75 years. However, that calculation assumes that only dedicated payroll taxes (which finance Medicare's Hospital Insurance or Part A) and beneficiary-paid premiums (which finance 25 percent of Medicare's Supplementary Medical Insurance or Part B) are available to finance the program. It ignores that by law and from Medicare's inception, general revenues are used along with premiums to finance Medicare's Part B expenses. Unless the administration proposes

to withdraw the statutory commitment to provide general revenue financing, the real “shortfall” is only one-third this amount. Further, the 75 year estimates involve long-term projections about which CBO and, in other places, the administration have expressed accuracy concerns. CBO has said that health costs are among the top three reasons for miscalculations in its projections. Interestingly, at the same time the administration reports a 75-year Medicare projection, it is unwilling to project its own budget proposals beyond 5 years.

The right way to address the estimated and accurately calculated shortfall is to keep the nation’s overall fiscal house in order. Between 2002 and 2011, Medicare’s trustees estimate that payroll taxes will generate a surplus of over \$510 billion. These and other revenues from members of the baby boom generation, now in their prime earning years, can be used to minimize Federal borrowing today, thereby strengthening the nation’s capacity to meet future needs when they retire.

But the 2001 tax cut and the additional \$674 billion proposed in the President’s 2004 budget move the Nation in precisely the opposite direction. In part, they use the Medicare surplus to finance a tax cut. And, by increasing debt, they add dramatically to the burdens that will fall on future generations. To exaggerate Medicare’s fiscal crisis, promote privatization, and cut taxes suggests that securing and strengthening the Medicare program, both now and in the future, is not the administration’s primary concern.

IMPACT OF ADMINISTRATION’S 2004 BUDGET ON MEDICAID

The administration’s 2004 budget proposes to make available \$3.25 billion in 2004 and \$12.7 billion over 7 years to share among States that agree to accept predetermined Federal allocations or block grants to fund services to low income populations. States who accepted the additional funds would be expected to repay them in years eight, nine and ten, regardless of program needs. The proposal is therefore budget neutral to the Federal Government over the 10 year period.

This Medicaid proposal has much in common with the administration’s Medicare proposal. First, the fiscal relief offered by the proposal is insufficient to address State budget pressures that are endangering Medicaid. The early year Federal funds are tiny relative to State fiscal deficits estimated in the range of \$70–\$85 billion in State fiscal year 2003. Second, the proposal offers States an untenable choice: gain even modest relief now but lose the current commitment to guaranteed Federal matching payments, designed to flow with the number of people eligible and the actual costs of their care.

Inadequacy of the proposed Federal support. Recessions place States between a rock and a hard place when it comes to Medicaid financing. At the same time recessions increase the number of low income people seeking Medicaid coverage, they reduce the availability of State revenues available to finance that coverage. Coupled with increases in health care costs—notably for prescription drugs—States find themselves with demands that exceed the revenues they have available. Without Federal fiscal relief, States’ likely response is to cut back the coverage that Medicaid provides. As of December 2002, proposed or implemented cutbacks were estimated to leave a million people without health care coverage.

What’s needed to prevent these cutbacks is a significant increase in the Federal Government’s share of Medicaid costs—a boost in the matching rate—in order to cushion the recession’s impact. Instead the administration is proposing not only a small funding increase that States must repay but also caps on Federal funds for Medicaid regardless of program needs. The proposal’s repayment requirement would actually cut Federal funds after 7 years, regardless of the number of eligibles or costs of services at that point in time. The fact that the repayment cut would begin at precisely the point the baby boom population begins to turn 65, increasing the number of low income elderly people eligible for Medicaid, makes higher costs then almost a certainty.

Inadequacy of block grants. Whatever its form, capped rather than open-ended funding is not responsive to the needs of the Medicaid population, the providers who serve them, or the States who share responsibility for financing their care. Medicaid is now the nation’s largest health insurance program, providing health insurance to low income families and people with disabilities, filling in Medicare’s gaps for low income elderly, and providing virtually the only safety-net for people who need long-term care. To support these services, the Federal Government provides States open-ended matching funds: the more people who are eligible for service and the more services costs, the more States receive in Federal matching funds; the fewer people eligible, the less States receive.

As explained by Andy Schneider in the “Kaiser Family Foundation’s Medicaid Resource Book” (July 2002), financing arrangements that guarantee States at least

half the costs of services (up to 83 percent in the lowest income States) encourage States to extend coverage beyond levels their own resources would support and make funds automatically available when circumstances create a need. Recession is one such need. The Urban Institute estimates that an increase in the unemployment rate from 4.5 percent to 5.5 percent produces an increase in Medicaid enrollment of 1.6 million—an increase that, under current law, is automatically supported by Federal funds. Public health emergencies are another such need. Medicaid covers an estimated 55 percent of persons living with AIDS and 90 percent of all children living with AIDS. When the number of people affected increases or the costs of treatment rise, Federal funds automatically increase to share the burden.

Predetermined Federal allotments or block grants cannot achieve these goals. Block grants are distributed according to specific formulas, not according to the number of people served or the actual cost of services. Although the administration has not spelled out its proposal in detail, replacing guaranteed matching payments with capped funding is inevitably less responsive to the needs of vulnerable people. As my Georgetown colleague Cindy Mann has explained, predetermined allotments, even with rates of increase (which the administration has not specified), do not allow for variations in need across States (due to variation in health or economic circumstances) or for unanticipated changes in national circumstances. Had Federal funding for Medicaid in 2002 been based on costs projected in 1998, for example, Mann estimates that financing would have been 12-percent below actual spending.

Reliance on uncertain projections to provide Federal funding is particularly likely to jeopardize Federal support for Medicaid services to low income elderly and disabled populations. Medicaid is now the only source of prescription drug protection for these vulnerable populations (and the administration's Medicare prescription drug proposal would not necessarily replace these Medicaid responsibilities). Medicaid is also the nation's long-term care safety net—financing almost half the nation's nursing home expenditures. Given the expected growth in the elderly and disabled population, capping Federal funds is a strategy to shift responsibility for serving the baby boom population from the Federal Government to the States.

The administration describes its proposal as providing States “flexibility” to use resources more creatively and presumably more efficiently to meet their needs. However, no creativity in delivery can offset likely increases in numbers of people in need and increases in the cost of services over which Medicaid has little if any control. With capped funds, States' ability to “flexibly” expand coverage—provide coverage to currently ineligible uninsured populations or continue to expand home and community-based long-term care services—will be hampered, not enhanced, given the need to cover the inevitably rising cost of existing obligations. Either that, or expansions will come at the expense of people already in need. The key to true expansion of protection is enhanced, guaranteed Federal matching payments, not capped Federal funds.

Indeed, with capped Federal funds, “flexibility” is nothing more than a euphemism for cuts in protection that Federal rules currently do not allow: creating waiting lists for enrollment, favoring some parts of States over others, charging even the poorest beneficiaries out-of-pocket payments for service, and limiting access to any and all services based on fiscal concerns. Although the administration proposal may exempt from some such restrictions Medicaid's so-called “mandatory” population groups—primarily poor children, and elderly and disabled people eligible for Supplemental Security Income (SSI) (that is, with incomes below 74 percent of the Federal poverty level)—it is unclear whether these exemptions would apply to all the services these groups currently receive. New types of restriction may apply to optional services (for example, prescription drugs, dental services, physical therapy, and eyeglasses). For optional groups—which include elderly and disabled people with incomes above 74 percent of the Federal poverty level—the majority of elderly Medicaid nursing home residents, pregnant women with incomes above 133 percent of the Federal poverty level, near poor children and very poor parents—States would appear to have total discretion to limit the terms and scope of coverage. The same may be true for the State Children's Health Insurance Program, funding for which is incorporated in the newly proposed State allotments.

In general, a cap on Federal funds will constrain coverage for any and all groups and services subject to that cap. Similarly, elimination of an array of current Federal Medicaid standards—like those related to nursing home quality, access to emergency rooms and other protections under managed care, and timely processing of applications—will affect any and all groups and services now benefiting from them.

Overall, the administration's Medicaid proposal in no way secures Medicaid financing for vulnerable populations. Instead it takes advantage of States' current fiscal weakness to encourage States to take a bad risk: trading assured Federal financing in the future for a bit of new revenue and authority to cut spending today.

CONCLUSION

In his most recent State of the Union Address, President Bush described Medicare as “the binding commitment of a caring nation.” The same language applies to Medicaid. A strong Medicare prescription drug benefit along with fiscal prudence is needed to secure our binding commitment to Medicare. Enhanced and guaranteed Federal matching payments are needed to secure our binding commitment to Medicaid. In his 2004 budget, the President abandons rather than secures these commitments. A caring nation should reject these proposals.

Chairman NUSSLE. Do members have any questions?

Mr. Shays or Mr. Scott. Mr. Scott. Oh, I am sorry. Well, let—do you have questions?

Mr. SCOTT. I will go next.

Chairman NUSSLE. Mrs. Capps.

Mrs. CAPPS. Thank you Mr. Chairman.

I would like to ask you to respond, Professor Feder. The Bush administration has said that all the current beneficiaries would continue getting current benefits. You kind of disputed that a bit. But I want to bring out this part that the Secretary referred to today as the so-called “optional beneficiaries,” or benefits that are optional, that could be cut as Federal dollars become more limited.

I say this, in the light of almost every State facing a deficit with its own budget right now, it is certainly going to be right up front there if this legislation should pass or if this proposal of the administration becomes law.

You have made some comments about this, but again, what do you think about this argument and who are—maybe you can describe some of these optional beneficiaries. What would they do without the availability of Medicaid and what would happen to them as more and more people become unemployed?

Ms. FEDER. I would be happy to address that.

I think there has been some uncertainty. As we have discussed the details, actually both proposals are not fully laid out. And there has been some inconsistency in the information on whether, as the Secretary said today, mandatory populations would continue to receive benefits, or more accurately, whether they would be subject to the capped funds. I believe even today, he spoke about perhaps exempting the mandatory population from the capped funds for mandatory services, but not optional services, as was pointed out.

To be more precise, mandatory population groups are primarily the poorest population groups, the poorest children and elderly and disabled people who are eligible for Supplemental Security Income, SSI. Those people have incomes below 74 percent of the poverty level. These people, along with optional groups in the population—which include the bulk of nursing home residents—people also rely on optional benefits. Optional benefits include benefits for prescription drugs, benefits for dental care, benefits for physical therapy, benefits for eyeglasses.

So those optional benefits, even for the poorest population, would be constrained potentially under the caps. And for the optional population groups, those people who are just above poverty or have incomes above SSI level for the bulk of nursing home residents, for the beneficiaries receiving home care, those populations and their services are totally up for grabs and at the States’ discretion.

And the difference—even though those benefits are optional now, the State must define eligibility rules that apply across States.

They must provide comprehensive benefits for the population they make eligible. And so, as they squeeze, they cannot be arbitrary in the cuts they are putting into place. So what is needed is money so that those States won't have freedom to cut in ways that may be arbitrary.

Mrs. CAPPS. It is rather a nightmare scenario to think of what would happen to nursing home residents, for example, should this proposal be enacted.

And then, if I could go on, because I want to give you a chance to elucidate and respond to so many members, along with the Secretary, saying Medicaid and Medicare programs are just too expensive, they have been growing at such a high rate we can't afford them. What are some other ways that we should consider our responsibility in this arena and the kind of valuable services that these services provide to our population?

Ms. FEDER. I am glad you asked Congresswoman Capps, because the issue is not affordability of these services. Cutting back program protections doesn't make the costs of health care go away. It simply shifts them to the people who bear those costs, and for many, it makes them unable to get it. The issue is not affordability; the issue is our Nation's priorities.

I personally am appalled at the notion that some would propose a \$674 billion tax cut at this time and argue that decent protections for Medicare beneficiaries, for prescription drugs, for poor and vulnerable populations, for health and long-term care services are unaffordable. And over the long term the issue is fiscal prudence to enable this Nation to address the additional costs that will inevitably come as our generation turns age 65. Those costs, we know they are coming. The job is to minimize debt today so that we can cope better in the future. That's exactly the opposite of what we are doing, what is being proposed.

Mrs. CAPPS. Thank you.

Thank you, Mr. Chairman.

Chairman NUSSLE. Thank you.

Mr. Shays.

Mr. SHAYS. Thank you, Mr. Chairman.

I would like to thank both of our witnesses. It is kind of awkward sometimes, when you are the second panel after a Secretary, but you both are such noted scholars and experts on these issues that I know we continue to rely on both of you for your advice and counsel.

I have to tell you that what frightens the hell out of me is that when I look at basically two-thirds of our budget on automatic pilot, and I think that I am supposed to be in a legislature that is supposed to come to grips with these issues, and I look at Medicaid going up at an average of 9-percent a year and Medicaid close to 7—that is what the average kind of is. And I think it is such a big bulk of government spending, and, I think, of opportunity costs that it drowns out other things.

And then I think that we have already learned that our gross domestic product, 14.4 percent is on health care in general, and I think that our American businesses have to compete overseas with countries that their gross domestic product might be at 5 percent, like, you know, Formosa or Taiwan.

So I guess what I want to ask you both is, how do we slow the growth in these gigantic programs so they ultimately don't crowd out other very needed programs?

Ms. WILENSKY. That's a very large question to handle in a hearing. I think, in this country, we will spend more on health care than in other countries because we are not inclined to wait. We want easy access to new technologies. We tend not to want to have a lot of constraints on our providers, and when we place those constraints, or attempt to place those constraints, people respond badly. I believe it will be much more a question of whether people feel they are getting value for the money that they are spending, and when they don't, they get very frustrated.

To me, it is instructive to consider a managed care backlash we had in this country in the late 1990s. We did not see a similar kind of response from Federal employees who, when they are unhappy, every November can vote with their feet and find a different health care plan.

I don't want to pretend that this model is a panacea and is not going to challenge us as to how much we want to spend on the currently working versus how much we want to spend on the currently not working. These are difficult issues and there is no easy resolution. But the question of whether or not some kinds of programs, put in place, are able to respond better to what people want than others is what you, as Members of Congress, have to decide.

What we are seeing, in part, now, on Medicaid is the aftermath of many States have done what a lot of us wanted them to do in the late 1990s, expand benefits, expand populations that they covered, and expand payments to providers. They are being caught in a fiscal bind with no ability to deficit-finance and having to respond in a simple way, to reduce expenditures which is usually to try to cut providers' rates or to cut benefits now, in some cases, or populations.

What you are able to do as Members of Congress is to try to help design programs that make sense with these changing demographics. I am not sure what we are going to—this country next about trying to restrain health care spending. We are in the spending phase because nobody has been very comfortable with seeing restraints come back in place.

I don't think we are going to repeat the 1990s, and I don't think we are going to go back and repeat some of what we did in the 1980s. Whether or not we move to a Federal employees' model, whether or not we allow individuals to make better choices in terms of the kind of health care they want, whether we have flexibility or whether we go back to have more regulatory strategies, I think that is really what we are going to have to decide as a country: What do we want to do next?

But I don't think we are going to—this country is going to continue spending substantial amounts on health care. The fact that we are so proud that we doubled the NIH budget is only going to make it more difficult, not less, because there will be many technological advances to go along with our aging population.

It is really a question of whether we can have people feel like they are getting value for their money, and they are in a position to make the choices they want, or do we want to have a much more

structured, regulatory approach. Judy and I differ in terms of what it is that makes sense, particularly for, say, our Medicare program.

Either as a program or as a component program, there are fundamental philosophical issues that the Congress is going to have to deal with. When we have seen the expansions talked about for the uninsured, there really is a fundamental philosophical question about whether or not you want to use refundable tax credits and grouping mechanisms, or do you want to expand Medicare and Medicaid to the currently uninsured as a way to try to bring people into insurance coverage. These represent legitimate, philosophical disputes that people can have and still feel passionately they want to see the problem solved.

Mr. SHAYS. And the light is on, but I am sure Mr. Scott doesn't mind my going on longer.

The bottom line is, I think, we have so much distortion now in the marketplace in taking care of the uninsured because we are not going to—we don't throw them off a cliff. We just give them a different kind of health care.

Dr. Feder, feel free to make some comments.

Ms. FEDER. Thank you, Mr. Shays.

I agree with much, though not all, as she knows, of what Gail said. And I want to go back to the way you framed the problem, which was in terms of the percentage of GDP we spend on health care, a growing amount for the Nation as a whole, because I think, as you recognized in that comment, it is the entire health care system that causes costs to rise.

The unique problems of Medicare, it is not that Medicare is inefficient. It is that Medicare—and particularly looking out into the future—has to deal with larger numbers of older and disabled beneficiaries. They have the same problems with health care costs that the entire Nation has, not different ones; indeed, because of the payment control mechanisms, they actually are able to do somewhat better than the private sector in controlling costs.

But health care costs are rising, and deciding whether we are getting value for the dollar—we are, after all, an affluent Nation; our GDP is expected to rise per worker by 50 percent over the next—what is it—through 2035. How we want to use those dollars is our choice.

I would also add—

Mr. SHAYS. Let me just say, the problem is, in one way it is our choice; in another way, it isn't quite our choice. That is, when you see that we are going to have—I have some companies that are going out of business in my district because they are not able to compete with countries that don't have such large health care costs and so on. And you know their labor costs are not.

Ms. WILENSKY. I do not buy that. Their total labor cost is divided between wages and fringe benefits, and if they can't compete, it is because of their labor compensation, the total labor compensation, and not the notion that there is some piece of it that is growing faster.

Mr. SHAYS. No, I think there are a lot of pieces. But if you are paying \$15,000 for health care insurance for your employee, it makes it pretty hard.

Ms. WILENSKY. What it means is that the workers are going to get squeezed on wages, and of course, what we saw in the 1990s is because we were so much more successful in slowing down the rate of health care spending, we were able to see substantial increases in wages in the 1990s without inflation.

Mr. SHAYS. So your argument—and we will get back to you, Dr. Feder. But your argument is, bottom line—

Ms. WILENSKY. It is productivity. And what happens in terms of total labor compensation, that is what makes you competitive or not.

Mr. SHAYS. Of which health care is a much larger amount in the United States than it is for other countries?

Ms. WILENSKY. It is, but relative to the total package it is actually quite small.

Mr. SHAYS. Well, great. Then I don't feel as scared.

Ms. WILENSKY. I think it is an easy—it is an easy excuse as to why a company is having trouble.

Mr. SHAYS. I am not looking for excuses. I am just very concerned that my employees now have—my constituents no longer have jobs, and I am trying to get some answers to it.

But, Dr. Feder, we kind of interrupted you.

Ms. FEDER. That is quite alright.

What—on this point I think there are also differences between the way we finance medical care in this Nation and the way it is done in other countries. In other countries they bear those costs. Not all countries have extensive health insurance systems or as costly health care. But in other countries it is financed through the tax system and it doesn't fall in the same way on individuals, on particular employers.

So there are many ways that we have the issue of whether we want to continue to support the advancing of health care, adopting new technology that is providing us a lot of good, along with, perhaps, a lot of unnecessary service. We do have to figure out, if we don't want to do that, how we limit what we spend on health care, a very challenging choice. It should not be done to limit those who are most in need of care, the elderly and disabled beneficiaries of Medicare, leaving younger populations unaffected.

We shouldn't be leaving the uninsured hanging out to dry when the problem is not the health care costs for that 40-some million people, but rather the costs for all of us who have health insurance. But we as a Nation need to grapple with it appropriately. It is not beyond our ability to deal with.

Mr. SHAYS. Thank you both.

Thank you, Mr. Scott, for your patience. Mr. Scott, you have as much time as you want.

Mr. SCOTT. Thank you, Mr. Chairman.

I think—in follow-up to your question, I think Dr. Feder has suggested that if we had universal health care, that would relieve the employers of paying a significant portion of their wages and would make us more competitive. And we have also heard that the programs we are trying to deal with now, Medicare and Medicaid, you take the health care system you have got and expenses out there, and we are just buying what is out there. If we could get a hold

on the health care system and the increases, then we would be a lot better off.

But in that light, if we are dealing with a private system rather than Medicare or Medicaid, private has—you have got to pay for the services, you have got expenses, you have got a profit. There are only three little pots you can play with, and if you are not going to reduce the services, where are Medicare and Medicaid in terms of cost of administration?

Ms. FEDER. As you know, Medicare in particular, I believe that the figure is less than a handful of percentage points—2 to 5 percentage points, 2 percent of Medicare in administrative costs is the figure that I recall.

Mr. SCOTT. What is private system?

Ms. FEDER. Private sector varies by the size of the group being insured. My belief is that for employer-sponsored insurance in large firms, it is in the neighborhood of between 10 and 11 percent. And for small businesses it is in the neighborhood of 30 to 40 percent.

Mr. SCOTT. So you can't—you are doing as well as you can on expenses, you don't have a profit, so how can you possibly do better in the private system than Medicare or Medicaid?

Ms. FEDER. I have got to tell you, Mr. Scott, it beats me. I think, and the record shows, as I said, that Medicare does a far better job historically of controlling costs than does the private sector. Claims about a competitive system or the Federal Employees Health Benefit Program have simply not been borne out. They—we have not seen a slowdown in health care costs.

Mr. SCOTT. OK. Now, as I understand this proposal, you get a prescription drug benefit? You go into an HMO, is that the deal on this thing?

Ms. FEDER. An HMO or another—the administration has said a private health insurance plan because they have considered options beyond HMOs.

Mr. SCOTT. Once you get into the private sector, is there any limit to what they can charge you on co-pays?

Ms. FEDER. I believe actually in terms of what the administration has laid out in detail—and the details are sketchy on the proposal, but my understanding is that they would be, they are proposing to make some specifications of a benefit plan, but allow variation within it. So some variation within limits.

Mr. SCOTT. If the HMO that you get into goes broke, then what happens?

Ms. FEDER. That is a good question and not one to which I have seen an answer, and one which we have had a problem with.

Mr. SCOTT. And once you go to a HMO can you get back to Medicare.

Ms. FEDER. I believe I heard the Secretary say no, but I don't know the answer to that in their proposal.

Mr. SCOTT. OK. Medicaid, now, there has been a question of whether this thing is capped or not. After this thing goes and if you choose that option, do you get a set amount of money or not?

Ms. FEDER. My understanding of the proposal is that it is to replace the current system that provides Federal dollars on a matching basis, based on the number of people who actually sign up and

the costs of their service. It would replace that, for a substantial portion at least, if not all of Medicaid, with predetermined allotments to the States.

Mr. SCOTT. So the State of Virginia would get one big check regardless of who they enroll, based on what they used to be spending?

Ms. FEDER. In a word, that is pretty much true.

Mr. SCOTT. And if they enroll more people, that is on the State; and if they enroll less people, that is good for the State.

Ms. FEDER. Or the State budget.

Mr. SCOTT. State budget.

Now, if you buy in, you can't get—I mean, if you buy in, you can't get back to the regular Medicaid. After about 6 or 7 years—he kept kind of doing this to the curve, where you get under the cost of inflation—if the cost of medical care keeps going at 9 percent, in the fullness of time, you are going to be way behind the curve as I understand it.

Ms. FEDER. Well, the way I understood it—and it was clear, I thought, in his use of the term, forward-funding—it means give the money to you up front, then take it back at the end, as I understood it.

And even though he said that it was not a cut, as he showed the trend line, by doing this, he did indeed say that in years 7, 8 or 9, 10, that States would receive less than that inflation trend line, that baseline.

So I think that your interpretation is correct, that becomes a cut.

Mr. SCOTT. So when he said you wouldn't have to pay it back, that wasn't really the whole story. You just wouldn't be getting enough.

Ms. FEDER. I didn't understand that, because I believe that the forward-funding, if you get more up front, that means that you have to get less in the back.

Mr. SCOTT. In future, with the costs going way up, we could just increase it, say, instead of 9 percent, 6 percent, 5 percent, whatever kind of a budget he wants to do; and the State of Virginia would just get that check and we would be on our own after that.

Ms. FEDER. Well when you move away from the commitment that we have now to match the payments based on the eligibles and the costs, then you can decide what rate of increase you want to apply. I have not seen it well explained, what the administration intends, although they sound as though they are talking about a baseline—which is the projected rate, as he said, changing from year-to-year.

But policy could be changed. It becomes quite simple to ratchet that down as is the experience in other areas. But—well, go right ahead.

Mr. SCOTT. The State doesn't have to sign up for this and your recommendation would be to leave well enough alone?

Ms. FEDER. Oh, I think it is a really bad gamble. I think it is appalling that we would only provide States aid if they sign up for it, because it is really forcing them to make what I would argue is a very, very bad choice.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman NUSSLE. Thank you. I just have a couple of things. We appreciate your time today.

The first is, with regard to—and you were on MedPAC. You were the—in fact, you chaired MedPAC, didn't you, Dr. Wilensky?

You know, it seems to me one of the frustrations that we have, or at least that I have—I can't speak for everybody, but one of the frustrations we have is that the data we are using to make determinations of impact and how things are—how things are going, how the challenges within Medicare in particular are being handled by our system are often 2 years old or longer. And is that still true, A; and B, what can we do about it? And doesn't it—doesn't that information make our decisions incorrect from the beginning, or inaccurate from the very beginning if you are basing it on information that is 2 years old?

Ms. WILENSKY. Two years is usually good in health data, to have the data not be more than 2 years out of date. There have been some attempts to try to get information sooner. The American Hospital Association has a survey that is used to provide information that I think is about a year old. But if you are trying to use actual information in terms of spending or cost reports, it is very difficult to have it quicker just because by the time it takes to come in, and for bills to be paid.

It does seem peculiar in an age of instant information that we can't find better ways to transmit information within the government. It is possible that some of the effects of the HIPAA requirements, which have transaction standards, will be to have information more readily available after it is all in place.

But it is a source of frustration.

Chairman NUSSLE. One other thing that I—or just since you are here, you are the—you are the co-chair of the President's Task Force to Improve Health Care Delivery for our Nation's veterans. And I wanted to ask you, because there has been some discussion lately, and in fact, bills that have been introduced in the most recent Congress and now, I assume, considered to be introduced in this Congress, to change the method of financing this from a discretionary annual program to a mandatory funded program; and I guess what I am curious about is, is the task force considering a recommendation in that regard?

When are—I guess first, when are the recommendations coming out? I suppose I shouldn't ask you to tilt your hand too much, but if you would tip your hand, is it heading in that direction or maybe a different way of financing the veterans program?

Ms. WILENSKY. Our recommendations will be made to the White House no later than May of this year. We had an interim report that was out last summer. This activity has been one that has taught me Medicare is not as hard a problem as I had thought relative to other issues. Much of what the task force is looking at has to do with ways to try to have health care between the VA and the DOD—for retirees and veterans—be integrated in a better way so that resources can be shared, so that health care can be more transparent for the active duty to retiree status of an individual. And so we are—many of our activities have involved looking at information systems, trying to go to single physical discharges rather than having duplicate physical discharges.

We have also looked at the issue of a funding mismatch. The problem is that if you have major waiting times in the VA system, it makes it very hard to talk about sharing or coordination between the VA and DOD when you have one system that is already so backed up.

We are in the midst of our final deliberations and as of now, the task force—these are all open meetings, so anybody can come listen as we proceed over the next 2 months. But the task force seems to be leaning to make an impartial distinction. The first refers to the categories, what had been called 1-through-6s, those who were service-connected disabilities and the indigent.

With geographic adjustments, it is 1-through-7s in the new definition, and to look at that group differently from the category—so-called Category-8s, or the old 7s who have neither service-connected disabilities nor are they indigent. At this point we are leaning toward a way to try to assure full funding for those with service-connected disabilities and for the indigent without directly discussing, or at least at this point, recommending the funding mechanism.

As you might imagine, as a former administrator, I am very gunshy about adding to the large pot of expenditures that Mr. Shays has already noted is off of the table in terms of discretionary decision-making. But to also recognize we need to make sure that there is full funding for this group of veterans who have service-connected disabilities and/or who are indigent, whatever mechanism is used.

We are also engaged in a discussion about what, if any, policies might seem appropriate for the Congress to consider as to the Category-8s. We have not come to any conclusions either with regard to the funding or with regard to this issue. The task force seems to be leaning in this direction to recognize a difference between those that have service-connected disabilities or who are indigent and those who were newly allowed to use the VA as a result of the 1996—in the Millennium legislation.

I think we are all feeling a sense of frustration that Congress' legislation and funding seem to be inconsistent. We recognize that technically the Congress provided the Secretary with the ability to close enrollment, but Congress seems very unhappy when the Secretary actually tries to do that.

We are likely to have the sentiment that would-be funding and intent need to go closer together.

Chairman NUSSLE. Well, thank you. I mean, I am sure that there are more areas we could get into, but I will spare you that because I know May is just around the corner, and we are all very anxiously awaiting those recommendations. But it sure sounds like you are touching all of the most important component parts. There are many, as you know.

I want to thank you both for your testimony and for your advice. I am sure you will continue to provide it in this kind of forum as well. As you said, there are many other ways that we can discuss this. An open hearing isn't always the most easy way to accomplish that. But we appreciate all the ways that you have done those in the past, and we appreciate your testifying today.

If there is nothing else to come before the committee, we will stand adjourned.

[Whereupon, at 1:50 p.m., the committee was adjourned.]

