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A REVIEW OF THE ADMINISTRATION'S FISCAL YEAR 2006 HEALTH CARE PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

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(II)

CONTENTS

Page

Testimony of:
Leavitt, Hon. Michael O., Secretary, U.S. Department of Health and Human Services 11

A REVIEW OF THE ADMINISTRATION'S FISCAL YEAR 2006 HEALTH CARE PRIORITIES

THURSDAY, FEBRUARY 17, 2005

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

The committee met, pursuant to notice, at 2:12 p.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Hall, Stearns, Gillmor, Deal, Whitfield, Norwood, Shimkus, Wilson, Shadegg, Radanovich, Bass, Pitts, Bono, Walden, Ferguson, Otter, Myrick, Burgess, Blackburn, Dingell, Waxman, Markey, Brown, Rush, Engel, Wynn, Green, Strickland,DeGette, Capps, Allen, Schakowsky, Solis, Gonzalez, Inslee, Baldwin, and Ross.

Staff present: Chuck Clapton, chief health counsel; Jeanne Haggerty, professional staff; Eugenia Edwards, legislative clerk; John Ford, minority counsel; Bridgett Taylor, minority professional staff; Jessica McNiece, research assistant.

Chairman BARTON. The committee will come to order. We are honored today to have the Secretary of Health and Human Services, the Honorable Michael Leavitt, making his first appearance in the capacity before the Energy and Commerce Committee. Secretary Leavitt has got a distinguished public service career; Governor of Utah, head of the National Governors Association, administrator of the EPA and now is Secretary of Health and Human Services. He has got a large task ahead of him. We have tremendous responsibilities in this committee and his agency regarding the public health of the United States of America. Just one program of many. He is responsible for Medicaid. Right now it is a $196 billion per year program growing and doubled in—we also need to take a look at the implementation of Medicare reform. I hope that this committee will undertake a comprehensive review of the authorization of the National Institute of Health. I do also believe we should look at the Food and Drug Administration. We should look at the National Cancer Institute, Centers for Disease Control; these are all issues that are in Secretary Leavitt's purview.

Mr. Secretary, We are extremely pleased to have you before this committee. I am going to give every member of the committee a chance to make a brief opening statement. They will come to you for such time with their main concern and I am sure that everyone on the committee will have questions for you. As I told you in the anteroom, though, there is both good news and bad news. The

House is through voting for the week, so most of us are going to be rushing to catch airplanes, so I don't think you can expect to get a second round of questions today.

I would now like to yield to the Senior Minority Member of this committee, the former chairman of this committee and the Dean of the House, the Honorable John Dingell of Michigan for a 5-minute opening statement.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Good morning. Let me begin by welcoming Secretary Michael Leavitt to his first appearance before the Energy & Commerce Committee. We look forward to hearing him testify about the Administration's Fiscal-Year 2006 Health Care Priorities.

Secretary Leavitt is new to the Department of Health and Human Services; but luckily for all of us, he is no stranger to the complicated world of health care. As Governor of Utah, he fought to make Medicaid more flexible, provided new health benefits for the uninsured, and dramatically improved immunization rates above the national average. I believe that his experience and insights will provide strong leadership in the years to come. Mr. Secretary, I look forward to working closely with you to improve this country's health care system.

Mr. Secretary, you have a formidable year in front of you. First and foremost, I would like to praise the Administration and you, Mr. Secretary, for your ambitious plans for reforming the Medicaid program. For years, we have discussed the necessity of looking seriously at this program, and for years we have done nothing.

While we have done nothing, the program has continued to expand without any oversight. For fiscal year 2006, the Federal share of Medicaid outlays is expected to be almost $193 billion, a $4.3 billion dollar increase from last year, and a $16 billion increase from 2004. Medicaid is now the largest single Federal health care program, and is often the largest item in most state budgets.

I am extremely interested in hearing more about the reforms outlined in the President's budget proposal. States need additional flexibility. At the same time, we also need greater accountability. Federal dollars given to states for Medicaid should be used only to provide for beneficiaries' health care services. Reimbursements for prescription drugs should be at an accurate rate, which reflects the true costs paid by pharmacists. The laws governing Medicaid eligibility should not create incentives for individuals to manipulate the system and transfer assets to qualify for long-term care. My Committee has already held hearings on a few of the proposals outlined in the budget, and we will be holding more. Especially in these tight fiscal times, it is critical that we ensure that every Medicaid dollar is used to improve the health care of the people who depend on this program.

This year the Administration also has the important task of implementing the new Medicare prescription drug benefit provided in the Medicare Modernization Act (MMA). Implementing the new benefit is a top priority for Congress as well. Beginning January 1, 2006, seniors will FOR THE FIRST TIME have comprehensive coverage of their prescription drugs by the Medicare program, and I want to work with you to ensure that the transition happens smoothly and efficiently. This new benefit will be a great help to Medicare's beneficiaries.

Quite frankly, the tactics that have been used by opponents of the Medicare bill disappoint me. Scaring seniors into not enrolling in a Medicare prescription drug card program that would have saved them money is inexcusable. Complaining about so-called new "cost estimates" of the bill that compare the cost of the drug benefit over two different time periods and reflect the gross cost without factoring savings is dishonest. Arguing that if the Federal government should negotiate prescription drug prices to drive down the cost of medicine, when the non-partisan Congressional Budget Office has said that doing so would not produce substantial savings is just not accurate. It is these types of "Medicare myths" that will harm seniors—not a new prescription drug benefit.

I am also deeply committed to reauthorizing the National Institutes of Health (NIH). Most programs under NIH have not been authorized in over a decade. Shockingly, outside of entitlements, many health programs have been funded been under lapsed authorization. I've made no secret of the fact that I don't believe this is a responsible practice and want my Committee to return to a stronger role in reviewing programs and program authorizations.

The Energy and Commerce Committee has the largest jurisdiction over health care of any legislative congressional committee, and thus we play a key role in creating legislation for better health care. I am proud that in the past, we have worked in a bipartisan fashion, and I hope that continues into this new Congress. We work best when we work together. We could not have passed into law the Medicare Modernization Act without the input and support from Democrats. I want to be able to work with our Democratic Members to continue to improve our health care system.

As Chairman of this committee, I plan to work with President Bush, Secretary Leavitt, Members of Congress, and our health care colleagues to continue this important progress and to seize the opportunity for better health and responsible health care.

Thank you again, Mr. Secretary, for appearing here today. I look forward to hearing your testimony.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. Welcome, Secretary. I ask you to accept my statement to be inserted in full in the record. I will try to extrapolate——

Chairman BARTON. I would also like to compliment your choice of soft drinks. It is the first time I have seen you drinking a Diet Dr. Pepper. I may be rubbing off on you a little bit.

Mr. DINGELL. The budget before us seriously shortchanges the most vulnerable people in our society. This is the unfortunate result of reckless tax cuts that have benefited the wealthy few. The elderly, the poor, the disabled will now pay the price. The President proposes $1.6 trillion in tax cuts over the next 10 years. Medicaid will be cut by $60 billion. Deep cuts in Medicaid are unfair. Medicaid faces many challenges, serving 50 million people who are among the most poor and vulnerable in our society. It is the only program that provides financial assistance for middle class and poor seniors in nursing homes, adequate health insurance for individuals with disabilities and health care coverage for one in four of our children and their families.

Are the costs of Medicaid going up? Yes. Medicaid suffers not so much from "inefficiency" or rigidity, but rather from rising health care and prescription drug costs, increased enrollment due to declining employer-sponsored coverage, rising numbers of uninsured due to the Nation's economic woes, and a society which is aging.

In spite of all of this, Medicaid's per capita growth rate of 6.1 percent is less than the private sector's 12.6 percent. The President's own baseline dropped by $91 billion from previous estimates, indicating that spending is being curbed. But the President's budget also includes deep cuts to Medicaid on top of this existing reduction in spending, clearly sending us in the wrong direction. Rather than cut the program, we should shore it up. If we do not, States will have no choice but to raise taxes or to reduce or completely eliminate coverage for some of the most weak and vulnerable in our society.

If these reasons are not compelling enough, remember that cutting Medicaid is also bad for business. Cuts to Medicaid leave more Americans uninsured or under-insured. This means that providers will have to make up for lost revenue by shifting costs to private payers and employer health coverage will bear the brunt of that cost.

Again, this budget "proposes to provide States with additional flexibility in Medicaid to further increase coverage amongst low-income individuals and family without creating additional cost to the Federal Government." Does that mean more efficiencies, or simply

telling States they can cover more people by giving somebody less, whether it is providers, seniors, children, or individuals with disabilities? Is this a step toward the block grant program that we hear about?

On Medicare, recent revelations of another increase in the cost of prescription drug laws tells us we cannot afford bloated payments to HMOs and to drug manufacturers. It is most unfortunate President Bush will use his veto to protect them. That is clearly wrong. Allowing the Secretary to negotiate drug prices, or not paying HMOs the 137 percent of fee-for-service costs would allow us to reduce costs. It would also allow us to improve the benefit by providing coverage for drugs between $2250 and $3600 of spending and to rescind upcoming cuts in physicians' payments.

Public health service budget proposals are also bad—bad medicine, not good government. The general theme is to eliminate, cut, or to freeze many programs of proven worth. The Centers for Disease Control and Prevention's chronic disease program is being cut, the preventive health services block grant is being eliminated, bioterrorism preparedness funding is being cut by more than 12 percent, HIV/AIDS treatment and prevention programs remain inadequately funded, biomedical research is shortchanged by an increase in name only and the Food and Drug Administration's chronic under-funding will continue.

Don't take my word for it. The American Public Health Association has called the budget "shortsighted." The Association of State and Territorial Health Officials says the cuts in the Administration's proposed 2006 budget "would weaken the ability of the State and local public health officials to respond to bioterrorism, emerging infectious diseases, or other public health threats and emergencies." The Association of American Medical Colleges is "deeply disappointed" in the President's 2006 budget. The Association of American Universities budget says that the budget "would erode research and the innovative capacity of our nation." The American Nurses Association states that the "president's proposed funding is insufficient to address the increasing nursing shortage." Patient groups for cancer, diabetes, heart disease, HIV/AIDS, and others have expressed similar concerns.

All this just to pay for past, present and future tax cuts to those who are most fortunate among us? We and future generations will pay very dearly if these unfair and unnecessary cuts are enacted and if this budget passes in the form in which it now is. Thank you, Mr. Chairman.

Chairman BARTON. Thank you, Congressman Dingell. We now recognize the chairman of the House subcommittee, Mr. Deal, for a 1-minute opening statement.

Mr. DEAL. Thank you, Mr. Chairman. I join with you in welcoming Secretary Leavitt to our committee today, having worked with him in his former role as EPA Administrator. I know that he has the skill and the knowledge necessary to serve as excellent Secretary; commend the President for his selection of you and I welcome you to this committee. We look forward to working with you. I yield back. Thank you, Mr. Chairman.

Chairman BARTON. We thank the gentleman from Georgia. We would recognize the gentleman from California, Mr. Waxman, for a 1-minute opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman. I welcome the Secretary of HHS. I think he has the unenviable task of trying to defend one of the worst budgets in history, as I can recall, during the time I have been here. The Bush budget slashes Federal support for Medicaid, threatening the safety net program for the poorest and most vulnerable of our citizens. It also hints at erosion and repeal of basic standards that protect people in nursing homes, people with disabilities, low-income children with family incomes only slightly above poverty. It also suggests an NIH budget that won't keep pace with inflation which will erode the ability of that institution to find cures and other ways to save lives and reduce suffering. The resources for FDA and the CDC are quite remarkable in light of a recent flu vaccine debacle—it is a strange response, indeed. The money for unproven and misleading abstinence-only programs is increased dramatically, but funds are eliminated for proven preventive health services funded through State block grants. Mr. Chairman, I welcome the Secretary. I hope I will have a chance to inquire further about some of these issues.

Chairman BARTON. We thank the gentleman. Recognize the gentleman from Texas, Mr. Hall, for an opening statement.

Mr. HALL. Thank you, Mr. Chairman. I just congratulate Governor Leavitt on the services he has rendered, on being here today, and for the opportunity to work with him the next year. Thank you, sir. I yield back.

Chairman BARTON. We recognize the gentleman from Ohio, Mr. Brown, for an opening statement.

Mr. BROWN. Thank you, Mr. Chairman. Thank you for joining us today, Secretary Leavitt. I appreciate our candid conversation last week. Thank you. All my questions about the President's budget boil down to this, I simply can't understand how the President's moral values permit him to give multi-millionaires tax cuts they are not even asking for, while choking off programs that protect children from abuse, seniors from destitution, and our communities from crime. Programs like Medicaid already run on fumes and programs like Medicaid matter. The President is not making the government more efficient, he is making it less effective.

A budget should be an accurate reflection of what a society cares about. This budget doesn't reflect the concerns my constituents share with me every day; concerns of businesses and civic organizations and churches in my district. This every man for himself budget reflects a narrow ideology that not only invites human suffering, it tests the cohesiveness of our society. The programs under this committee's jurisdiction reflect the day-to-day concerns of Americans. They extend a lifeline to kids and seniors in poverty, they sustain the public health, they foster medical progress. The President's budget starves these programs while it gives more to the most privileged. I hope the Secretary can explain why.

Chairman BARTON. Thank you. The gentleman from Kentucky, Mr. Whitfield's, recognized for an opening statement.

Mr. WHITFIELD. Mr. Chairman, I waive opening statement.

Chairman BARTON. Okay. The gentleman from New York, Mr. Engel, is recognized for an opening statement.

Mr. ENGEL. Mr. Chairman, I will waive my opening statement so I can have an extra minute later on.

Chairman BARTON. Okay. The gentleman from Ohio, Mr. Gillmor, is recognized for an opening statement.

Mr. GILLMOR. Thank you, Mr. Chairman. I just want to welcome the Secretary and commend him for the great job he has done in the many past positions he has held. We look forward to working with you. Thank you. I am hiding behind Mr. Norwood's sign.

Chairman BARTON. The gentleman from Massachusetts, Mr. Markey, make a statement.

Mr. MARKEY. Thank you, Mr. Chairman. Welcome, Mr. Secretary. I am very concerned, Mr. Secretary, that the President's budget, with large cuts in both Medicaid and long-term care programs will hit our Nation's most vulnerable, the hardest—are putting an enormous strain on our State budgets. This short-sighted budget also cuts prevention programs and other programs that have initial costs but will result in savings in the long run. Last week we learned that despite the fact that the price tag for the best Medicare bill the drug companies can buy has skyrocketed to new heights.

The President is refusing to consider any changes to the bill that will reduce cost. The President could easily slash the price if he would simply give you the authority to negotiate prices on behalf of all Medicare beneficiaries, but the President has said he will veto any attempts to change his Medicare drug bill to lower costs to seniors in our country. That is a big mistake, Mr. Secretary, and we are going to have a powerful debate in this country this year in order to deal with that issue.

Chairman BARTON. Thank the gentleman. Gentleman from Illinois, Mr. Shimkus, wishes to make an opening statement?

Mr. SHIMKUS. I will waive.

Chairman BARTON. Okay. Gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I am glad we have this hearing and Secretary Governor, I thought always once a Governor, always a Governor, so welcome to your first appearance for our committee and I welcome the chance to talk about the Administration's health care budget.

I want to applaud the Administration for meeting its commitment to doubling the FQHCs. I think that is so important in our country and also for the health care technology funding. But I have to admit, I was disappointed with the continued effort to eliminate the community access program, the HCAP program that is been a Godsend for over 150 communities throughout our—in 42 States. It helped bring our providers together to see how we can deal with the uninsured. In Houston, we actually deal with for-profits, nonprofits, everyone to see how we can deal with it, our hospital systems and also our program system. And I know, on the Senate side, Senator Murray, fought to restore the funding last time and I am going to stand with her again to make sure we can do that.

Like other Federal programs, there are elements of Medicaid that I think that certainly warrant our examination and I wholeheartedly, though, disagree with the Administration's assertions

that the program is inefficient. True, their costs have increased, but Mr. Secretary, the Medicare and private insurance have increased even more than Medicaid. Mr. Chairman, I would like my full statement be placed in the record.

Chairman BARTON. Without objection, so ordered.

Gentleman from New Hampshire, Mr. Bass. Gentlelady from Colorado, Ms. DeGette. Gentlelady from California, Ms. Bono. Okay. The gentlelady from California, Ms. Capps. Okay. Gentleman from New Jersey, Mr. Ferguson.

Mr. FERGUSON. I will waive, Mr. Chairman, except to welcome the Secretary. We are delighted he is here and looking forward to working with him. Thank you.

Chairman BARTON. All right. The gentlelady from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and welcome, Secretary Leavitt. In my view, the President's budget worsens the health care crises in the United States in many ways, but at the top of my worries about this budget are the proposed cuts to Medicaid. At a time when over 45 million Americans, including 9 million children, are uninsured for the entire year, Medicaid has been a life raft. It is cost-effective. The per capita increases in Medicaid are less than half of those in the private sector. When the need is so great, how can the Bush Administration justify $60 billion in Medicaid cuts?

I am particularly disturbed by your statements that our only real commitment is to "mandatory populations." Optional beneficiaries are not extras. They are children and pregnant women and persons with disabilities struggling to live on poverty or near-poverty incomes. I believe this is a dangerous budget that will put the security of a million American families in jeopardy and by jeopardizing the health of our people, weaken our economic well-being. I will have some questions about these optional, so-called optional populations. Thank you.

Chairman BARTON. Thank you. Gentlelady from North Carolina wish to make an opening statement? Does the gentle lady from California, Ms. Solis, wish to make an opening statement?

Ms. SOLIS. Yes. Thank you, Mr. Chairman, and welcome, Mr. Secretary. Briefly, we have already heard about the problems with Medicaid, the cuts, the potential cuts, and I am very concerned about what might take place in California. And with—especially with respect to the inner-governmental transfers that I know you are going to be looking at. They have worked reasonably well for us in California. Please make that consideration to take a second look. We just met with our Governor, Mr. Schwarzenegger, and talked about that in depth.

But I am more concerned, also, about health care profession training programs that are going to be eliminated in the Department of Health and Human Services. As you know, minorities only make up 9 percent of the nurses, 6 percent of the physicians, and 5 percent of the dentists. This program is something that is much needed if we are to strive for diversity in Federal Government, so I would hope that those funds would be restored and look forward to working with you on health care issues and health care disparity issues that exist in our country. Thank you.

Chairman BARTON. Does the gentleman from Texas wish to make an opening statement? Dr. Burgess.

Mr. BURGESS. Mr. Chairman, I will waive. I just want to welcome the Secretary to the committee.

Chairman BARTON. Okay. Does the other gentleman from Texas, Mr. Gonzalez, wish to make—okay. Gentlelady from Tennessee, Ms. Blackburn?

Ms. BLACKBURN. Thank you, Mr. Chairman. Mr. Secretary, thank you. We appreciate you being here and I am particularly interested in a portion of the President's budget that would allow greater flexibility to the States managing their Medicaid. My State is a great example of why this is needed.

I am from Tennessee and about 10 years ago we had a program, TennCare, that was implemented to provide greater health care coverage. It is known largely as the test case for Hillary Clinton's health care and as you are probably well aware, we had a waiver for the program. It has resulted in some difficult situations, some budget crunches and is on the brink of catastrophe. And it is a financial crisis, a fiscal crisis to which we are very closely attuned; double digit increases each year and our Governor has had some tough decisions to make this year. So we look forward to working with you, we look forward to hearing from you. Thank you, sir, for being here.

Chairman BARTON. We thank the gentlelady. The gentleman from Maine, Mr. Allen, wish to make an opening statement?

Mr. ALLEN. I do, Mr. Chairman. Thank you. Mr. Secretary, welcome. Two of our greatest challenges of the rising number of uninsured and the increasing burden of health insurance on our Nation's employers if the President's budget reduces and in some cases completely eliminates many important programs which strengthen our healthcare infrastructure.

The President's solution to dealing with the uninsured is to trot out old proposals, association health plans, health savings accounts and tax credits. There is little evidence, in my view, that these proposals would significantly reduce the number of uninsured or bring down costs for employers. As Richard Wagner, the head of General Motors said the other day, "Our national health care crisis threatens the health and global competitiveness of our Nation's economy." When it comes to Medicaid, I am convinced that simply shifting costs back to the States, providers and beneficiaries is not likely to form a solution and so I really urge us to think long and hard about the budget we have in front of us and try to come up with one that does a better job with health care. I am sure you will have a different view, but I am glad to have you here. Thank you very much.

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

Ms. BALDWIN. I will waive.

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

Mr. ROSS. Yes, sir, Mr. Chairman. I appreciate the Secretary coming to testify today and like many of my colleagues, I am deeply concerned about some of the proposals in the Administration's budget in regard to Medicaid. Medicaid serves over one quarter of

the total population of my home State, which is Arkansas, and more than half of these recipients are children. In fiscal year 2004 nearly 700,000 children and adults were eligible for medical care through the Medicaid program. 75 percent of the nursing home patients in Arkansas are provided care through Medicaid.

I met with our Governor, Governor Huckabee, who is vice chair of the National Governors Association and the lead Republican on this very issue last week in my office here in Washington and he expressed concerns regarding the sustainability of Medicaid and the impact of any reduction of Federal assistance with administering the program. Therefore, as the Administration develops its changes to State funding rules, administrative payment cuts, and other reforms, Mr. Secretary, I just ask that you please do not lose sight of those who need Medicaid to live and what an impact any cuts would have on the small, rural and poor States like Arkansas.

Chairman BARTON. Is there any other member present which has not been given an opportunity to make an opening statement that wishes to do so? Seeing none, the Chair would ask unanimous consent that all members not present have the requisite number of days to put their statements in the record in their entirety. Without objection, so ordered.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. HEATHER WILSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW MEXICO

Thank you, Mr. Chairman, for holding this hearing today to review the President's budget for health care. And thank you, Secretary Leavitt, for being here today.

Let me start with what I believe are highlights of the President's budget. The budget includes a $304 million increase for community health centers, including $26 million to build new health centers in low-income communities. The budget also includes needed funding for health information technology initiatives, including $125 million for the Office of the National Coordinator for Health Information Technology.

But there are many items for concern for me in this budget, none of which are more important than Medicaid. I'm not against making changes to Medicaid that result in savings. In fact, I believe some of the specific Medicaid proposals in the President's budget are changes that are needed and would improve Medicaid. But I believe those changes will have consequences and can't be made in a vacuum. Starting with a budget number and only looking at changes that produce savings to meet that number may not be the right way to go here. We must look at the overall impact of these changes on the Medicaid program and its ability to provide access to high-quality health care for low-income children, pregnant women, disabled, and elderly Americans.

I believe most people in this room are aware that I have introduced a bill to create a Bipartisan Medicaid Commission to make recommendations for real reforms that would improve Medicaid. Nothing in this budget talks about having a national discussion about financing long-term care, the cost of which will double in the next ten years. Nothing in this budget talks about improving chronic disease management in Medicaid, encouraging prevention to keep people healthy. The commission would provide the right forum to carefully deliberate needed policy changes and ensure the long-term financial stability of the program.

I look forward to hearing your thoughts on this legislation, Mr. Leavitt, and I look forward to working with you as the Administration continues to develop and refine its ideas for Medicaid reform.

PREPARED STATEMENT OF HON. JOE PITTS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Chairman, thank you for holding this important hearing today. I will be brief since we are all eager to get to the Secretary's testimony. I just want to welcome

Secretary Leavitt to your first hearing before the committee, and let you know that I look forward to working with you.

Mr. Chairman, I know many of my colleagues will focus on Medicaid. Let me just say, at the outset, that while I believe our committee certainly our work cut out for us in finding the savings the President requested. However, I am certain that, if we put politics aside, we can work together diligently in a bipartisan manner to meet the Presidents goals in this area.

There are two other topics I would like to touch on very briefly. Last April, HHS limited attendance at its July International AIDS Conference in Bangkok, Thailand, to 50 federal employees at a cost of $500,000. That was down from the $3.6 million spent to send 236 people to the 2002 conference in Barcelona, Spain. Twenty-nine members of Congress sent a letter to Secretary Thompson last year thanking him for limiting attendance to this conference. Mr. Chairman, I would like to insert that letter into the record.

I applaud the Department's leadership in working to scale back the largess of the federal involvement at these international conferences. Further, I appreciate the Department's ongoing efforts to change the way the conference and travel system works at HHS. Total annual US HIV/AIDS spending in 2004 was $18.5 billion, and Congress passed a five-year, $15 billion initiative to combat global Aids. Clearly, focusing resources on AIDS treatment and effective prevention programs should be a higher priority than HHS spending millions of dollars on a single conference.

Secondly, I support the President's request for a $34 million increase in funding for SPRANS community-based abstinence education grants and hope Congress fully funds his proposal. Overall, our government spends $12 to promote contraception for every dollar spent to encourage abstinence. However, these spending priorities are exactly the opposite of what our parents say they want taught to their teens. In a recent Zogby poll, an overwhelming majority—85 percent—of parents said that the emphasis placed on abstinence for teens should be equal to or greater than the emphasis placed on contraception.

Further, I understand that HHS has jurisdiction over part of the Global AIDs funds. As you may know, my amendment to this law last Congress required that one-third of the prevention funds be used to teach abstinence until marriage, following the successful model Uganda developed. I just want to encourage you to follow the president's vision for this and make sure this funding gets proper oversight.

Again, welcome Mr. Secretary, and I look forward to working with you on these and other issues of importance.

PREPARED STATEMENT OF HON. C.L. "BUTCH" OTTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IDAHO

I would like to thank the chairman for holding this hearing and congratulate Secretary Leavitt on his new post.

While health care costs continue to rise and we discuss ways to trim costs, I think it is important to recognize we may be treating the symptoms of the system and not the disease. Until we put personal responsibility back into the health system, through emphasizing healthy behaviors and structuring health programs that put the actual costs of care in front of consumers we are going to face budget constraints like we see in Medicaid. The Medicaid budget problems at hand dictate we find a new approach. I agree with the Administration's proposal that would give states more flexibility in Medicaid spending. States must have the opportunity to shift resources to ensure the right care is delivered to the right folks.

I look forward to Secretary Leavitt's testimony and working with the administration in this regard.

PREPARED STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Thank you Mr. Chairman.

It is a pleasure to welcome Secretary Leavitt to today's hearing and to thank him for his many years of public service to our country.

As the Chairman of the 21st Century Health Care Caucus, I am pleased that the Secretary shares my passion for the benefits that health information technology can bring to improving the quality of care, reducing medical mistakes and managing the costs of health care.

I applaud the President's 2006 budget for providing better options for how we pay for health care including association health plans for small businesses, expanded Health Savings Accounts, and medical liability reform. More importantly, I am

pleased that the President plans an unprecedented commitment to health information technology and to expanding our nation's community health centers.

The budget takes a strong stance on eliminating waste and duplication in social spending and entitlement programs. We must be careful to ensure that we balance the intention to eliminate waste with our efforts to provide health care to those who need it the most. With over 45% of mandatory spending going towards these programs, the federal government should be driving the change to reforming health care by shifting the focus from "Who," is paying to increasing the quality of "What," it is that we are paying for with an emphasis on quality as a means of improving affordability and access.

As a child psychologist, I am also pleased with the Administration's proposal for the "Cover the Kids Program," to provide $1 billion in grant money over two years to help coordinate Federal, State, school and community Medicaid/SCHIP outreach efforts to make sure that children who are eligible for these vital services get the care that they need and that we are paying for.

I look forward to hearing the Secretary's thoughts today and to working together to bring our health care system into the 21st Century.

Chairman BARTON. Mr. Secretary, welcome to the Energy and Commerce Committee. We look forward to your comments. You are recognized for such time as you may consume, after which we will have some questions for you.

Secretary LEAVITT. Thank you, Mr. Chairman.

Chairman BARTON. You need to push that button—there is—on the actual microphone there is a button you push. There you go, right there.

STATEMENT OF HON. MICHAEL O. LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary LEAVITT. Thank you. Mr. Chairman, I am delighted to be here. Mr. Dingell, I am very pleased for a chance to work with you again. Mr. Chairman, I am sensitive to the fact that there are members of the committee who have deadlines to meet that may involve transportation and I will tell you that I have discovered, in my role as Cabinet Secretary, an arrangement that Cabinet Secretaries have with the airlines and that is if we are not there, they just leave, anyway. So I would like to be sensitive to that and submit my full statement for the record and I would just like to summarize.

Chairman BARTON. Without objection, so ordered.

Secretary LEAVITT. The President and I share a very aggressive agenda over the course of the next year. It is an agenda that I believe will take us closer to being a nation where health insurance is within the reach of every American, a Nation where medical technology and information technology can provide a system that creates fewer mistakes, lower costs and better care. The budget is $642 billion. It is an increase of 10 percent over the previous fiscal year, an increase of some $58 billion. I want to be the first one to acknowledge that that is a great deal of money and that it is my responsibility, as the Secretary, to ensure that those dollars are spent wisely. I hope today we can talk about the Medicare Modernization Act and the prescription drug rollout, what I believe to be a historic opportunity for us to put prescription drugs into the hands of many who need them in this country.

I would like to just acknowledge that recent press reports have inaccurately claimed that our cost estimates have dramatically increased. That simply is not true. I would like to comment on Medicaid. I hope we will have a chance to talk about that some. There

are many Governors who are deeply concerned about this. You have alluded to it. What they are concerned about is that they are having to leave behind optional populations that they desperately want to continue to provide coverage for. The current system is inflexible, rigidly inflexible, and it is of great concern to them and great concern to us. My objective is to preserve the coverage for those groups and to expand to more. I believe it can be done. We can cover more people on the nearly $5 trillion that we will be spending over the course of the next 10 years.

I hope today we can talk some about SCHIP and what a remarkable success that has been and what we could and should learn from that as we look to provide health care to more people. The President has put forward a budget that will include $125 billion over the next 10 years in a way that we believe will provide access to health insurance for some 12 to 14 million additional Americans. We will be requesting $2 billion, I might add, to increase the number of those served by our community health centers. A number of you are aware that the President has set a goal to have an additional 1,200 of them. We will not only meet that goal but exceed it with a proposal that would add it to 40 additional centers in the poorest of our counties.

I hope we will have a chance to speak about the health care system, the need to transform it, to create a personalized patient-centered kind of medicine that will allow us to have fewer mistakes, and have higher forms of care at lower cost. The President has proposed $125 million at the beginning, at the underpinning of that, which is technology. Protection of our homeland should be a topic of our conversation today. If we include the 2006 requests, since September 11, 2001, the President will have spent or requested $19 billion. It is beginning to have a real positive impact.

FDA has been raised by some. The budget includes a $1.9 billion appropriation. That is an increase of $81 million since last year. This is a matter of great concern to me. The citizens of our nation need and deserve safety in their drugs and their food. This would allow us to combat the threats to our food safety. The 2006 budget would also expand activities to educate adolescents and parents on the risks associated with sexual activity while they are young and to help them make good choices. In conclusion, Mr. Chairman, this is a strong, fiscally responsible budget. It is one that I believe comes at a challenging time for the Federal Government, but I believe it will strengthen our country, our economy and continue to allow us to protect our homeland.

[The prepared statement of Hon. Michael O. Leavitt follows:]

PREPARED STATEMENT OF HON. MICHAEL O. LEAVITT, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Good morning Chairman Barton, Congressman Dingell, and members of the committee. I am honored to be here today to present to you the President's FY 2006 budget for the Department of Health and Human Services (HHS). The President and I share an aggressive agenda for the upcoming fiscal year, in which HHS advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the People's money.

In his February 2nd State of the Union Address, the President underscored the need to restrain spending in order to sustain our economic prosperity. As part of this restraint, it is important that total discretionary and non-security spending be held to levels proposed in the FY 2006 budget. The budget savings and reforms in

the budget are important components of achieving the President's goal of cutting the budget deficit in half by 2009 and I urge the Congress to support these reforms. The FY 2006 budget includes more than 150 reductions, reforms, and terminations in non-defense discretionary programs, of which 19 affect HHS programs. The Department wants to work with the Congress to achieve these savings.

The President's health agenda leads us towards a nation of healthier Americans, where health insurance is within the reach of every American, where American workers have a comparative advantage in the global economy because they are healthy and productive, and where health technology allows for a better health care system that produces fewer mistakes and better outcomes at lower costs. The FY 2006 HHS budget advances this agenda.

The FY 2006 HHS budget funds the transition towards a health care system where informed consumers will own their personal health records, their health savings accounts, and their health insurance. It enables seniors and people with disabilities to choose where they receive long-term care and from whom they receive it. Equally important, it builds on the Department's Strategic Plan and enables HHS to foster strong, sustained advances in the sciences underlying medicine, in public health, and in social services.

To support our goals, President Bush proposes outlays of $642 billion for HHS, a 10 percent increase over FY 2005 spending, and more than a 50 percent increase over FY—2001 spending. The discretionary portion of the President's HHS budget totals $67—billion in budget authority and $71 billion in program level funding. In total, the HHS budget accounts for almost two-thirds of the proposed federal budget increase in FY 2006.

The Department will direct its resources and efforts in FY 2006 towards:

- Providing access to quality health care, including continued implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003;
- Enhancing public health and protecting America;
- Supporting a compassionate society; and
- Improving HHS management, including continuing to implement the President's Management Agenda

Americans enjoy the finest health care in the world. This year's budget provides opportunities to make quality health care more affordable and accessible to millions more Americans.

MEDICARE

HHS will be working in FY 2006 to successfully implement the Medicare Modernization Act (MMA), including the Medicare Prescription Drug Benefit and the new Medicare Advantage regional health plans. I know there has been a lot of discussion over the past week about the cost of the new Medicare proposal, and I want to address that issue today. Recent press reports have inaccurately claimed that our cost estimates have dramatically increased. This is simply untrue.

The passage of time is the main reason that the FY 2006 budget shows a higher net federal cost ($723.8 billion) for 2006-2015 than the cost estimate for 2004-2013. In the original cost estimates, the first two years in the ten-year budget window were for years before the new drug benefit was implemented (2004 and 2005). The ten-year budget window reflected in the 2006 budget includes ten full years of actual drug benefit spending. In effect, the passage of time has dropped two low-cost dollar year estimates (only transitional assistance spending) from the budget window and added two high-cost years, due to anticipated increases in average drug spending and the growth of the Medicare population. People should not be surprised that the numbers look different as a result of the advance of time.

Some individuals have asserted that the estimate for MMA implementation is now over a trillion dollars. This assertion is completely unsupported by facts. The trillion dollar figure is a gross estimate that neglects to subtract out hundreds of billions of dollars of federal revenue, including beneficiary premiums, state payments, and other offsetting federal savings. Focusing exclusively on gross spending levels without considering the offsetting savings creates false impressions and does a disservice to the budget process and to Medicare beneficiaries.

Moving beyond the subject of funding, I hope we can all begin to focus on the task at hand—ensuring successful implementation of a strengthened and improved Medicare program with the new prescription drug benefit. Between now and January 1, 2006, we have a lot of work to do, and I give you my commitment that we will not fail. I know not everyone in this committee supported the passage of the Medicare bill, but it is now law, and in 10 ° months, almost 43 million Americans will be eligible to receive much needed assistance with the high cost of prescription drugs. Let us put aside our differences and work together towards the goal of ensuring that

seniors and people with disabilities are successfully sign up for their new benefits. We all owe that to them.

UNINSURED

In FY 2006, the President also proposes steps to promote affordable health care for the approximately 45 million Americans who are currently uninsured. The President proposes to spend more than $125.7 billion over ten years to expand insurance coverage to millions of Americans through tax credits, purchasing pools, and Health Savings Accounts. To improve access to care for many uninsured Americans, the President's budget requests $2 billion, a $304 million increase from FY 2005, to fund community health centers. This request does two things. It completes the President's commitment to create 1,200 new or expanded sites to serve an additional 6.1 million people by 2006. By the end of FY 2006, the Health Centers program will deliver high quality, affordable health care to over 16 million patients at more than 4,000 sites across the country. In 2006, health centers will serve an estimated 16 percent of the Nation's population who are at or below 200 percent of the Federal poverty level. Forty percent of health center patients have no health insurance and 64 percent are racial or ethnic minorities. In addition, the President has established a new goal of helping every poor county in America that lacks a community health center and can support one. The budget begins that effort by supporting 40 new health centers in high poverty counties.

Moreover, the President proposes a budget that would expand access to American Indian and Alaska Native health care facilities, staff six newly built facilities to serve the growing eligible population of federally recognized members of Native American Tribes, and address the rising costs of delivering care. In FY 2006, the Indian Health Service will provide quality health care through 49 hospitals, more than 240 outpatient centers, and more than 300 health stations and Alaska village clinics. In total, the President proposes increasing health support of federally recognized tribes by $72 million in FY 2006, for a total of $3.8 billion.

The President and the Department are also committed to resolving the growing challenges facing Medicaid. Medicaid provides health insurance for more than 46 million Americans, but as you are all aware, States still complain about overly burdensome rules and regulations, and the State-Federal financing system remains prone to abuse.

This past year, for the first time ever, states spent more on Medicaid than they spent on education. Over the next ten years, American taxpayers will spend nearly $5 trillion dollars on Medicaid in combined state and Federal spending. The Department proposes to make sure tax dollars are used more efficiently by building on the success of the State Children's Health Insurance Program (SCHIP) and waiver programs that allow states the flexibility to construct targeted benefit packages, coordinate with private insurance, and extend coverage to uninsured individuals and families not typically covered by Medicaid.

The President proposes to give states more flexibility in the Medicaid program in order to enable states to increase coverage using the same Federal dollars. The tools we have at our disposal today were not available when Medicaid was created. States largely agree that current Medicaid rules and regulations are barriers to effective and efficient management. Over the past ten years, Medicaid spending doubled. At its current rate of growth (7.4%), the Federal share of Medicaid spending would double again in another ten years.

The growth in Medicaid spending is unsustainable. I intend to enter into a serious discussion with Governors and Congress to decide the best way to provide states the flexibility they need to better meet the health care needs of their citizens.

The President plans to expand coverage for the key populations served in Medicaid and SCHIP by spending $15.5 billion on targeted activities over ten years. The Budget includes several proposals to provide coverage, including the "Cover the Kids" campaign to enroll more eligible uninsured children in Medicaid and SCHIP. In addition, the extension of the Qualified Individual (QI) and transitional medical assistance programs will ensure coverage is available to continue full payment (subject to a spending limit) of Medicare Part B premiums for qualified individuals, and provide coverage for families that lose eligibility for Medicaid due to earnings from employment. Also, community-based care options for people with disabilities will be expanded through the President's New Freedom Initiative, including authorizing $1.75 billion over five years for the Money Follows the Person Rebalancing demonstration.

Overall, these efforts to expand health insurance coverage, as well as those in other Departments, work together to extend health care coverage and health care services to millions of people. Thanks to the comprehensive nature of this agenda,

workers are already investing money tax-free for medical expenses through Health Savings Accounts, Americans have increasing flexibility to accumulate savings and to change jobs when they wish, and more Americans are accessing high-quality health care. We estimate that 8 to 10 million additional people will gain health insurance over the next ten years. Together, these efforts to expand insurance coverage and improve the Medicaid and SCHIP programs will cost approximately $140 billion over the same period.

At the same time, we are taking steps to ensure states can use their Medicaid funds to the fullest potential to reach more individuals in need of health care. The budget includes proposals that will assure an appropriate partnership between the Federal and state governments. We would like to work cooperatively with the states to respond to the challenges in Medicaid. We must eliminate the vulnerabilities that threaten Medicaid's viability. In our budget, we have proposed a series of legislative changes that will ensure Medicaid dollars are used appropriately to fulfill the program's purpose to provide health care coverage for low income families and elderly and disabled individuals with low incomes. Under this proposal, inappropriate federal spending on Medicaid intergovernmental transfers and spending resulting from other current loopholes in Medicaid law will decrease by $60 billion over 10 years.

As a former Governor, I understand the pressure on states in developing their budgets, particularly given the lack of flexibility in the current Medicaid law. However, some state officials have resorted to a variety of inappropriate loopholes and accounting gimmicks that shift their Medicaid costs to the taxpayers of other states. Obviously, states that are not engaging in these activities will not be affected by the proposals in the same manner as states that are. Collectively, the overall impact of the $60 billion ten-year decrease in federal Medicaid spending on states will in reality be about $40 billion, because by changing the calculation of prescription drug payments to be based on the average sales price and by tightening asset transfer rules, approximately $20 billion in state spending will be saved. And it should be noted that two-thirds of the savings will occur beyond the initial five-year budget window.

PREPAREDNESS

The HHS FY 2006 budget will also build on the Department's achievements in strengthening our ability to detect, respond, treat, and prevent potential disease outbreaks due to bioterrorist acts.

It will enable the National Institutes of Health (NIH) to increase research efforts in developing bioterrorism countermeasures and to fund biomedical research at current levels, it will allow the Centers for Disease Control and Prevention (CDC) to expand the Strategic National Stockpile, and it will support the Food and Drug Administration's efforts to defend the nation's food supply. This proposal requests $4.2 billion to continue this work, an increase of almost 1500% over 2001. This request raises to $19 billion the cumulative amount invested since September 11, 2001 on public health preparedness, and that investment is showing tangible results.

Let me mention just a few of the highlights and also note that HHS works in close cooperation with DHS on many of these activities, including the medical surge initiative and food node threats and vulnerability assessments:

- HHS has a responsibility to lead public health and medical services during major disasters and emergencies. To support this, we are requesting $70 million for the Federal Mass Casualty Initiative to improve our medical surge capacity. We are also investing $1.3 billion to support work at CDC and the Health Resources and Services Administration (HRSA) to improve state and local public health and hospital preparedness.
- In the event of a major health emergency, one posed by either nature or through the intentional use of a weapon of mass destruction, the Strategic National Stockpile would provide Americans with almost immediate access to an adequate supply of needed medicines. In order to ensure the effectiveness of the Stockpile, we're requesting $600 million to buy additional medicines, replace old ones, provide specialized storage, and get any needed medicines and supplies to any location in the United States within 12 hours. $50 million of this will go to procure portable mass casualty treatment units.
- We're requesting $1.9 billion for the Food and Drug Administration (FDA)—an increase of $81 million over 2005. $30 million of this request would be directed to improving the agency's national network of food contamination analysis laboratories and to supporting vital research on technologies that could prevent threats to our food supply. HHS also proposes to dedicate $6.5 million more than in FY 2005 to evaluating and communicating drug safety risks to the pub-

lic and applying scientific expertise to explore the risks of medical products already on the market.

We now have a heightened awareness that the nation's critical food safety infrastructure must be better protected. FDA quickly learned that pursuing more field exams, alone, is not the most effective strategy for providing this protection. The new Prior Notice requirement on the shipment of foods allows FDA to conduct intensive security reviews on products that pose the greatest potential bioterrorism risk to consumers in the United States. We intend to compliment these inspection efforts with further improvements to the national network of food contamination analysis laboratories, and to provide support for vital research on technologies that could prevent threats to food supply. Investments like these will allow FDA to work smarter in the future.

The Food and Drug Administration is an integral component in our efforts to promote and protect the health of the United States public. Its mission is broad, and the agency's decisions affect virtually every American on a daily basis. In addition to food defense, the proposed $81 million increase will be focused on achieving specific improvements in drug safety and medical devices.

The budget includes a total of $747 million for human drugs and biologics, an increase of $26 million. With these funds, we propose to strengthen FDA's Office of Drug Safety with an increase of $6.5 million, for a total of $33 million. This increase will better equip the Office to carry out Center-wide responsibilities for drug safety analysis and decision-making. Critical staff expertise will be augmented in such areas as risk management, communication and epidemiology. Increased access to a wide range of clinical, pharmacy and administrative databases to monitor adverse drug events will be obtained. Also, external experts will also be used to a greater degree to evaluate safety issues.

Medical device products regulated by FDA must be safe and effective. The budget requests $289 million, an increase of $12 million, to improve timely performance in the review of applications, as well as, maintaining consistent high standards of safety and quality. Additional funds will also be directed towards medical device postmarket safety activities.

VACCINES

The FY 2006 budget also includes targeted efforts to ensure a stable supply of annual influenza vaccine, to develop the surge capacity that would be needed in a pandemic, to improve the response to emerging infectious diseases before they reach the United States, and to improve low-income children's access to routine immunizations.

HHS plans to invest $439 million in targeted influenza activities in FY 2006, in addition to insurance reimbursement payments through Medicare. The budget includes a two-part $70 million approach to ensure industry manufactures an adequate supply of annual influenza vaccine. The Vaccines for Children (VFC) program will again set aside $40 million in new resources to ensure an adequate supply of finished pediatric influenza vaccine. The discretionary Section 317 program will use $30 million to get manufacturers to make additional bulk monovalent vaccine that can be turned into finished vaccine if other producers experience problems, or unusually high demand is anticipated.

To improve low-income children's access to routine immunizations, the budget includes legislative proposals in VFC that I believe should be strongly supported by the members of this Committee. This legislation would enable any child who is currently entitled to receive VFC vaccines to receive them at State and local public health clinics. There are hundreds of thousands of children who are entitled to VFC vaccines, but can receive them only at HRSA-funded health centers and other Federally Qualified Health Centers. When these children go to a State or local public health clinic, they are unable to receive vaccines through the VFC program. This legislation will expand access to routine immunizations by eliminating this barrier to coverage and will help States meet the rising costs of new and better vaccines. As modern technology and research has generated new and better vaccines, that cost has risen dramatically. For example, when the pneumococcal conjugate vaccine became available, it increased the cost of vaccines to fully-immunize a child by about 80 percent. FDA has recently approved a new meningococcal vaccine that will further raise the cost to fully-immunize a child—making this legislation even more important.

To improve our Nation's long-term preparedness, NIH will invest approximately $119 million in influenza-related research—nearly six times the FY 2001 level. The budget also increases the Department's investment to develop the year-round domestic surge vaccine production capacity that would be needed in a pandemic, in-

cluding new cell culture vaccine manufacturing processes, to $120 million. These research and advanced development efforts will be complemented by expanding CDC's Global Disease Detection initiatives from $22 million to $34 million to improve our ability to prevent and control outbreaks before they reach the U.S.

OTHER BUDGET INITIATIVES

The toll of drug abuse on the individual, family, and community is both significant and cumulative. Abuse may lead to lost productivity and educational opportunity, lost lives, and to costly social and public health problems. HHS will assist states in FY 2006 through the Access to Recovery program to expand access to clinical treatment and recovery support services, and to allow individuals to exercise choice among qualified community provider organizations, including those that are faith-based. This program recognizes that there are many pathways of recovery from addiction. Fourteen states and one tribal organization were awarded Access to Recovery funding in FY 2004, the first year of funding for the initiative. This budget increases support for the Access to Recovery initiative by 50 percent, for a total of $150 million.

Expanding abstinence education programs is also part of a comprehensive and continuing effort of the Administration, because they help adolescents avoid behaviors that could jeopardize their futures. Last year, HHS integrated abstinence education activities with the youth development efforts at the Administration for Children and Families (ACF), by transferring the Community-Based Abstinence Education program and the Abstinence Education Grants to States to ACF. The FY 2006 budget expands activities to educate adolescents and parents about the health risks associated with early sexual activity and provide them with the tools needed to help adolescents make healthy choices. The programs focus on educating adolescents ages 12 through 18, and create a positive environment within communities to support adolescents' decisions to postpone sexual activity. A total of $206 million, an increase of $39 million, is requested for these activities.

Our request also includes approximately $18 billion for domestic AIDS research, care, prevention and treatment. We are committed to the reauthorization of the Ryan White CARE Act treatment programs and request a total of $2.1 billion for these activities, including $798 million for lifesaving medications through the AIDS Drug Assistance Program.

Finally, we constructed the FY 2006 budget with the knowledge that health information technology will improve the practice of medicine. For example, the rapid implementation of secure and interoperable electronic health records will significantly improve the safety, quality, and cost-effectiveness of health care. To implement this vision, we are requesting an investment of $125 million. $75 million will go to the Office of the National Coordinator for Health Information Technology, to provide strategic direction for development of a national interoperable health care system. $50 million will go to the Agency for Health Care Research and Quality to accelerate the development, adoption, and diffusion of interoperable information technology in a range of health care settings.

PROGRAM PERFORMANCE

The President and the Department considered a number of factors in constructing the FY 2006 budget, including the need for spending discipline and program effectiveness to help cut the deficit in half over four years. Specifically, the budget decreases funding for lower-priority programs and one-time projects, consolidates or eliminates programs with duplicative missions, reduces administrative costs, and makes government more efficient. For example, the budget requests no funding for a number of smaller, duplicative community services programs and the Community Services Block Grant, which was unable to demonstrate results in Program Assessment Rating Tool evaluation. The Administration proposes to focus economic and community development activities through a more targeted and unified program to be administered by the Department of Commerce. It is due to this focused effort to direct resources to programs that produce results that I am certain our targeted increases in spending will enable the Department to continue to provide for the health, safety, and well-being of our People.

Over the past four years, this Department has worked to make America and the world healthier. I am proud to build on the HHS record of achievements. For the upcoming fiscal year, the President and I share an aggressive agenda for HHS that advances a healthier, stronger America while upholding fiscal responsibility and good stewardship of the People's money. I look forward to working with Congress as we move forward in this direction. I am happy to answer any questions you may have.

Chairman BARTON. Thank you, Mr. Secretary. Let me get the clock changed and you surprise me. Most Cabinet Secretaries take 5 minutes just to say hello, so I am——

Secretary LEAVITT. Is it possible to reserve that time?

Chairman BARTON. I think you are going to get plenty of opportunity to use it in the question and answer. The Chair would recognize himself for the first 5 minutes of questions.

Mr. Secretary, I think as chairman of this committee, I owe it to you and obviously to the President and the people of the United States to indicate to you what I think this committee's priorities are for this Congress. Every one of the subjects that I am about to list in and of itself is worthy of a full hearing and a full debate, but today is a general oversight review. I think the first thing we are going to do as a committee is continue our efforts to oversee the implementation of the Medicare Modernization Act that includes, as we gear up for the rollout of the prescription drug benefit that is scheduled to take effect next year.

The second thing I would like our committee to emphasize is a review and hopefully a passage of reauthorization bill that would reform and modernize the National Institute of Health. We have doubled their budget during the first 4 years of the Bush Administration, but the agency is still run like it was 13, 14, 15 years ago. As you know, Dr. Zerhouni has just announced a new policy on consultations, which I totally support. I would really love for our committee to work with you and the Governors, the State legislatures, to see if there is some consensus on how we could reform our Medicaid program. In many State budgets it is the No. 1 and No. 2 budget item. The goal should be to try to find the ways to get more real dollars to low-income Americans in every State in the union and I think in order to do that we need to begin to think of innovative solutions and not just rearrange the deck chairs in the existing program.

Last, but not leastly, there has been considerable controversy at the Food and Drug Administration about their drug approval process. There have been a number of major drugs that have been withdrawn from the market for various reasons. I think we owe it to the American people to work with you and Dr. Crawford, who is I think soon to become the permanent administrator of the FDA, to see if we can't find a way to maintain the FDA as the gold standard for drug approval and get drugs to the marketplace as quickly as possible, but also as safely and as effectively as possible.

And I would add a fifth one. We have had a problem in this country in the last year in shortage of vaccinations for flu. It is beginning to appear as if we may have overstated the problem, but there still is a real problem in making sure that we have continuing supplies for next year and the year after that. So we will be looking at that.

So my question is, in having stated what I believe to be the major priorities for this Congress, for this committee, if we were to pick one of those, that we ought to try to start working on immediately in terms of a legislative agenda, I would say would be reauthorization of NIH; perhaps a review of the existing Medicaid program. Would you like to share your views on those two issues

about what you think, Mike, can be done and how you see yourself in the Bush Administration moving in those two areas?

Secretary LEAVITT. Indeed I would, Mr. Chairman. May I just say that I believe the rollout of the Medicaid and Medicare prescription drug benefit is an historic moment and let us all acknowledge this is big, both in terms of the task and its importance. One of the things I would appeal to you on is that we recognize the size of this task and that we partner together. The Congress has a big stake in having this accomplished and accomplished well and I would like to work directly with not just this committee, but with the Congress in general so that when you are in your districts, you are able to pitch in and help seniors gain access to this. This is an exciting moment where I believe seniors across the land will not only have access to a new drug benefit, but it will create a robust, competitive marketplace that I believe will ultimately impact and drive the cost of prescription medication downward.

On Medicaid, may I also say I believe that this is a problem that has to be dealt with. There is a time in the life of every problem when it is big enough you can see it, but small enough you can still solve it, and we are on the verge of losing that opportunity with Medicaid. States are desperately seeking ways to maintain coverage for optional population groups. They do not want to see them leave the program. Governors, such as myself, for years have been able to add groups through optional populations. To see those turn around now and have to be leaving the program is not what is in our heart or in our mind and I believe there are ways in which we can cover more people using the substantial investment we are making in this country.

Now, if I could just add one other, and that is, Mr. Chairman, I believe there is an issue that connects many of your priorities, and that is information technology and the need for us to deploy information technology. There is a huge opportunity for us in the Medicare rollout to begin to modernize the system of delivery, to modernize what we learn about prescription drugs, and to be able to put into the hands of the FDA information about drugs we have already approved that badly need to have more information gathered that can increase the health and safety of our people. So I hope that that could also be considered as part of your agenda.

Chairman BARTON. I am out of time. Could you briefly comment on your general view about reauthorization of the National Institute of Health?

Secretary LEAVITT. The National Institute of Health is a treasure. As you suggest, we have doubled our investment there in recent years. It is now time for us to make certain that we are using that in the wisest possible way and going after priorities in a coordinated fashion to the degree that we need new tools. And I agree that there is a need for us to continue to work to do it better. You have talked about Dr. Zerhouni and his ideas. There are many others. I would be supportive and look forward to any opportunity to work on increasing the fruit of what we have now planted.

Chairman BARTON. Thank you, Mr. Secretary. The Chair now recognizes the gentleman from Michigan, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, thank you for your courtesy. Mr. Secretary, again welcome. Mr. Secretary, the budget cut $60 billion from the Medicaid program, is that correct?

Secretary LEAVITT. There are 3 categories.

Mr. DINGELL. No, no, no. It is either correct or it is not correct. Which——

Secretary LEAVITT. There are 3 categories that add up to $60 million with an additional 15 of add-backs. Nearly 20 add-backs.

Mr. DINGELL. Thank you. Now, this means then that to make up that $45 billion then, you will have to either cut people, cut provider payments or raise taxes, is that right?

Secretary LEAVITT. That basically is a dispute between the Federal Government and the States on who——

Mr. DINGELL. You have got $45 billion to make up. How are you going to do it?

Secretary LEAVITT. I would be very pleased to reconcile it. If you look at the President's budget, there are basically 3 areas of change in reduction and two areas of add-back. The first area of change is on prescription drug medication. The idea is we are paying too much. We believe we can save $15 billion for the Federal Government and $11 billion for the States by changing the way we pay.

Mr. DINGELL. So are you shifting, then, monies—the burdens to the States?

Secretary LEAVITT. In a way——

Mr. DINGELL. To pick up a larger share of the cost?

Secretary LEAVITT. We will both benefit from that one. We will benefit——

Mr. DINGELL. But you are—I am trying to figure who is going to pick up this cost. Somebody is going to pay $45 billion. Who is it? You are telling the Feds are not. Are you telling me the States are not?

Secretary LEAVITT. We believe that there is a funding partnership between the Federal Government and the States and that the States, in certain situations——

Mr. DINGELL. Governor, I have 3 minutes and 27 seconds to address these questions. I need your help and I need you to answer the questions as narrowly as you can. Somebody is going to pick up that $45 billion. Who is it? Feds, States, providers? Somebody is going to do it. Who?

Secretary LEAVITT. A good piece of it will be pharmaceutical companies who don't get as much money.

Mr. DINGELL. Okay.

Secretary LEAVITT. A piece of it will be people who are not giving away their assets and then we will have a dispute that we have got to resolve with our friends, the States.

Mr. DINGELL. Now, it is fair, is it not, Governor, that the States are already having major financing difficulties in coming up with money from existing budgets to address Medicaid?

Secretary LEAVITT. That is true.

Mr. DINGELL. Do you think that the States will raise their local contributions or raise taxes or allow local taxes to be raised to address these questions of shortfalls in Federal funding coming to the States?

Secretary LEAVITT. Let me again say, Congressman, we will spend $5 trillion over the next 10 years. The question here is can we do a better job of spending it? I believe that——

Mr. DINGELL. Who is going to pony up this money?

Secretary LEAVITT. I believe the States can very well find ways to cover more people using the investment that they have now and that we can cover not fewer, but more.

Mr. DINGELL. If I were talking to Governor Leavitt, would he be telling me that or is this Secretary Leavitt that is telling me that?

Secretary LEAVITT. Oh, the song that I am singing now, sir, is one I have sung for a long time. I believe that if we give the States flexibility, they can cover more people. It is rigid in its inflexibility and we have an opportunity, I think a historic one, to approve that.

Mr. DINGELL. You are going to give more flexibility and less money?

Secretary LEAVITT. Not less money. We are going to be spending more than 7 percent more money every year for the next 10 years.

Mr. DINGELL. But on a straight-line projection, you are going to be giving them less money in relationship to the demands upon that money than you did last year, isn't that correct?

Secretary LEAVITT. Congressman, as they have said many times, Washington is the only place where you can reduce the amount that a person anticipated and call it a cut when we are going to be adding some $5 trillion. Not adding, but spending $5 trillion.

Mr. DINGELL. Everybody plays games, Mr. Secretary, as you well know, with the budget. We only get the budget after the games have been played with it at OMB and we find that there is less money being spent for these things on a per capita basis and what I am trying to figure out is how then will this shortfall be made up and who is going to be the lucky volunteer that pays for it? So far, you have indicated that in some magical way there is going to be—there will be additional funds made available for somebody because we are giving flexibility to the States, but we are still leaving the States in a situation where they are having less money for a lot of things than they did last year or this year.

Secretary LEAVITT. As I have spoken to you privately and I will now publicly, there are a number of States who I believe are not meeting the full measure of their agreement under our partnership and this is not a question of—many States are.

Mr. DINGELL. This means they are not spending, then, the money that they should spend.

Secretary LEAVITT. This means that they are——

Mr. DINGELL. This means that the services that are needed by the recipients of Medicaid will not be available. For example, nursing home care will probably be cut or other programs of this kind will be cut, isn't that so?

Secretary LEAVITT. Again, Mr. Dingell, we are going to be spending a lot more money, not less, and I believe we can use that money in a way that will allow us to expand the number that——

Mr. DINGELL. Our chairman, Mr. Secretary, has the gavel up, but you have reminded me of the loaves and fishes. The last time that happened it was referred to in the Bible in a very interesting story. I am not sure that anybody in this Administration has those powers, although I will not——

Secretary LEAVITT. That is not a standard I would like to be held to either, sir.

Chairman BARTON. Gentleman's time has expired. The chairman of the Health Subcommittee, Mr. Deal, is recognized for 5 minutes.

Mr. DEAL. Thank you, Mr. Chairman, Mr. Secretary. We heard you make a very important announcement earlier this week with regard to FDA and the issue of drug safety. Would you elaborate on that and tell us what the next step is in that undertaking?

Secretary LEAVITT. It has become, I think, evident that the people of this country want to see an atmosphere and a culture of openness and independence at FDA and we intend to deliver that. I announced that we would have a drug safety board and that we would begin to monitor more aggressively the many drugs that have already been approved for market. In making drug approvals we often use trials, clinical trials, where we measure a certain number of people for a certain amount of time and we are able to make scientific judgments about the safety. They may involve a thousand people for 6 months. In the next 6 years a million people may use that same drug and there are a million data points available to us about what help the drug provided and in some few cases, the harm. Our goal is to use the capacity of information technology to harness that information, to provide it to the public in an open, transparent way so that we can learn from what we are experiencing in post-market uses of those drugs.

Mr. DEAL. Thank you. Let me shift back to Medicaid for just a minute. Most of us, at least on this side of the aisle, have agreed with the concept of giving the States more flexibility and that by doing so they can make the money go further. I presume that is the general thrust of the reforms that you are proposing and I would simply ask do you see these reforms as necessitating legislative action by us or do you currently have the mechanism to make those reforms possible?

Secretary LEAVITT. Mr. Deal, they will require legislation in most cases.

Mr. DEAL. And I assume we will be seeing that proposal in the very near future?

Secretary LEAVITT. Yes. I am actually working with a bipartisan group of Governors to develop what I hope will be a proposal that can be brought to this committee for help. The Governors desperately need help here. They want to maintain the coverage on these optional groups, but they need flexibility and they are working hard to come up with some proposals that would untie their hands and allow them to accomplish just that.

Mr. DEAL. Thank you, Mr. Secretary. I am going to yield back, Mr. Chairman.

Chairman BARTON. Gentleman yields back. The distinguished ranking member of the Health Subcommittee, Mr. Brown of Ohio, is recognized for 5 minutes.

Mr. BROWN. Thank you, Mr. Chair. Mr. Secretary, as you know, the public's confidence in drug safety has been shaken over the past few months before you arrived on the scene. It seems we ought to be looking at the part that direct-to-consumer advertising has played in scandals like Vioxx because of DTC advertising, demand for blockbuster drugs explodes right away as soon as the

drug goes on the market rather than the slow increase we used to see from doctors' word of mouth and in magazines and all of that, and that dramatically increases exposure to potentially deadly side effects more quickly. During Vioxx's first year in the market, Merck spent $160 million in DTC advertising and even though subsequent studies showed that for many patients, drugs like Advil were just as effective as the far more expensive, but heavily marketed Vioxx, non-stop advertising prevent that fact from having any meaningful effect on sales. My question is do you plan to do anything, as the Secretary, about direct-to-consumer advertising, given its safety and cost impact?

Secretary LEAVITT. Congressman, information is good. Inaccurate information is bad, exaggerations would be bad, unsubstantiated claims would be bad. We have the power to cause that to cease when it occurs and we will use it.

Mr. BROWN. Do you really think that that kind of mass advertising is the best way to educate and empower the public?

Secretary LEAVITT. Used properly, it is a powerful tool for good. Used improperly, it is a powerful tool for bad and the objective and duty of a regulator is to find those cases in which inaccurate information has been offered or exaggerated claims have been offered and to act. And we have that power and we will act.

Mr. BROWN. Was Merck spending $100 million a year an example of used—of your term "used improperly?" Secretary LEAVITT. That is not a judgment I am in a position to make at this point.

Mr. BROWN. The House passed legislation yesterday that holds broadcasters legally responsible for airing indecent programming even if the broadcasters themselves did not produce that content. With revelations about Vioxx and with revelations about other drugs, it seems it could be only a matter of time before someone sues a broadcaster for airing an ad that encourages consumers to buy a pill that ends up harming them. Are you concerned by the possibility that incomplete or misleading content in drug ads is going to become a legal liability for TV and radio stations?

Secretary LEAVITT. To the extent that that is true, I would guess that would be a big worry to them. My concern is that information has value when it is presented in an objective and reasonable way. It becomes a liability and has the potential to harm when it contains inaccuracies or exaggerations. The FDA currently has the authority necessary to stop that when it occurs and we will use that authority.

Mr. BROWN. But I recall that FDA doesn't fund particularly well that part of the agency that looks at those advertisements. What do you—well, how do you propose that those advertisements are examined a little more assiduously than they have been and how are you going to aggressively protect the public when it is clear in the last handful of years the FDA hasn't been able to do or hasn't chosen to do that?

Secretary LEAVITT. That regulatory power needs to be used in partnership with the considerable scientific prowess that that agency holds. It is the gold standard around the world despite the fact that there have been controversies of late. It is a remarkable agency with dedicated people who have the capacity, if anyone in the world has to make those decisions, is the FDA.

Mr. BROWN. Does it need more funding to be able to examine those ads properly?

Secretary LEAVITT. Well, the President has proposed $81 million more than last year. We have a huge mission. We believe we can conduct that mission in the context of the budget that we are presenting.

Mr. BROWN. Okay. Thank you. Thank you, Mr. Chairman.

Chairman BARTON. Before I recognize Mr. Hall, just as a follow-up to Mr. Brown's question, under the Constitution and current law, drug manufacturer has the right to advertise its product so long as it does so in a truthful and generally accurate fashion. In other words, if you wanted to stop some of these advertisements, we would either have to amend the Constitution or at a minimum, get a statute that prescribed the limits under which those advertisements could occur. Is that correct?

Secretary LEAVITT. That would be my understanding.

Mr. BROWN. Could you yield for a moment on that point?

Chairman BARTON. Sure.

Mr. BROWN. I guess—I am not a lawyer and I am certainly not a First Amendment lawyer, but I also know that we have looked on tobacco and alcohol advertising. Without a Constitutional amendment, we looked at striking a balance between free speech and the public interest and I would hope that when a drug has harmed as many people as Vioxx seems to have had and Resilin and other drugs from time to time that we would strike that balance and not protect corporations as a free speech no matter what, which seems to be the interpretation of many.

Chairman BARTON. I would just add that some of these drugs that have been withdrawn have helped millions of people lead better lives and if we are going to strike a balance, let us strike a balance.

The gentleman from Texas, Mr. Hall, is recognized for 5 minutes.

Mr. HALL. Thank you, Mr. Chairman. Governor, like you, a lot of us have had experience—I was at the local or the county level for 12 years as a judge and 10 years in the senate at the State level and up here for 24 years. You, too, were Governor and mine is more of a practical question than it is anything specific about the budget because we know the problems and we know what we will have to do to cure them. But just—you have the benefit of having been a Governor and being on the other side now, the Medicaid battle today, it seems that really should arm you. Discuss, if you would, what your experience with Medicaid as Governor of Utah was, how you handled it and what successes you had and what challenges you faced and how that colored or lost the reforms that are proposed in this budget.

Secretary LEAVITT. Congressman, perhaps the best way would be to isolate one circumstance that I think illustrates the principles I am talking about. The Congress, and in a large measure the good works of this committee and others, passed the SCHIP program some years ago. It has provided the capacity for approximately 5.6 million of our citizens' children to be covered. I believe Congress wisely provided a degree of flexibility in the bill that allowed States to ask a very important question: What is basic quality care?

Congress provided 5 choices. They could define quality as Medicaid or they could say it is the same roughly as the State employees receive or what Federal employees receive the best HMO in the state, or a composite of those. Those are 5 choices to define quality, not just 1, Medicaid, but 5.

We were a State that concluded we would not choose Medicaid because we believed we could do it more efficiently. And I am happy to report to you that we covered, with the same coverages that my children had while I was Governor, 35 percent more children on the same investment and they had the same coverage that my children had, in fact, better; lower co-pays than my children had. Now, I am just pointing out that if the State is going to provide for the Governor a set of benefits and the Governor's children, that is pretty good coverage. And we felt great about that.

What we felt best about was that we covered more children and that is the kind of thing I believe Governors across this country are seeking. They have optional populations right now that are on the verge of losing coverage because of the inflexibility of the current program. They want to preserve the coverage of those people. And if we work together, I believe we can do that. We can meet your objective of preserving their coverage and perhaps enhancing it in the same way we did with SCHIP for the number of children that we covered.

Mr. HALL. Thank you, Governor. I yield back my time. I will thank you for the 125 mil, somewhere in that area, for the health information technology. I think that is going to be very helpful. Thank you, sir. I yield back my time, Mr. Chairman.

Mr. DEAL [presiding]. Chair recognizes Mr. Waxman for 5 minutes.

Mr. WAXMAN. Thank you. Mr. Secretary, you said you want to help the States do more, but the proposed budget is to take $60 billion out of the Medicaid program and the States are already struggling to do what they are already doing. And one of the things you are proposing is to change the rules on how the States can pay for their share of the costs of the program. I want to concentrate particularly on the proposal to eliminate what is called inter-governmental transfers. These have always been a legitimate way of financing the non-Federal portion of Medicaid. In fact, they are explicitly recognized as legal in the law and you want to stop the States from doing this. Have you estimated the savings that you would achieve by changing the rules on intergovernmental transfers?

Secretary LEAVITT. Congressman, there are, in fact, as you point out, intergovernmental transfers that are very clearly and explicitly allowed in the law and we support that and acknowledge it. However, there are intergovernmental transfers that are not contemplated and here is what I believe the difference to be; when the State pays a provider——

Mr. WAXMAN. Let me interrupt you because you are going to get savings some way or other. You may have a distinction. Now, if it is legal, it is legal. If it is not legal, you ought to stop it now. So you are going to stop some things that are legal because you want to change the law to make it illegal and you are going to have less

money available to the States. How much less money are we going to have available to the States? That is my question.

Secretary LEAVITT. Congressman, you use the phrase "change the rules." We simply want to enforce the rules. Congress——

Mr. WAXMAN. So you don't need legislation for us to do that, do you?

Secretary LEAVITT. That is probably true in most cases and what we believe will occur over the course of the next 10 years is that there will, in fact, be a true partnership where the Federal Government is in essence putting up $.65—5½ or $5 trillion and the States will be putting up their share and together, we will provide coverage to more people.

Mr. WAXMAN. We represent districts with your partners in the States and so we want to know what it is going to mean to our State. Last March the Administration came in and said they were proposing to do something like this and I asked them for a commitment that we would get, well, legislative language. We have not received that. I would like to know if you could give us the legislative language. And the second thing I would like to have is the State-by-State analysis. We would like to know what it means for our State if you are going to change, in some way, these intergovernmental transfers. Will you have that available for us?

Secretary LEAVITT. I have committed to provide others and will provide you the best information that we can accurately provide as to which of the provisions we see being violated regularly and what we believe or would estimate them to be. It is a complex and it is something, frankly, we are negotiating with the States one State at a time. Our meeting today, as a matter of fact, with your Governor——

Mr. WAXMAN. I know that. He told us.

Secretary LEAVITT. [continuing] then meeting with others.

Mr. WAXMAN. But the reason it is so vague to us is if there is going to be a change in intergovernmental transfers, which is an essential way the States now have money to pay for their share and you make changes in that, that means they have less money. I want to know how much less money my State is going to have. I know other members are going to know how much less money they are going to have and if you are going to do it on a State-by-State basis, then you are not having a uniform rule. Maybe you are trying to press each State to agree to something, but that is a different matter.

Now, if they don't have that money available to them, how are they going to be able to give Medicaid coverage to those that now get it? You talked about optional. My colleagues might be interested to know that 60 percent of the program is considered optional, either optional populations or optional benefits. Optional populations are the people in the nursing homes and the disabled. That is maybe two-thirds of the expending of the program. We in this committee proudly have passed legislation to make sure women with breast cancer get covered for their treatment if they qualify for their status in poverty. Those optional services are like pharmaceutical services. States don't have to provide it. Now, those States that are providing those services now and most of them are providing most of those optional services, how are they going to pay

for it? Are they going to have to raise taxes? Are they going to have to cut benefits? Are they going to cut providers? What is going to happen?

Secretary LEAVITT. That isn't true in every State. There are some States who are not using intergovernmental transfers inappropriately. And this is an awkward and difficult conversation we are having with having every one of our funding partners. We are simply saying to them we want to be partners and let us just——

Mr. WAXMAN. Well, then let me give you very parochial—I want to know what it means for California. We have got a couple other Californians on the committee on both sides of the aisle. What is it going to mean for California? I can't imagine any of the intergovernmental transfers in California being improper or illegitimate. It all goes into health care. It serves the needs of the populations that need healthcare and if those sums are taken away, I see they are going to have a real problem in California. I think you are asking us to buy into a budget number of $60 billion and I am not sure how you are going to achieve that $60 billion cut. It looks like you don't really know how you are going to achieve that $60 billion cut, either. Before we adopt a budget calling for it, we better get the legislative language and the State-by-State analysis and I would like to have you guarantee that we will get that before we vote on our budget.

Secretary LEAVITT. I will give you every piece of information I have that is credible.

Mr. WAXMAN. Mr. Chairman, I want to ask unanimous consent to put in the record a letter that Mr. Dingell wrote to the Secretary on this very subject. It ought to be in the record so members will know what the Secretary has been asked to provide for us and I think it is important we get it. Thank you, Mr. Secretary.

Mr. DEAL. Without objection.

I would ask members to adhere to the clock.

Mr. WAXMAN. And excuse me. If there is an actuary figure that is different than yours, I hope you will provide that to us, as well. We didn't get the actuary's figures on Medicare, but we should get them on Medicaid.

Mr. DEAL. We do have members who have travel plans, so I would ask everybody to please adhere to the time clock. At this time I recognize Dr. Burgess for 6 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. Mr. Secretary, let us stay on intergovernmental transfers just for a moment because I think my State, Texas, does not participate in intergovernmental transfers and I will just tell you I, for one, would prefer that we all play by the rules and if it is preferable that we get our funding through a shell game, then Texas needs to be educated by California on how to do that, but I would prefer that this be a direct transaction between the Federal Government and the States and that we not finagle the books in order to up reimbursement to our States because I don't think it is fair that Texas not receive the same percentage of dollars back that another State might receive. Is that a fair assessment?

Secretary LEAVITT. Well, there are consultants who you can hire who will show you just how to do it.

Mr. BURGESS. Okay.

Secretary LEAVITT. You know, it might be, Mr. Burgess, helpful if I could just take a moment and describe——

Mr. BURGESS. Please.

Secretary LEAVITT. [continuing] in large terms what is happening here. Assume that there are three people who live in a cul-de-sac. There is Mr. Federal and Mr. States and the Jones family. The Jones family has a daughter that has a chronic disease that requires constant help, but they have no health insurance. It costs about a thousand dollars a month. So Mr. State and Mr. Federal get together and they decide they want to help the Jones family. Mr. Federal says to Mr. State, why don't you go work with the Jones family because you know them well and when you have worked that out, come back and give me the bill and I will pay 65 percent of it. Well, it works out great. In fact, the doctor sends the bill directly to Mr. State and Mr. State comes over to my house, the Federal house, and I write him a check for my 65 percent.

Well, this goes on for a while and it works out pretty well until it gets difficult for us to come up with that money and Mr. State then goes to the doctor for the Jones family and says here is a deal that will be good for both of us. You know the $1,000 a month? Why don't you raise the price to $1,500 and then give me Mr. State's discount coupon for $300 and then he brings it over to my house and says I have got bad news. The $1,000 has now gone to $1,500, so let us think about this. He says here is your share. I say okay, two-thirds of $1,500 is, let us see, $1,000. Well, the clinic is now getting $1,200, Mr. Federal is now paying $1,000 instead of $666 and Mr. States, he is paying $200 instead of $500. My point is that we all want the Jones family to have their care, it is a laudable thing, but it needs to be fair. And we don't think it is fair for a State who may, in fact, be not doing it and one that is not.

Mr. BURGESS. Thank you, Mr. Secretary. Can you just give us very quickly what the proposal that you talked about, you actually mentioned three change reductions and two expansions. You talked, before you were interrupted, about the prescription savings. Just very quickly take us through that, the change from average wholesale price to average sales price, what to expect from that.

Secretary LEAVITT. Simply stated, we are overpaying for prescription drugs and if we could just use the same system that we are using for Medicare, the States would save $11 billion, we would save $15 billion, and we simply just want to change it to where we are getting the lowest price. No patients and no Medicaid recipients will get their services and their pharmaceuticals, we will just save money. That is just smart.

Mr. BURGESS. Yes, sir. What were the other two change reductions that you were going to mention?

Secretary LEAVITT. The second is there are many in the country who have begun to give their assets away to their children so they qualify for Medicaid. In many cases, it is children having their parents give the assets to them so that as they go into nursing homes, they have coverage. This was not intended to be, in essence, the asset protection plan. It was intended to be a way of helping people who have no other alternative, and the States are asking us to tighten those laws and we think we should.

Mr. BURGESS. Do you think we can partner in some way to allow individuals who have provided for long-term care insurance for themselves and their families to protect some segment of their assets should it then become—should they exhaust those benefits and have to go into a nursing home?

Secretary LEAVITT. Absolutely.

Mr. BURGESS. Okay. Then I assume the third change reduction would be the intergovernmental transfer, is that correct?

Secretary LEAVITT. The third is just a dispute between partners.

Mr. BURGESS. Okay. What about the two expansions that you alluded to?

Secretary LEAVITT. The two expansions are No. 1, a $10 billion set aside to cover more children and to go out into the communities and find those children that are eligible but not being covered. The second would be to begin a transition between where we are today, where people are essentially required to be served if they are disabled or elderly in an institution or a nursing home, and allow them to be covered and to have help in community or home settings. There is just under $5 billion there.

Mr. BURGESS. In the last 30 seconds, is there any type of consumer-directed change we might—transformational change we could make in Medicaid to more efficiently spend those dollars that you alluded to?

Secretary LEAVITT. Congressman, every morning when I wake up, the first thing on my mind is health information technology because it ties all of these together. The power of the consumer can be linked through information technology, can be made more efficient, fewer mistakes, better care. That is, I think, the lynch pin to improvement.

Mr. BURGESS. Thank you, Mr. Secretary.

Mr. DEAL. Chair recognizes Mr. Markey for 5 minutes.

Mr. MARKEY. Thank you. Secretary, as a condition of getting accelerated approval, drug companies promise the FDA that they will complete post-marketing studies to prove the safety or efficacy of a drug. I am concerned that some of these drug companies are failing to keep their commitments and the public may be buying and using products that they think are safe and effective, but are no more than sugar pills or worse, are dangerous. On March 15, 2004, the FDA submitted a report to Congress regarding the progress of requiring post-marketing studies. According to that report, only 33 percent of drug studies and 62 percent of biologics studies were proceeding on schedule or have been completed. Why is the FDA allowing the drug companies to get away with not conducting post-marketing studies that the agency told them to perform as a condition of approving a drug that has millions of Americans continue to take drugs even though the long-term studies have not been completed?

Secretary LEAVITT. Our effort in providing and receiving new information on drugs that have been approved for market has been essentially passive. We have received information as incidents have occurred. That is not good enough and we need to improve it. We need to have those studies done and we need to continue to gather information from a myriad of opportunities we have. The new Medicare rollout is a wonderful new opportunity for us to begin

capturing information about the efficacy and the impact of pharmaceuticals. We need to gather the information and we need to make it available and we need to do it in a way that will inform physicians and patients and consumers in a rapid, transparent way.

Mr. MARKEY. You do understand, Mr. Secretary, that the drug companies keep these drugs out on the market even as they foot drag in the completion of the long-term studies, and the FDA does have the authority to withdraw approval for any of these drugs. Would you commit to withdrawing drugs from the market that do not complete, within the law, the long-term studies that are required by the FDA?

Secretary LEAVITT. Congressman, the FDA is the gold standard around the world. We have the benefit in this country of having the assurance of the entire scientific prowess of the FDA. Judgment calls need to be made. When they are, and when it calls for them to be withdrawn, we will withdraw them.

Mr. MARKEY. Well, unfortunately, without information, you can't withdraw. So what I would suggest is that companies are keeping information from you because they don't want you to know what the long-term effects of these drugs are and that, as a result, the public is at risk because the FDA does not force the completion of the long-term study. The risk then runs to families that are taking drugs that are later found to be endangering the health of those individuals taking the drugs. So where is the standard then? What is the guillotine moment where you cutoff the production and sale of the drug?

Secretary LEAVITT. As you may be aware, on Tuesday on this week, I announced the creation of a drug safety board which will be in a position to independently make those judgments. These will be people drawn from inside and outside of government who were not involved in the original approval of the drug, who have the capacity to make those decisions, to find those, as you referred to them, guillotine moments. My guess is that in time they will exist and we will, in fact, do as the law provides.

Mr. MARKEY. Well, you know, these post-marketing studies go right to the heart of the fiduciary relationship that the CEOs of the drug companies have with their shareholders, which is, of course, their top legal responsibility, to benefit shareholders. The problem is that the patients have an obligation that the companies also have, but the shareholders split the allegiance of CEOs.

So what I am going to do today is I am sending a letter to the Securities and Exchange Commission, asking them to ensure that there is a disclosure given to all investors in drug companies that there are outstanding studies of the efficacy of these drugs that the FDA has yet to call in that could affect the long-term stock valuation of these companies. Because I think the Securities and Exchange Commission could perhaps put more pressure on these companies to get to the answer so that investors aren't harmed and the pressure that we have had patients placing upon the FDA to get the information out, either from the drug companies or from the CEO or from the FDA.

Secretary LEAVITT. Let me make one thing very clear and that is that the Food and Drug Administration has one group to which

it is accountable, those who consume and take the drugs, the citizens of this country.

Mr. DEAL. Time is expired. The Chair recognizes Ms. Bono for 6 minutes.

Ms. BONO. Thank you, Mr. Chairman. Again, welcome, Mr. Secretary. First of all, I just would like to comment on our concern about the IGT issue. I, along with Congressman Waxman, just heard with our meeting with Governor Schwarzenegger, that he is working on these reforms. I am concerned that we are going to come out and pull the rug out from underneath our Governors as they are trying to reform and modernize our States and that our budget is not on track with what the State needs. Second, my colleague, Ms. DeGette, on the other side had to leave to catch a plane, so she asked if I would ask her questions and I said I would not but I would ask if we could submit to you in writing her questions about embryonic stem cell research, which I also am very interested in, so could we send it to you?

Secretary LEAVITT. Yes, we would be happy to respond.

Ms. BONO. Thank you. And then last, I have two more boutique issues that I am concerned about and I don't believe that we have addressed. My first question is regarding the Women's Health Initiative, which was a study that was being conducted on hormones on women. Once it was found that there are increased incidences of different cancers, the study was abruptly halted. And I believe women are still out there clamoring for answers to this and I am hopeful that you will take this into consideration. And by furthering any studies with the Women's Health Initiative, you might look at bio-identical hormones. Do you know why, in fact, bio-identical hormones have not been included and the necessary research has not been done on bio-identical hormones, but only on synthetic hormones?

Secretary LEAVITT. Representative Bono, may I suggest, that sounds like a question that would be well-responded to in writing?

Ms. BONO. Thank you. I just wanted to point out to you that this is extremely important and I think women really deserve this answer and only the NIH and only we can do this research.

Next, your predecessor cared a great deal about obesity and I have worked with Senator Frist on an obesity bill, the Impact Act, last Congress. To tell you the truth, I was a little bit torn with the legislation because I don't know how we legislate to cure obesity, but I do believe it is something that we need to handle sooner rather than later. I was wondering if you have any thoughts on obesity and the epidemic, both childhood obesity and adult obesity and the burdens on our society and how we can do something to help with that problem?

Secretary LEAVITT. I am persuaded, as you have been, that it is a substantial part of the health dilemma of this country, that there is an unquestionable link between obesity and diabetes and other heart ailments and cancer and that by getting to the heart of that, we will make substantial improvement other places. My own sense is that it is a matter of educating people to change their behavior, that it is about orienting our entire emphasis to not just be about curing disease, but in creating wellness and obesity is a big part of that.

Ms. BONO. Well, thank you. I look forward to working with you on it further. I am hopeful that the chairman of my full committee can also hold a hearing at some point in time on the Impact Bill which, again, looks at obesity and does address it as a disease. Thank you very much.

Chairman BARTON. We will certainly take that under advisement. Who seeks recognition on the Minority side? Mr. Engel of New York is recognized for 5 minutes, 6——

Mr. ENGEL. 6 minutes.

Chairman BARTON. Thank you.

Mr. ENGEL. First of all, welcome, Mr. Secretary. I have two somewhat lengthy questions, but I first want to identify with the remarks Mr. Waxman made about the potential elimination of IGTs. In a State like mine, New York, IGTs are very, very important and if we are going to go after them, we really need to have an answer of what is going to happen to the people that are using them for care; in the absence of care, what is going to happen to these people. I know you can take IGTs alone and say well, there are certain states that are doing very well and yes, this happens to be one of the instances that New York does very, very well, but New York certainly puts more money into Washington than it gets back and we really don't like eliminating the programs where we do well. It eliminates some of the programs where we are not doing so well and other States are doing well, so I think it is unfair to—well—certain States are gaming the system. The fact that we need the IGTs, and I am very concerned about, so I want to add my voice to that.

Mr. Secretary, since the attacks on September 11, there has been a renewed focus on emergency preparedness. Hospitals and public safety officials have scrutinized their readiness to comprehensively respond to nuclear, biological, or chemical attacks. I know everyone here agrees that it is critical that our hospitals be a top priority in funding should our nation become victim to a future attack, particularly in light of a December 2004 study by the Trust for America's Health stating that over two-thirds of States lack basic preparedness capabilities.

I have grave concerns regarding the budget, the 2006 budget, which public health officials have stated would actually weaken the ability of State and local public health to respond to bioterrorism and related public health emergencies. I want to draw your attention, Mr. Secretary, to a few of the questionable financing provisions, and when I am done, get your feedback on it.

If we start with hospital preparedness, your budget states that you are cutting $8 million out of the program, leaving a grand total of $483 million for the Nation's hospitals. It doesn't sound like a terrible cut until you realize a couple of things. First, the program is ridiculously under-funded as it is. An American Hospital Association report done 2 years ago says that hospitals in New York alone would need at least $750 to $850 million in funding for basic readiness. And my hospitals in New York tell me that HRSA, the program, was a joke even before the cuts because by the time it was divided, most hospitals got only about $45,000 each, and one of my hospitals used that for a security camera.

And my second point is that hospital preparedness, the main program, was actually not cut by $8 million, but nearly $34 million this year, since $25 million of overall funding has been allocated for a competitive demonstration grant and if you don't win the grant, you surely lose. So how does the Administration justify such gross under-funding and further cuts to hospital preparedness, particularly in light of a $130 million cut to CDC, State and local bioterrorism preparedness funding? I would like your answer and then I have a second question for you.

Secretary LEAVITT. Let me comment on two points. One is intergovernmental transfers. I want to make clear that there are some intergovernmental transfers that are not just acceptable to us, but we support with our money. If money goes into a provider and it stays there, we applaud that; that is our goal. It is when they are recycled in a way as to create more obligation for the Federal Government and to minimize theirs, that troubles us.

Second point. With respect to bioterrorism, it has been troubling to us that there is a substantial amount of the money to be drawn down by States that has still not been drawn down. We don't believe that the hospital capacity has been moving fast enough and so much of the new investment that you will see in this budget goes to develop national stockpiles so that we have the capacity to deploy, on a rapid response basis, within 12 hours, to any community in this country substantial or suitable supplies to respond. All the States are clearly benefiting from this new investment.

Mr. ENGEL. I would like to continue to dialog with you on it and because my hospitals are yelling bloody murder and that is not what they are saying to me.

The second question I have is, as you know, earlier this month our New York City Health Commissioner gave notice of a potential new strain of HIV that may be impossible to treat. For many, the identification of a possible AIDS super bug, recall the same fear that arose 20 or 30 years ago when the original AIDS virus was discovered. I think it is critical, more than ever, that we use the scarce funds to appropriately fund AIDS surveillance, prevention, and treatment programs wisely toward at-risk populations, so I am concerned that funding for HIV/AIDS prevention has been reduced by nearly $5 million, while abstinence education, a program that I think has limited effectiveness, is getting an increase of $38 million. HIV, as you know, is in a place we want to cut corners and while there is a modest increase in funding for ADAP under the Ryan White program, it really doesn't excuse the other shortfalls, so I would like you to mention that how do you justify spending so little money on HIV/AIDS prevention given the President's repeated commitment to fighting the spread of the virus globally.

And finally, I know from conversations with New York City health officials that many are concerned about the level of funding that will be required to track and research this new resistant HIV strain in New York City, should it be a serious and widespread a problem as we fear and if asked will the CDC provide necessary funds to New York health officials to respond to this potential new strain of HIV due to its impact on our public health. Can you answer that, about the cuts?

Secretary LEAVITT. I think the President's commitment, as you acknowledged, on Ryan White funds in the international and the continuation of research funds, makes evident his commitment here and maybe given the time, I could respond to you in writing with more detail.

Mr. ENGEL. Okay, I appreciate that. Thank you.

Chairman BARTON. The gentleman from Oregon, Mr. Walden, is recognized for 6 minutes.

Mr. WALDEN. Thank you very much, Mr. Chairman. I certainly appreciate the opportunity to have the Secretary come before our committee and congratulations on your new appointment and or is it sympathy, as I am never sure, the responsibilities you take on. Mr. Secretary, there are a couple of issues I wanted to raise that are somewhat specific to the Northwest or Oregon and somewhat broader than that. The first is my senators and I and other colleagues have said to CMS a letter requesting another look at a decision made in Region 10 involving Medicaid payments. Under an Oregon statutory framework, the State of Oregon is required to provide full-cost payment for hospital services provided to Medicaid patients when those services are provided at rural hospital at 50 or fewer beds, referred to as Type A or B hospitals. And Region 10 now says that may violate some Federal law and so it is one of those issues that I would like to draw your personal attention to; as I say, our delegation has sent a letter to Mr. Smith, the director of Center for Medicaid and State Operations in Baltimore. And so it is one we will be making sure you are aware of, as well.

Secretary LEAVITT. Thank you. I will assure that that is responded to.

Mr. WALDEN. In another issue that I and others had raised with your agency prior to your arrival there, it involves graduate medical education training and as I understand it, and we have never gotten a response back from the letter that was sent last year sometime, but it seems that hospitals cannot claim for Medicare graduate medical education payment purposes the time residents spend in non-hospital sites unless the hospitals pay a supervisory physician some amount even if the physician agrees to train the resident on a volunteer basis. So according to a family practice residency in Klamath Falls, Oregon, this policy, they believe, will result in teaching hospitals pulling their residents back into the hospital setting for training, thus limiting residents' exposure to the physician office and non-hospital environment. And we will get you more information on——

Secretary LEAVITT. I actually heard some of this this morning and it has raised my level of curiosity and I will do what I can to be responsive to you.

Mr. WALDEN. I appreciate that. Earl Pomeroy, from North Dakota, and I are the co-chairs of the Rural Health Care Coalition for this period and there are a number of other issues that we are raising that I will give to you and not expect immediate answers here today, but we have sent a letter to you raising them and one of them, though, I would throw out at you is that your predecessor, Secretary Thompson, did establish a Health and Human Services Rural Task Force that was charged with examining how HHS programs can be strengthened to better serve the healthcare needs in

rural communities and I am just seeking your sort of commitment to continue that process, especially coming from a State like Utah. I am sure I am preaching to the choir here.

Secretary LEAVITT. Well, I understand well the dilemmas of delivery in rural America. I have observed what I think to be a quite prudent choice that has been made on how to get to those problems. For many years we have tried to surgically find ways in which to bolster with various programs, I see in this budget a different strategy, and that is to essentially use a rising tide lifts all boats. We have dramatically increased or improved the reimbursement rates through the Medicare Bill by some $25 billion. That is a substantial infusion going directly into the system and allowing communities the flexibility that is required to make a difference, and I like that. As a person responsible to deliver in rural America, I think that makes a lot of sense.

Mr. WALDEN. Now, I appreciate that and I think the Medicare Bill is probably singularly the most important improvement in rural health care that we have seen passed in the Congress, certainly in my time here. However, my understanding is only 4 of the 118 Rural Health Care Services Outreach grants funded between 2001 and 2003 focused on the Medicare population. Apparently these are grants that may be targeted. The vast majority of grantees are not Medicare providers, thus receive no benefit from MMA, so there may be some other pieces in the budget that may adversely affect our rural areas.

I want to follow up on something that Dr. Burgess talked briefly about, as well. I spent 5 years on a community non-profit hospital board before coming to the Congress. I was in the legislature and dealt with health care issues when we not only passed but implemented the Oregon Health Plan, which was trying to get at Medicaid population to do as you say with SCHIP, insure more people but hold the cost by prioritizing how you do it. I would encourage you in your work with the Governors to think outside the box on Medicaid because it seems like we sort of nibble around the edges, we cut here and think we can shove costs there and I will tell you, if there is one thing that really struck home with me on the hospital board, it was the amount of rules and regulations and audits and as you say, I mean, we hired somebody to come in and tell us how to bill more properly so we could get more money back.

It is a standard process out there, all within the rules, but we have created a bureaucratic, no offense, but a rules-based system that is so complicated that you have to hire professionals to come in to tell you just how to bill. And I have often wondered if there isn't a better way to give the providers or the States or somebody—there has to be a way to cut through the incredible complex procedures that we have put in place. We could save so much money and deliver such better health care if maybe we measured the outcomes rather than the bureaucracy.

Secretary LEAVITT. Congressman, may I just echo what you said? If we could measure outcome and hold ourselves against that standard, as opposed to filtering everything we do through binders full of regulations, we would have better outcomes.

Chairman BARTON. Gentleman's time has expired. My list shows that Mr. Allen actually got here before Ms. Capps, but that is not

right. She says it is not right. I am going to yield. I will recognize either Mr. Allen or Ms. Capps, whichever one of you arm wrestles the best. Okay, Ms. Capps has apparently recognized—6 minutes or 5 minutes?

Ms. CAPPS. 6 minutes——

Chairman BARTON. 6 minutes.

Ms. CAPPS. —Chairman, and thank you very much and thank you, Mr. Allen. Thank you, Mr. Secretary, for your testimony and for spending this much time with us. I have three different topics to bring up in this time and so I appreciate this time. First, to continue or perhaps conclude the discussion of my California colleagues, will you make available to us the actuaries which estimated the budget savings from your various Medicaid proposals? By this, I mean the actuaries that predict the cutting the IGTs will save certain amounts or increase outreach will cost this much or whatever. I would like to ask for this, as specific as possible and in writing?

Secretary LEAVITT. I am happy to provide you with the information I have on how it was scored. I will tell you that there are a lot of complications, as the people at CBO would tell you on how they arrive at those estimates looking out 10 years and there are disagreements, I suppose, available to be analyzed on why, so——

Ms. CAPPS. Well, we would like to have access to the actual actuaries, if possible, please, sir.

Secretary LEAVITT. I will do my best to give you everything that I have that is credible.

Ms. CAPPS. Thank you, Mr. Secretary. I am holding in my hand the 2005 Blue Cross and Blue Shield Service and Benefit Plan book for Federal Employees Program. You have made a number of public statements about how Medicaid benefits are more generous than those in the Federal Employees Program and how Medicaid should be more like our private insurance plans, so I want to ask you about two benefits not covered under FEHBP and how Medicaid beneficiaries would fare without them.

Now, the Blue Cross plan document says it does not cover maintenance or palliative rehabilitative therapy. Would you address, please, "optional infant" with cerebral palsy in a family with an income of about $1400 a month who requires weekly maintenance therapy to prevent complete atrophy of his muscles. Address how living in pain and suffering because Medicaid doesn't cover such therapy or should Medicaid cover such therapy and I want to ask you another example on that, too.

Secretary LEAVITT. I will respond with this construct. There are populations of our citizens, those who are disabled, those who are elderly, those who are elderly and disabled, those who are in foster care, populations of our young, of our children who are in the lowest possible income brackets or the lowest income brackets; they need to have not just acute care or insurance, they need multiple services.

Ms. CAPPS. So that wouldn't be covered in——

Secretary LEAVITT. Well, many of those—there are also people in the optional groups who fall under there and the States need the capacity to do that. My point all along is we need the capacity to

treat groups according to their situation and the help they need, not a situation where we provide the same thing to everyone.

Ms. CAPPS. Okay, so then the comparison with the private insurance is not for every population group?

Secretary LEAVITT. In our SCHIP program, we provided States with the flexibility of being able to design programs around the needs of the recipients and it is a brilliant way to go because it provides us the capacity to provide coverage to more.

Ms. CAPPS. Let me ask you about another population. The Blue Cross plan document does not cover admissions to non-covered facilities such as nursing homes. The vast majority of seniors in nursing homes as so-called optional beneficiaries. How about the millions of individuals with disabilities in elderly, in institutions? How would they manage or would this be another exception to the private insurance plan?

Secretary LEAVITT. Again, if you were to go back to SCHIP it wouldn't be covering elderly, but we provided the option of being able to design it. I believe that many States are now viewing value in creating home and community care where they can provide the coverage that the citizen wants, what the recipient wants, in the place they want it as opposed to dictating the fact that it will happen in a nursing home. And if a State had that flexibility, they not only could cover them in the way they wanted, meaning the person wanted to be served, but they could also cover more of them.

Ms. CAPPS. Okay, but if a person is not using a benefit, Medicaid isn't paying for it and how does this save money unless you take benefits from people who are using it?

Secretary LEAVITT. Again, I don't see us taking benefits from people who are using them. I am suggesting that there are large populations of those served by Medicaid who simply need help buying insurance.

Ms. CAPPS. Okay.

Secretary LEAVITT. And what we provide them with is the same benefit we provide for someone who has a disability and that is not, in my judgment, the best use of resources.

Ms. CAPPS. I want to switch to another topic, if I could, just for my last few seconds. President Bush indicated in his State of the Union address that his budget would be targeting for elimination, and it did eliminate programs that are not getting results, yet he has proposed a $38 million increase for unproven abstinence only programs, sex education programs. Recent evaluations of 11 different abstinence only programs show that the programs had no lasting positive effect on younger people's sexual behavior and may even result in riskier behavior by teenagers. In 2001 a report released by the National Campaign to Prevent Teen Pregnancy found no credible studies of abstinence only programs showing any significant impact on participants' initiation or frequency of sexual activity and the National Academy of Science's Institute of Medicine has criticized the investment of hundreds of millions of dollars in unproven abstinence only programs as poor fiscal and public health policy. So in a few seconds, could you explain to me why the administration recommended that we increase funding for this program that hasn't been proven effective, but in fact may even put young people at risk?

Secretary LEAVITT. Well, in the 2 seconds we have left, I will simply say abstinence is 100 percent effective.

Ms. CAPPS. The programs I am talking about. Everyone agrees with that.

Mr. DEAL [presiding]. Gentlelady's time has expired. I recognize Mr. Whitfield for 6 minutes.

Mr. WHITFIELD. Thank you, Mr. Chairman, and Mr. Secretary, thank you for being with us this afternoon. It is my understanding that Utah has one of the most comprehensive and technologically advanced prescription drug monitoring programs in the country and about 20 States that have these programs, and I have even been told, I don't know if it is true or not, but that you were Governor when Utah created their monitoring program and as you probably know, in the last Congress, we passed legislation on the House side establishing a prescription drug monitoring program with the support of Frank Leone, Charlie Norwood, Ted Strickland and others, and Senator Sessions had introduced it on the Senate side and I do notice that President Bush, in his budget, has provided some funding for monitoring programs.

Our legislation would have placed this with the Department of Health and Human Services and of course, the goal was simply to enable all of the States to have a program, meet certain basic requirements, establish a stable funding stream and allows the sharing of information across State lines. And of course, Secretary Thompson was quite supportive of our efforts and I would just like to know, with your background particularly as it relates to Utah, would you be supportive of this type of a program, trying to Federalize it and encourage States to establish these programs?

Secretary LEAVITT. Mr. Whitfield, earlier I said and I will repeat for emphasis, when I wake up in the morning, the first words that come to my mind are health information technology because I believe it weaves together most of the subjects we have been talking about today. The capacity for FDA to monitor drugs that have been approved for market, literally tens of millions of data points that can be gathered in anonymous ways to be able to provide the FDA with powerful insights into the impact of drugs, the worldwide web being able to then put that information into the hands of those who need it; consumers, physician, pharmacists. The ability, then, for electronic health records to where we are eliminating the inefficiencies on purchasing, allowing us more dollars to be able to provide benefits for health coverage like our colleagues have been suggesting are so badly needed. All of this weaves together.

Now, it is going to require, in my judgment, a large national collaboration. There are very few ways to get to the kind of national system, not Federal, national system, where we are essentially creating standards by which people begin to operate and provide additional support for. It is well within our grasp and for that reason the President has proposed $125 million as a means. Beyond that, other agencies of Federal Government, State governments, private providers all need to pull together. The words are health IT. It is the secret to many of the things that we have been talking about today.

Mr. WHITFIELD. Well, thank you. You know, Mr. Norwood and I plan to reintroduce this legislation and the purpose, of course, is

to provide that impetus with the States to create programs because the first program is, I think, around 40 years old and yet, we still only have 20 States that have good programs, so——

Secretary LEAVITT. I look forward to working with you on this. You have my full enthusiasm and complete interest.

Mr. WHITFIELD. Thank you so much. A second issue I want to discuss just briefly, we all recognize we have a very complex health care system and it is fragmented and I know that President Bush is totally supportive of these community health centers and since he has been president, he has provided more money each year in his budget and I know that these are effective centers. I have one in my district and everyone sings its praises, but I am just curious, is there anyone at Health and Human Services looking at how these community health centers complement or work with the Medicaid program, the Medicare program, because all of a sudden we have got these health centers and anyone is eligible, they can go and there is a sliding scale for what you pay for services, but is there any long-range plan coordinating the service that they provide with the existing government health programs?

Secretary LEAVITT. My level of experience at the department is still new enough that I cannot respond properly to date. I will be happy to respond in writing, but I would like to tell you that the promise of community health centers, I believe, we are only beginning to see. In my own State, we created a small network of these and in essence, then, created a little HMO, if you will, and provided a health card we were able to provide basic, very basic, but basic health insurance to 18,000 people in our State who didn't have it before with money we were able to take from savings in other areas. Using that community network, we were able to provide basic quality care, preventative care and others; not as good of coverage as we would like, but we linked it together with some other things. There are lots of imaginative ways to use these and they need to be coordinated closely with Medicaid and Medicare.

Mr. WHITFIELD. Well, I mean, I agree with you and someone even made the comment and not seriously, because no one has even looked at it, but someone made the comment we might be better off as a nation to take the dollars being spent in the Medicaid program and establish community health centers around the country, so——

Secretary LEAVITT. 6.1 million people will be served this year. And by the way, we don't count among those who have insurance, because they don't have insurance. However, they are getting care and it is increasingly higher quality.

Mr. WHITFIELD. Absolutely. Thank you.

Mr. DEAL. Gentleman's time has expired. Chair recognizes Mr. Allen for 5 minutes.

Mr. ALLEN. Thank you, Mr. Chairman. Mr. Secretary, the $45 billion in reductions in Medicaid spending works out to about $4.5 billion a year over 10 years. But there is another number that is worth keeping in mind and that is $89 billion. That is the amount in tax cuts that people earning over $350,000 a year will keep in 2005 alone. The administration budget has $23 billion in additional tax cuts over 5 years proposed, which is on an annual basis, about what the reductions in the Medicaid program are. I think those

numbers speak more loudly and clearly than you or I can about this administration's priorities. It is why we feel that putting more of the burden on State taxpayers and on Medicaid beneficiaries is really the wrong way to go.

I am prepared to concede to you that there certainly are circumstances where additional flexibility could yield some savings at the State level; not in every State, not at every time, but clearly, I think you are right about that, but I believe, unless you tell me differently, that the $45 billion figure was a budget figure. It wasn't based on any sort of calculation of what the savings could be in all 50 States over the next 10 years and I think, in your testimony before the Senate, you recognized that frankly, there will be lower benefits. Yesterday you told Senator Bingaman that the States need help coping with Medicaid costs now, I agree with that. But you also said that States should be able to cover more people in optional populations with the same amount of money by offering a less costly set of benefits. To me, that means that some people will get fewer benefits than they have today under Medicaid under your proposal. Isn't that right?

Secretary LEAVITT. It is possible.

Mr. ALLEN. You also said yesterday that if we don't allow States to give people fewer benefits, many will, and I quote, "many will simply lose coverage." Is that true, as well?

Secretary LEAVITT. Well, that is certainly true. I want to make sure I am understood. We have a mandatory set of groups that we have made a commitment with an entitlement to, we all know who they are, and there are no block grants in the President's budget, there are no involuntary caps. We recognize the need to keep trust and faith with those groups. There are other groups who are covered by Medicaid that basically need insurance. They need help buying insurance. And the question is do we treat both of those groups precisely the same or do we recognize that given the fact that they need help buying insurance that we could provide more help to more people if we treated them in a way that was consistent with their needs, not with the same level of care as those who need for long-term care, or those who have needs for additional services beyond which virtually anyone else in society gets?

Mr. ALLEN. In theory, you know, I understand what you are saying in theory, but the bottom line impact is going to be—I mean, for example, I understand that it is something like 60 to 70 percent of Medicaid dollars go to nursing homes, or close to that. And I have been through nursing homes in Maine and the people who are in nursing homes in Maine today, as opposed to 20 years ago, really need to be in nursing homes. That is a terribly disabled population. And it seems to me that when you start doing this budget from the top down, when you make a decision at other levels of the administration, that we are going to do enormous tax cuts for people earning over $350,000 a year on the one end, but we are going to start reducing the amount of money flowing to the States. We say we are going to provide—you say you are going to provide flexibility, that is a little bit of help, but the bottom line is, as you said yesterday, that somebody, some people are clearly going to have either less coverage or no coverage. And that, it seems to me, is the bottom line.

Secretary LEAVITT. I would invite you to just look a little south of you to two States, New Hampshire and Vermont. Vermont has adopted a waiver that allows them to use home and community care with their elderly citizens. New Hampshire has chosen not to. There are dramatic differences in the number of people that can be covered in Vermont and the way in which they are covered. As I recall, the number is roughly 50 percent of those in Vermont who are of that age or in nursing homes, and it is roughly 85 percent in New Hampshire. And it costs roughly twice as much. The net effect is that two States, both your neighbors, next door to one another, one pays twice as much to care and they are able to care for roughly half as many people.

Mr. ALLEN. And just to conclude, Mr. Secretary, I am not contesting that point. I do recognize there are differences in States, I do recognize there are efficiencies to be had. My only point is the $45 billion is an arbitrary number, not related to what you think can be achieved by efficiencies in the 50 States, and we are going to have to see how that works out. But the bottom line is some people are going to be worse off, they have to be.

Secretary LEAVITT. This is not a debate over whether we should pay, it is a question of who should pay.

Mr. DEAL. Gentleman's time is expired. Chair recognizes Mr. Stearns for 5 minutes.

Mr. STEARNS. Thank you, Mr. Chairman, and welcome, welcome. You have been through quite a bit here. I have got two questions and I don't think they have been asked yet. The President's budget seemed to suggest a need to recalibrate peoples' expectation regarding Medicaid, its role and its limitations and I remember when we had the welfare debate here and we came up with plans and nobody thought we would pass it, but we did try to say that we wanted to have some personal responsibility and we had some limitations in it. And I guess after reaching this consensus and finally after it was vetoed 2 or 3 times by the President, we finally passed it, and I guess I would say to you and ask your best personal opinion whether there is a way to bring to the Medicaid program this personal responsibility and a sense of ownership of what they have so that they would be more mindful, not only of the cost, but also how to improve health maintenance for themselves?

Secretary LEAVITT. I believe we can do for Medicaid what we did for welfare.

Mr. STEARNS. Good. That is good to hear. That is good. Governor Bush came up here and talked about some of the problems he had and he and other Governors were working on this Cash and Counseling program they had. You are familiar with it. It provided beneficiaries with the flexibility and self-design over their personal care. It was conducted in Florida, Arkansas and New Jersey and I understand now it is expanding to 11 States that I have here, in a map. It has been demonstrated to have dramatic and satisfactory satisfaction with both the people and the savings of money. It improved the health outcomes and cost no more than traditional delivery systems and I think Governor Bush is to be commended for doing this, and the other Governors. I think the Robert Wood Foundation, Johnson, the Robert Wood—Johnson Foundation has been a partner in this and we have got in the prescription drug bill a

Cash and Counseling demonstration for Medicare. And I was hoping that you would look at that and perhaps give me an idea of what you think, as a legislator, I could do to help you in developing both Cash and Counseling for Medicaid and for Medicare to bring in more personal responsibility.

Secretary LEAVITT. Thank you. I look forward to that.

Mr. STEARNS. Okay. That is it. Thank you, Mr. Chairman.

Mr. DEAL. Thank you, gentleman. Ms. Schakowsky is recognized for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Secretary. I appreciate your patience and staying to answer these questions and clearly, this will be an ongoing dialog because so many of these things can't be dealt with just today and are so critical. I want to focus in on one question, as I said, about this issue of the mandatory populations, but I just want to tell you that I would love to be part of the conversation, too, about stem cell research, about drug safety. I have a friend who had some anxiety, who ended up committing suicide after taking anti-depressants and I know we have dealt with some of that with young people, but her family is convinced that that drug had something to do with it. The whole issue of information about trials and testing and public access to those.

I am concerned about some of the things that you said. I know that they have been brought up in many different ways and by different members, but you gave a speech before the World Healthcare Congress in early February where you said, I will quote, "The optional populations on the other hand, may not need such a comprehensive solution. Most of them are healthy people who just need help paying for health insurance," which is what you said, but I wanted to ask some additional questions about so-called optional beneficiaries and find out which benefits you think they should not receive, if that is the route that States are forced to go.

Let me give you a couple of examples that I have thought of, of real-life people. A 63-year-old widow who has multiple conditions; fibrosis of the lungs, rheumatoid arthritis, high blood pressure, whose income is $700 a month, which is just too much to qualify for SSI and become mandatory eligible for Medicaid because her income is low enough in her State to qualify for Medicaid home and community-based care. So which services in the Medicaid benefit package should be eliminated for her, you know, physician services, hospital services, prescription drugs? And let me just run through them and then you can answer.

Another example might be an 85-year-old with Alzheimer's with a monthly income of $1500, which is about 200 percent of poverty, qualifies for nursing home care. Under the law, she is allowed, as our other Medicaid—to keep $30 a month for personal needs, something I hear a lot about from people because it is such a low dollar number. But the remainder of her income goes to the nursing home to support her care, but even that isn't enough to keep her off Medicaid as the nursing home care costs more than her income. So which services in the Medicaid benefits package do you think should be eliminated for her and as my colleague from Maine said, increasingly, people in nursing homes are very, very sick.

No. 3, a 7-year-old boy with autism living with his parents whose income is greater than $1310 a month, 100 percent of poverty for

a family of three. He qualifies for Medicaid through a home and community-based care waiver. Which services in the Medicaid package do you think should be eliminated for him? Physician services, preventive care, hospital care? You know, again, in theory, as my colleague, Mr. Allen said, there is a lot of things that can be said about cutting costs, but when you face these individuals, where do you start cutting?

Secretary LEAVITT. Let me answer that by offering another couple. A 58-year-old man and a 56-year-old woman who are married; she works as a waitress, he works as a mechanic. They work two jobs. Together, they make about $24,000 or $28,000 a year just above the poverty line, and they have nothing. I guess the question I would have, all of those people that you have identified to me sound like people who need not just insurance, but they need services and I don't propose anything that would distract from the States' ability to do it, but what about this couple who doesn't have anything and the States would like not only to be able to provide coverage to the people you have described, but also to these, and they believe they have the capacity, if they can give the people that you have talked about the same benefits that you and I get, or the same benefits that the biggest HMO in the State provides and then they could provide basic coverage to this couple, which is better?

Ms. SCHAKOWSKY. Well, it is just that when you—overall, when you see that there are going to be cuts in Medicaid, I think the notion that we should—you said at some other point that there are, you know, why give Cadillacs to some when you could give a Chevy to others? I mean, I guess when I talk about these people, we are not talking about Cadillac services. Why should we take from some poor to give to other poor when there, for example, are billions of dollars in tax cuts for the wealthiest? I agree with your description of that family, but budgets are a question of priorities and I think they are misplaced here.

Secretary LEAVITT. You know, it has never occurred to me—I say never occurred to me—it has never seemed right to me that we would say we are taking from one poor person to give to another. We are managing the resources of taxpayers to try to help the most possible people. We are not taking money from poor to give to other poor; we are taking taxpayers' dollars and saying how can we help the most people in the best possible way?

Mr. DEAL. The gentlelady's time has expired. Dr. Norwood is recognized for 5 minutes.

Mr. NORWOOD. Thank you, Mr. Chairman. Governor, welcome.

Secretary LEAVITT. Thank you.

Mr. NORWOOD. I am pleased you are here. Some people call this the greatest committee on Capitol Hill and I agree with those some people. And we are pleased to work with you. I am excited about your new posting and I will bet you are, too.

Secretary LEAVITT. I am.

Mr. NORWOOD. You have got some possibilities here to do some really great things in the next 4 years and we want to be part of working with you on that.

Secretary LEAVITT. That pleases me.

Mr. NORWOOD. Now, I have a lot of questions and they are detailed and I don't want——

Mr. DEAL. I am going to give you an extra minute. You are entitled to 6 instead of 5.

Mr. NORWOOD. Thank you so much, Mr. Chairman. The questions I need answered in writing. Frankly, I don't want a 5-minute answer, I want some thoughtful answers and I think it is best done in writing, so I will take my little few minutes and try to raise your level of curiosity to an issue that is very important to me. I want to talk to you about this on behalf of Congressman Simpson and Congressman Linder and Chairman Don Young. Before I do, I want to make sure I got it right, so you correct me if I am wrong, but the Public Health Service Corps is under your jurisdiction?

Secretary LEAVITT. True.

Mr. NORWOOD. And within that, we have the Indian Health Service that is under your jurisdiction?

Secretary LEAVITT. True.

Mr. NORWOOD. So you are the man. It stops with you. That is what I wanted to be sure of. Now, I have a great concern with the Indian Health Service and I hope you can help me and I hope we can sit down and talk through this at some time, but the dental—I mean, the Indian Health Service has approved the use of dental health aids in Alaska. Now, I have looked high and low and nobody in America knows what that is. There is no such title. It is not taught or trained in any institution of higher learning that I am aware of. My problem is whatever a dental health aid is, the Indian Health Service is going to allow them to perform highly skilled procedures without sufficient training. The limited amount of training that they are supposed to receive would not let them qualify to be licensed in any State in America.

Now, an important first rule for me is do no harm, and I am scared of this thing and so is Congressman Young about his constituents. I want to think, and I believe it to be true, that the services under your authority will have respect for State law and the traditional role of States in determining appropriate scope of practice. I don't think it is a good idea at all for the Indian Health Service to bring in from out-of-country training, under-trained, unlicensed providers into Alaska that are clearly acting outside the licensure requirements of the State of Alaska, in fact, of any State in America.

Now, I know you have been here just a few weeks; 30, 40 days, something like that. So I don't expect to get detailed answers right here. I hope you and I can have a grown-up discussion about it at some time, but three little quick queries. Does HHS take any steps to ensure that providers that receive Federal dollars are properly licensed in the States they provide care?

Second question. Do you agree with the proposition that States are the appropriate entities, and I am so glad you are a former Governor, to license health care professionals?

And third, if time permits, maybe you could give us just a comment on the general principle of respecting State Scope of Practice Laws and maybe we can get detailed at another time.

Secretary LEAVITT. Question one.

Mr. NORWOOD. Yes, sir.

Secretary LEAVITT. I don't know.

Mr. NORWOOD. Okay. It is all right.

Secretary LEAVITT. Question two. Yes, I believe that the States are the appropriate way.

Mr. NORWOOD. I hope.

Secretary LEAVITT. Question three. I believe, though I am not sure; the last time I testified in this room, it was on federalism.

Mr. NORWOOD. No wonder I want you to be the new Secretary. If you would, perhaps maybe your staff and we could just get together to talk about this. We are very greatly concerned that we are going to set some precedents that is going to hurt our country in terms of dental health care and it needs to be nipped in the bud. I do know how difficult it is, it has got to be, to deliver dental care in Alaska. I mean, half the year you can't even get out there. But many people are willing to try to help solve that problem in the private industry, but we don't want the system we have set in place to protect patients in the Nation to be torn apart in the process of trying to treat the natives. We want to help, we will help, but you and I need to get together sometime and talk about this.

Secretary LEAVITT. Congressman, this is a subject that I think does warrant a lot of discussion. I reference the fact that I was to here to talk, as a Governor, about federalism. I believe we are in a period of history where political boundaries are not as relevant in a practical way as they might have been 50 or 100 years ago.

Mr. NORWOOD. Understood.

Secretary LEAVITT. I mentioned the fact that when I wake up in the morning and I am thinking health IT, what that means is we have the capacity to move big blocks of information instantly across not just the States or the country, but the planet and that it is requiring us to think through, in a new way, ways to provide the protections that come from State licensing and the efficiencies that a global economy requires. I believe this conversation is a very important one and I look forward to having the conversation with you. I think the principle is that the Federal Government establishes standards, but we have to leave to the local communities the capacity to have local strategies.

Mr. NORWOOD. But you are not going to help the government establish standards that dumb-down care for patients, I know.

Secretary LEAVITT. True.

Mr. NORWOOD. And they do that sometimes in their effort to say we are trying to help everybody. But we must not do harm. There are things that can be done, I agree, but this thing goes too far and I look forward to working with you on it.

Secretary LEAVITT. Thank you, sir.

Mr. NORWOOD. Mr. Chairman, I know you are not going to believe this, but I am going to give you back my little bit of time.

Mr. DEAL. It is already gone. We appreciate the thought, anyway. Ms. Baldwin is recognized for 6 minutes.

Ms. BALDWIN. Thank you, Mr. Chairman. Welcome, Mr. Secretary. I note that your predecessor and his predecessor before both hailed from Madison, Wisconsin, my district, immediately before occupying their position as Secretary of DH and HS, but welcome, nonetheless.

Secretary LEAVITT. Thank you very much.

Ms. BALDWIN. I wanted to follow up on a question that has been alluded to but not specifically asked by previous speakers, and that

regards embryonic stem cell research. And as we all know, in August 2001, President Bush banned Federal funding for research on new embryonic stem cell lines that were created after the date of his announcement. President Bush's policy, in my opinion, has severely limited the number of stem cell lines available for research and we know, as scientists, including those in my district, believe that this embryonic stem cell research could lead to incredible breakthroughs in treatment and knowledge of diseases, conditions such as Alzheimer's, Parkinson's, cancer, diabetes, spinal cord injuries and more. I, for one, believe that we should lift the ban on funding, Federal funding for new stem cell lines, embryonic stem cell lines, but I wonder whether you plan to review or revisit this policy. If so, I would like to hear about your plans in that regard and let you know that many members both side of the aisle would be very happy to work with you to review that policy.

Secretary LEAVITT. Representative, I share in the hope and optimism for stem cell research. I would like to point out that the President's decision empowered dramatic increases in the amount of stem cell research that occurred. He made what he believes, and I believe, as well, to be a decision, a moral decision on embryonic stem cells. I have spoken with him about it. I understand the reason he made the decision. I understand why he believes it is a moral decision. I concur with him and I will support him in that decision.

Ms. BALDWIN. So no, you do not plan on reviewing or revisiting that during your tenure?

Secretary LEAVITT. I will be supporting the President's position.

Ms. BALDWIN. Okay. You have said, in your testimony, that you were hoping for some questions on the Medicare prescription drug rollout next year and I have a couple that certainly emanate from my district and the concerns that have been raised about that rollout. Specifically, our State has a Pharmacy Plus waiver and we have had a great deal of success in making prescription drugs more affordable for especially low-income senior citizens through what we have called our SeniorCare program. And it appears, as we see some of the new regulations with the Medicare Modernization Act that it may be the intent to rapidly extinguish the four Pharmacy Plus waivers that are in existence. This would have a devastating effect on people that I represent. We have calculated sort of side-by-side how they would be served under SeniorCare versus how they would be served under the Medicare prescription drug benefit. They are much better off if they remain in the SeniorCare program. What assurances can you give to Wisconsin seniors that the administration will not force Wisconsin to terminate its SeniorCare program as a result of the new regulations that deal with budget neutrality renegotiations of these waivers?

Secretary LEAVITT. CMS is going to work very closely with States who have these waivers to enable them to provide comparable drug coverage to their beneficiaries. In fact, our objective is to have our systems be able to work with them so they not only are compatible, but they work hand-in-hand.

Ms. BALDWIN. And as you have more specifics, I certainly want to keep in touch with this because it is something that has been a vital lifeline for our seniors in Wisconsin. Lastly, specifically deal-

ing with dual eligibles, those individuals who are both on Medicare and Medicaid, I am wondering if you can identify specific measures that CMS will be taking to ensure that the transition for dual eligibles as they go from Medicaid to this Medicare prescription drug benefit commences goes as smoothly as possible to avoid any disruptions in access to essential medications. Especially we are concerned about people with severe mental illness. In the case of a dual eligible, for example, who is auto-assigned to a preferred drug plan that does not cover the mental health medications that they are currently taking. What sort of provisions or contingencies or plans do you have in order to ensure that the beneficiary does not have any uninterrupted coverage?

Secretary LEAVITT. Representative, our first priority, of course, is to assure that a decision is made on behalf of all recipients and that no one is dropped from coverage because of a lack of decision. We also recognize that there may be those who will have special needs where one decision will be measurably better than another and we intend to be imminently flexible and work with them until we have—and very willing to make changes to accommodate them. There is no question that many people will need to make decisions quickly and that some will not make the decisions. We are going to make a decision and then work with them to make certain it is the right decision.

Ms. BALDWIN. Thank you. I yield back, Mr. Chair.

Mr. DEAL. I thank you. Representative Wynn is recognized for 5 minutes.

Mr. WYNN. Thank you, Mr. Chairman. Mr. Secretary, thank you for your patience. On the subject of Medicare physician payments, currently payments remain well below the rate of inflation and cuts of 4 to 5 percent are predicted annually between 2006 and 2013. In that time, the physician costs will rise by 19 percent, the Medicare payments will fall by 31 percent. We are already seeing physicians leaving the Medicare program. What actions are you going to take to prevent physicians continuing to leave the program given the shortfall?

Secretary LEAVITT. You have defined very carefully and skillfully the dilemma and, frankly, the solution for us to work together to come up with a solution. The Secretary needs to be working with this committee to find a solution. I recognize the dilemma. We have got to work together to find a solution.

Mr. WYNN. Well, I appreciate that. I look forward to working with you on that, but we are also going to have to have some more money in the—similarly, on Medicaid, you are proposing about $60 billion in cuts over 10 years and you have acknowledged to my colleague, Tom Allen, that there is going to be increased cost sharing and less benefits. You said that that is likely to happen. Now, my question to you is won't this result in an increase in uncompensated care? People with insurance are going without care because they can't afford the cost sharing responsibilities as the premiums go up. This has got to be even worse for the poor. So my question, won't uncompensated care go up? Two, won't this put an additional burden on hospitals? And three, won't this drive up private insurance, which means four, won't small businesses have a more difficult time providing insurance?

Secretary LEAVITT. Important that I am understood here. The President has proposed three changes in Medicaid. One of them is a reduction in the amount we pay for pharmaceuticals, not to those receiving benefit, but to the companies we buy it from.

Mr. WYNN. If I can just jump in. Didn't you agree that there would be a reduction of benefits? I am sure there are some other features involved in the President's budget, but in the interest of time, isn't it true that there would be a reduction of benefits and increased cost sharing?

Secretary LEAVITT. Not automatically. The States—I am suggesting that there will be many people who will fall on the system, just like you are saying, if they don't have coverage and right now, the States are struggling to find ways to keep the people insured who they have insured and they——

Mr. WYNN. And so the States are going to have less money, isn't that true?

Secretary LEAVITT. No. Well, the States——

Mr. WYNN. Well, a $60 billion cut over 10 years.

Secretary LEAVITT. We made a deal with the States. The deal is we will pay roughly 65 percent if they will pay 35. All we want is for States to keep the deal.

Mr. WYNN. Does that result in a $60 billion cut over 10 years?

Secretary LEAVITT. It means that States are going to have to step up and pay their part of the deal and not——

Mr. WYNN. Will States have more people to cover?

Secretary LEAVITT. I suspect that populations have, in fact, been expanding, but an important——

Mr. WYNN. So you have more people to cover with less money. Doesn't that, by definition, mean that there are going to be lower benefits or higher deductible, the higher cost sharing by people on the lower end of the economic spectrum?

Secretary LEAVITT. Congressman, you have large groups of people who are optional coverage groups now that are on the verge of losing their coverage because States do not have the flexibility to be able to find ways of covering them. What we are proposing is to use methods that would allow the States to manage those groups while keeping——

Mr. WYNN. But the bottom line is that the amount of money the States will get will be less, so it seems to me that this is worsening the problem.

Secretary LEAVITT. This isn't a function of whether or not the money goes into Medicaid, it is a question of who puts it in.

Mr. WYNN. Okay.

Secretary LEAVITT. There are many States who are meeting their part——

Mr. WYNN. How will the States, given the fact that they are currently strapped, how will they come up with their share of the money? They will have to raise taxes, isn't that true?

Secretary LEAVITT. It will be different in every State. What we are asking is that they be given flexibility so that they can manage the money that they are currently spending——

Mr. WYNN. More flexibility, but more people, isn't that true?

Secretary LEAVITT. Well, we would hope that they could cover more people, yes.

Mr. WYNN. With less money.

Secretary LEAVITT. And we believe it can be done with flexibility. There are many States who come to the Secretary of HHS and offer waiver requests and say we believe that given flexibility we can not only continue to cover people that we worry we won't be able to without this waiver——

Mr. WYNN. If you increase the cost sharing, which you have indicated will happen, won't that result in more uncompensated care as people are unable, as the poor are unable to meet those obligations?

Secretary LEAVITT. Congressman, our conversation is leaving out one important fact and that is we are not talking about less money going into Medicaid, we are talking about a 7 percent increase every year for 10 years that over the——

Mr. WYNN. I have been asking you about a $60 billion cut over 10 years and each time you have acknowledged that that's the cut.

Secretary LEAVITT. No, I am acknowledging that over the next 10 years we will spend $5 trillion. There will be more money every year going in. What we are talking about is whether or not the rate of growth is 7.6 percent or 7.4 percent.

Mr. WYNN. Okay. Well, we seem to be going around and around and my time has expired. I yield my time. Thank you, Mr. Secretary.

Mr. DEAL. Mr. Inslee is recognized for 5 minutes.

Mr. INSLEE. Thank you. Mr. Secretary, over to your right here. My name is Jay Inslee from Seattle. Welcome to your new post, wish you the best of luck. If you have any problems in your job, just give me a call, because I was Region 10's director for a while, so I solved all the problems at HHS. There are a few that haven't been implemented yet.

Secretary LEAVITT. I need your phone number.

Mr. INSLEE. You give me a call and we can work—but one of them is local, as many of our concerns are and I am from one of the States that we are very visionary in increasing our SCHIP eligibility some time ago, back in 1997 and was rewarded by the Federal Government before your tenure with the penalty, if you will, of not getting coverage for a significant number of our young folks. And we hope that we will be able to work with you in an effort to resolve that. We are not the only State, as you know, there were punished for our being ahead of the curve a little bit and being an early adopter of our increased enrollment. I think you may have heard about our $2 billion shortfall in Washington State. I know Washington State is not alone in that regard. I hope that you can give us some assistance in designing a way that will remove that getting hit with a 2x4 financially because we were ahead of about 40 other States in advancing the cause that you now seek to advance. What can you do to help us in that regard?

Secretary LEAVITT. I am uncertain, but I will look forward to working with an experienced hand to try.

Mr. INSLEE. I won't let you forget that. You know, it is our job to extract promises from secretaries, so I will try to hold you on that. It is a very serious issue because if we are going to expand eligibility and you are making this commitment to get these eligible but unenrolled people in, that is going to exacerbate the prob-

lem, in a sense, which is increasing our coverage, which is our goal, but causes additional financial stresses. So I will hope to talk with you again about this issue, to find a way and—you know, before we move forward, I hope we can look at this as a top priority first to remedy this inequity for us and several other States. I hope to talk with you about that.

Secretary LEAVITT. I will look forward to that conversation.

Mr. INSLEE. Thanks. As far as reimbursement levels, is there any thought being given to a more permanent fix to this? We are seeing very significant lack of coverage in our State in a variety—I know we are not alone. This is getting worse rather than better. We have this tremendous technology that is not available in parts of our State in no small measure because these reimbursement rates—is your administration considering any more permanent fix to this other than temporary stop-gap measures to give us some hope in that regard?

Secretary LEAVITT. I hear a lot about this. I have this conversation with lots of Members of Congress. It is pretty clear to me that we have got to work together to solve it. There are those in Congress who believe the Secretary has authority to do it. There are serious questions about that. What I do believe is that we are going to have to work together to find a solution. Not coming up with a solution is not an option in my mind.

Mr. INSLEE. Now, let me ask you a difficult question. Those were two softballs. Let me ask you a difficult one now. In listening to the budget proposals the administration, in your agency, they seem, by and large, except maybe enrollment, the effort to increase enrollment for eligible SCHIP kids, which we applaud—other than that, they pretty much seem, to me, budget-driven. We have budget issues; we are going to take policy issues to try to close those holes and those are driven by three things; our economic, sort of, recession for a period of time; the war/wars that we are now involved in; and the tax cuts, and one can argue about the percentage contribution to those. At what point would you discuss with the President the necessity of reviewing his revenue position in order to maintain your ability to fulfill your responsibilities? And maybe it is a little early in your tenure to ask you a hard question like that, but I hope you will think about it.

Secretary LEAVITT. Great question and one I wish I had more than 37 seconds to answer, but I will tell you, the President gave me a direct charge and it was to help Americans to live longer and to live healthier and to do it in a way that will help us maintain our economic competitiveness. Now, I believe that is an important charge and I think the key to it—and he also put into this budget $125 billion over 10 years to allow 12 to 14 million people who don't have health insurance to get it, and $125 million to begin to connect the Nation together with an IT system that will transform our health system. Those are big visionary objectives that have to be accomplished in order for me to meet my mission and I am delighted for a chance to work with an experienced hand at this problem.

Mr. INSLEE. Thank you. Good luck.

Secretary LEAVITT. Thank you.

Mr. INSLEE. Thank you, Mr. Chair.

Mr. DEAL. Thank you, gentleman. The Chair has three requests for documents to be added to the record. One is a letter from CBO to Chairman Barton dated February 16 of this year. The second is a report from the Office of Actuary of February 11, 2005, and the third is a letter from Ranking Member Dingell dated February 15 to Secretary Leavitt. Without objection, they are admitted to the record.

The Chair would recognize Mr. Burgess for an inquiry or request.

Mr. BURGESS. Thank you, Mr. Chairman. Mr. Secretary, if I could, and I know the hour is late and I will ask this and it is certainly okay to respond in writing, but I will have my office get—there has been several questions the last few minutes about Medicare reimbursement rates for physicians and it always brings up the question of balanced billing and what is going to happen with the STR or the MedPack formula, so let me get a question in writing to you, if I could, about that issue. And then finally, I would just ask, there has been some community health centers and I am relatively new here. This is the start of my second term. It seems to me that there are enormous barriers to entry for community health centers, getting one of those up and running and I would very much welcome talking with someone on your staff with my staff and myself about how to step-by-step go through that process. We have got 127,000 poor residents in Tarrant County who desperately need that type of facility, so I would——

Secretary LEAVITT. That conversation can take place.

Mr. BURGESS. Thank you.

Secretary LEAVITT. Thank you.

Mr. DEAL. I thank the members who are still here for staying and I thank the Secretary for his patience and for being with us today and we look forward to seeing you in the future and good luck on your job.

Secretary LEAVITT. Thank you.

Mr. DEAL. This hearing is adjourned.

[Whereupon, at 4:33 p.m., the committee was adjourned.]

[The Department of Health and Human Services failed to respond to questions for the record.]

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