THE 2003 BUDGET: A REVIEW OF THE HHS HEALTH CARE PRIORITIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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THE 2003 BUDGET: A REVIEW OF THE HHS HEALTH CARE PRIORITIES

WEDNESDAY, MARCH 13, 2002

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

The subcommittee met, pursuant to notice, at 10:15 a.m., in room 2322, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Upton, Greenwood, Deal, Ganske, Norwood, Wilson, Shadegg, Ehrlich, Pitts, Tauzin (ex officio), Brown, Strickland, Capps, Towns, Pallone, Deutsch, Stupak, Wynn, Green, and Dingell (ex officio).

Staff present: Patrick Morrisey, deputy staff director and counsel; Steve Tilton, health policy coordinator; Eugenia Edwards, legislative clerk; John Ford, minority counsel; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; David Nelson, economist; and Karen Folk, minority counsel.

Mr. BILIRAKIS. I call this hearing to order. I am extremely pleased to welcome the Honorable Tommy Thompson, Secretary of the United States Department of Health and Human Services.

Mr. Secretary, I first would like to wholeheartedly commend you on your leadership throughout the last year, and it has not been easy god knows. You have demonstrated remarkable capacity and ingenuity in the face of unforeseen hardships.

In particular, your leadership has been critical in developing our Nation's capacity to respond to the threat of bioterrorism. The purpose of today's hearing as we all know obviously is to discuss the priorities of the Department as reflected in the administration's fiscal year 2000 budget request.

To facilitate a dialog with the Secretary, which Ranking Member Brown and I are both anxious to do, I hereby request that members—I am going to limit members, with the exception of Mr. Brown and myself, and Mr. Tauzin, the chairman of the full committee, if he chooses to be with us, to 3 minutes.

I would ask all of the members to try to limit their time if they possibly can to even less than that so we can get through this.

Hopefully if we can do that, we might be able to go through a second round with the Secretary. I would ask unanimous consent that statements of all members of the subcommittee that are not here be made a part of the record.

The Department of HHS fiscal year 2003 budget continues our efforts to develop systems and programs to improve the health and

welfare of our country. The HHS request includes $448.8 billion in total outlays, an increase of $29.2 billion, or 6.3 percent over fiscal year 2002 levels.

As we should expect, this budget provides substantial increases for protecting our Nation against bioterrorism. The budget request totals $4.3 billion for this effort. As you know, Mr. Secretary, our committee has taken intense interest in bioterrorism over the years, and we hope to have legislation on this issue to the President very soon.

I look forward to continuing to work with you to ensure that we never have to face the reality of a bioterrorism attack, and I am certain that this is an area where we all agree that prevention is certainly the best policy option.

I would also like to thank you and the President for focusing on improving access to health care and modernizing Medicare. These issues are critical and we must work to reduce the number of uninsured in our country.

The focus in modernizing Medicare to include a comprehensive prescription drug plan is critical. We must act quickly to ensure that our Nation's seniors have access to the best available medical care in the world, and at the same time we must ensure that Medicare will be available to protect the next generation of Medicare beneficiaries.

The budget requests an increase for the Centers for Medicare and Medicaid services, CMS. I have been very pleased with the work that we have completed to improve and streamline the operation of CMS.

I hope that soon we will have a package of regulatory relief legislation from the Senate. It has been over there for quite a while. This is essential legislation that will help you continue to improve CMS' accountability, and responsiveness to beneficiaries and providers.

Mr. Secretary, the members of this committee and I look forward to working closely with you and the President to deliver policies that address these very difficult problems. We must protect our Nation against bioterrorism, help the uninsured, improve our health care system, and modernize Medicare. I now yield to my good friend, Mr. Brown, of Ohio.

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

PREPARED STATEMENT OF HON. MICHAEL BILIRAKIS, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Good morning, I now call this hearing to order. I am extremely pleased to welcome the Honorable Tommy Thompson, Secretary of the U. S. Department of Health and Human Services. Mr. Secretary, I would first like to commend you on your leadership throughout the last year. You have demonstrated remarkable capacity and ingenuity in the face of unforeseen hardships—thank you sir. In particular, your leadership has been critical in developing our Nation's capacity to respond to the threat of Bioterrorism.

The purpose of today's hearing is to discuss the priorities of the Department as reflected in the Administration's FY 2003 budget request. To facilitate a dialogue with the Secretary, which Ranking Member Brown and I are both anxious to do, I hereby request unanimous consent that the opening statement of all Members other than the Chairman and Ranking Member be limited to one minute, with full statements submitted for the record.

The Department of Health and Human Services (HHS) Fiscal Year 2003 budget continues our efforts to develop systems and programs to improve the health and

welfare of our country. The HHS request includes $488.8 billion in total outlays—an increase of $29.2 billion, or 6.3% over fiscal year 2002 levels.

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Mr. Secretary, the members of this Committee and I look forward to working closely with you and the President to deliver policies that address these difficult problems. We must protect our Nation against bioterrorism, help the uninsured, improve our health care system, and modernize Medicare. I now yield to my good friend, Mr. Brown of Ohio.

Mr. BROWN. I would like to thank the chairman, and thank the Secretary for joining us today. I respect your leadership, Secretary Thompson. I wish my message could be more positive this morning, however.

With all due respect, the administration has not given us much to work with. There are a couple of initiatives in the budget that makes sense from a policy perspective, and as the chairman said, the Bioterrorism Preparedness Provisions come to mind.

Then there are a number of initiatives which would make sense if they were not undercut elsewhere in the budget. For example, you rightly invest generously in NIH, which supports research into new medical treatments, but you cut funding for HRQ, which plays a crucial role in communicating that research to the medical community and to the public.

You create a new program called the Healthy Communities Innovative Initiative that targets chronic conditions, like diabetes, and asthma, and obesity. More power to you, but then you starve well respected and successful programs at CDC, and you guessed it, that target chronic conditions like diabetes, and asthma, and obesity. It makes little sense.

The administration puts money in the budget for health insurance tax credits, ostensibly to reduce the number of the uninsured, but then it doesn't propose rate regulation or guaranteed issue, or the other individual insurance market reforms that must be enacted if we want individuals to actually use those credits.

And although we know that 900,000 children will lose health insurance during the 3 year lag in S-CHIP funding, the budget doesn't correct for that. The President reinforces the health care safety net, while simultaneously cutting hole in it.

You increase funding for community health centers and the National Health Service Corps, and I applaud that, but you eliminate

the community access program which helps stretch limited resources to reach as many uninsured individuals as possible.

President Bush cuts funding for public hospitals, and children's hospitals, both of which provide life-saving care to the uninsured. The bottom line, Mr. Secretary, is that it is difficult for me to treat this budget as if it is a legitimate spending blueprint.

It isn't a logical or even viable spending blueprint. It is a political document. This budget pursues two basic goals, both of them political. One, President Bush is going after the entitlements, Mr. Secretary.

He is using this budget to means test Medicare and provide drug coverage outside the Medicare benefits package, knowing full well that Medicare's future depends on its ability to deliver comprehensive health coverage and its availability to all seniors, regardless of income.

They are using this budget to further the goals of your HIFA waivers; that is, you are using waivers, and in this case prescription drug waivers, to transform Medicaid from a Federal entitlement into a State block grant.

The second objective is as insidious as the first. The President stars major health care priorities to make room for more tax cuts. This budget literally ignores millions of retirees who can't afford their prescriptions. It simply ignores them.

This budget ignores tens of millions of Americans who can't afford health insurance. This budget doesn't even maintain existing public health programs like Ryan White at sustainable levels.

The budget doesn't include a dime to compensate for current and projected cuts in Medicare physician payments, even though no one, no one as far as I know, thinks that these cuts are appropriate.

There are no dollars in the budget to repeal the completely arbitrary $1,500 cap on therapy services, and no dollars to restore the cuts in graduate medical education funding, and no dollars to restore the 15 percent cut in home health.

But there is a $590 billion tax cut in the bill aimed, and in the budget, at tax breaks which overwhelmingly go to the most advantaged, and wealthiest of our constituents. This year the President is spending $590 billion on another tax cut after draining much of the surplus last year with a $1.6 trillion tax cut, instead of providing the prescription drug coverage to seniors, and addressing other pressing concerns.

That's what makes this a political document and not a budget. Did the administration think that the implications of the proposal wouldn't register with us, and that by going outside of Medicare to cover a basic health care need that you could weaken support for Medicare down the road.

This budget co-ops the prescription drug issue in an effort to begin unraveling Medicare and Medicaid, two public programs that have done more to promote the well-being of retirees, disabled Americans, and millions of low income children, than any other initiatives in this Nation's history.

And this budget unveils yet another multi-billion dollar tax cut, siphoning off dollars that could be used to provide prescription

drug coverage to seniors. Forgive me, Mr. Secretary, if I don't congratulate you on this budget.

Forgive me if a lot of us on this side of the aisle second-guess every sentence and every number in this budget. This administration has chosen tax cuts for the most affluent, instead of prescription drug coverage for our seniors.

With all due respect to you and the positive contributions that you, Mr. Secretary, personally have made, but once you launch an assault on Medicare and Medicaid, trust and forbearance go out the window.

When it comes to this budget, I only hope that Congress discards this wolf in sheep's clothing, and starts again from scratch. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The chairman of the full committee, Mr. Tauzin, for an opening statement.

Chairman TAUZIN. Thank you, Mr. Chairman. I want to thank you for holding this hearing and we are very fortunate to have a dear friend of this committee, Secretary Tommy Thompson, testify before us today.

And, Mr. Secretary, I want to thank you for appearing again before the subcommittee, and helping us understand this budget today. In the short year that you have been here, we have seen a dramatic shift in both the culture and the responsiveness of the Department of Health and Human Services.

We have seen this administration place health care very high on its agenda, and we have seen a real commitment to addressing the problem of the uninsured and strengthening the Medicare program, all issues that this committee is vitally interested in.

And I want to commend you for your dedication on these issues, and particularly your efforts in the war on terrorism. Your department, and your leadership, I think has demonstrated the will of the American people in combating this threat.

And the skill in which you have engineered the improvements in the departments under your jurisdiction to help America be a little safer is indeed extraordinary, and I want to thank you for that.

Today we are focusing obviously on the 2003 budget proposal, and from all indications it is a good budget. And in case people have not focused on this, this budget increases HHS spending by 6.3 percent.

It builds on the President's commitment to combat terrorism and to strengthen Medicare, and to double low income or to expand rather low income Americans' access to health care, and to double the NIH budget.

The NIH is the premier institute for research in America on health care, and is doing such vital work to find not only the causes, but the cures for so many diseases that ravage our citizens.

You came up here last year to tell us about your plans for streamlining the CMS, and I frankly have to tell you that you have done an excellent job. We are interested in knowing what are the next steps in that process, and what we might do.

When we created our patients first initiative, we learned a great deal, and it was as a result of that initiative and your work that we passed the regulatory relief and contracting bill on the floor with almost a unanimous vote for that effort.

During your testimony today, we are interested in learning what else we might do to lift regulatory burdens on providers and beneficiaries. We think again last year was just a first step, and I hope that you do, too.

We are deeply concerned about your efforts to modify the privacy rule, and obviously research and medical advances in wellness for our citizens depends upon the collection of valuable information.

And we feel that the rules still threaten that effort, and we encourage you to continue your efforts to reform it, so that we protect a patient's privacy, and also facilitate the gathering of vital information, not only personal identifiable information, but information critical to research and development of new products and services.

We have got an ambitious health agenda, Mr. Secretary. We want to finalize the bioterrorism bill, and as you know we are on that conference now. We are going to reauthorize PDUFA as soon as this committee can get to that important issue, and I think that is going to happen within a month.

We are working as you know to modernize Medicare and to reform it, and to produce a prescription drug benefit for the citizens of this country. We are committed to producing that by late May and June of this year on the House floor.

And we want to strengthen the welfare reform laws and enhance our safety net programs, and we invite your help and your counsel as we go forward. I want to mention that only a liberal viewpoint would define this budget as spending money on tax cuts.

The President is not spending money on tax cuts. The Congress voted to cut Americans' taxes, and to reduce the amount of money coming into this government that was building up surpluses.

We are not spending money on tax cuts. That is an extraordinary view that I hear around this capital. We are indeed spending more money, however, on HHS, and under your leadership we expect that money to indeed strengthen our programs and to work with us indeed to finalize our plans to promote a healthy America, and I thank you for that effort, sir, and appreciate you being here.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Chairman Bilirakis, thank you for holding this very important hearing. We are very fortunate to have Secretary Tommy Thompson, a true friend of the Committee, testify before us today.

In just one short year, we have seen a dramatic shift in the culture and responsiveness of the Department of Health and Human Services. We have seen this Administration place health care high on its agenda. We have seen a real commitment to addressing the problem of the uninsured and to strengthening the Medicare Program.

Mr. Secretary, you are to be commended for your dedication to these important issues, as well as your efforts in the war against terrorism. Agencies under HHS jurisdiction had one of the most difficult jobs last fall, yet they handled the bioterrorism crisis with great skill. On behalf of our Committee, let me say that we are grateful for your work.

Today, we are focusing on an issue that is particularly timely. We will be reviewing the Administration's Fiscal Year 2003 Budget Proposal. From all indications, this is a good budget. HHS spending increases by 6.3 percent from 2002. The budget builds upon the President's commitments to combat bioterrorism, to strengthen Medicare, to expand low-income Americans' access to health care services, and to double the NIH budget by next year. As a society, we should be thankful that this

Administration has focused so many resources on these important health care priorities.

Mr. Secretary, last year you came before our Committee to discuss some of your plans to streamline CMS, the Agency formerly known as the Health Care Financing Administration. On this issue, you've also done an excellent job.

In fact, in response to some of your recommendations and information we obtained from a Committee initiative—Patients First—we were able to pass a regulatory relief and contracting bill on the floor with an almost unanimous vote. During your testimony today, we are interested in learning whether you have additional suggestions about how we can further reduce regulatory burdens on providers and beneficiaries. Last year's legislation was only a first step. We welcome your input on how we can go even further.

We are also very interested in learning how you plan to modify the medical privacy rule, a rule that if left intact, will place significant new burdens on medical providers, researchers and patients. Many Members of our Committee and I remain concerned about how the rule defines de-identified data for research purposes. We've heard from the research community that this provision will have a chilling effect on our ability to collect valuable patient information and that bothers me. This rule still needs some significant changes, so I ask you to keep working with us to improve the regulation and strike an appropriate balance between the legitimate privacy interests of patients and our medical system's need to utilize patient information to promote wellness.

There are so many important issues that we want to discuss with you today. As you know, our Committee has a very ambitious health care agenda, ranging from finalizing a bioterrorism bill, to reauthorizing PDUFA, to modernizing Medicare and adding a prescription drug benefit to the Program, to strengthening the welfare reform laws and to enhancing our safety net programs for low-income Americans. We could use your help to move these bills through the legislative process and to get them signed into law this year. The Administration's budget rightfully focuses on all of these issues and, while our positions may differ on some of the details, we know that this Administration is committed to putting patients first and to promoting a healthy America.

Mr. Secretary, as always, we are grateful that you are appearing before our Committee. We look forward to hearing your perspective on the Administration's health care priorities and to working with you to address the important health care issues confronting our country. Thank you.

Mr. BILIRAKIS. Mr. Pallone for an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. BILIRAKIS. All opening statements hereafter are limited to 3 minutes, a succinct 3 minutes I might add.

Mr. PALLONE. Thank you, Mr. Chairman. With all due respect to the chairman of our full committee, who mentioned liberal viewpoints, I don't know whatever you want to tag it, but the reality is that I think that Democrats are concerned about the fact that this budget really doesn't address the concerns of the average American.

I don't know if that is a liberal or a conservative viewpoint, but that is our viewpoint. Mr. Secretary, President Bush's budget in my opinion is proof that health care is not a priority of this administration.

Unfortunately, without dramatic changes made by Congress during the budget and appropriations process, more Americans will be uninsured, seniors will go without a true Medicare prescription drug benefit, and more seniors will lose their doctors due to inadequate Medicare reimbursements from the Federal Government to their doctors.

And during this economic downturn the President's budget is particularly cruel to the uninsured, poor, and disabled, who rely on Medicaid to help with health care costs. The President has proposed a $9 billion cut over a 10 year period in Medicaid payments to public hospitals, and comes at a time when Medicaid rolls are

expected to increase by 3 million people, including 2 million children.

If the administration is successful in making these cuts at a time when more people need Medicaid, we are going to see a dramatic increase in the number of Americans uninsured. And these cuts would not only harm Medicaid recipients, but also aggravate fiscal problems plaguing most States, including my home State of New Jersey.

I am also disappointed that the President rehashed a token prescription drug benefit program that does nothing to help millions of middle income seniors who are not struggling to pay for their prescription drugs.

The President requested $77 billion for prescription drugs for seniors, and an analysis shows that this would only cover about 3 million of the 40 million seniors. This attempt at proposing a low income drug benefit is clearly a political attempt for the President to avoid fulfilling a promise that he made to provide decent health care to seniors.

And I believe that any serious prescription drug plan must include all seniors who are Medicare beneficiaries. Another sham proposal offered on prescription drugs is the prescription drug discount card.

A recent GAO report clearly indicated that savings with this card would be slim to none. The discount cards are a mere gimmick, and again this attempt is a political ploy for the President to back down on seniors' need for a comprehensive prescription drug benefit.

Finally, the President has severely undermined the need to provide health care to the uninsured. His approach at providing inadequate individual tax credits leaves unemployed and uninsured workers with little leverage over insurers who charge premiums between $3,000 to $7,000 a year.

I believe that in order to guarantee the uninsured a package of necessary benefits the government needs to insure more people by expanding the S-CHIP program to parents of eligible children, and allowing people 55 and older to buy into the Medicare program.

Another part of the solution is to expand employer-based health insurance, in which employers would be required or somehow provided an incentive to provide health insurance to their employees in return for government subsidies.

And I don't say this, Mr. Secretary, just to be partisan, or just to be mean, or something of that nature. I really believe that health care is a major crisis that we face right now, and more needs to be done by the administration. Thank you.

Mr. BILIRAKIS. Mr. Upton for an opening statement.

Mr. UPTON. Thank you, Mr. Chairman, and I have a full statement for the record. Mr. Secretary, we welcome your participation here. I want to thank you again for the continued commitment of this administration and you to double the NIH budget, and we continue to be on that track within a 5 year time span.

And it is so important that we find a cure for cancer, cystic fibrosis, and so many different things. I also want to welcome your participation, as I know it is there, and the administration's, as we go through a successful effort to come up with a prescription drug plan that will benefit our seniors.

I know that we are going to spend some time this morning on fixing the physician fee as well. I have heard from so many of my physicians across Southwest Michigan, and I think our State has been impacted by more than $100 million in reductions in payments, and an average of more than $5,000 per physician.

I look forward to working with you and the administration so that we can try to correct this problem. I yield back the balance of my time.

[The prepared statement of Hon. Fred Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, thank you for holding today's hearing on the President's fiscal year 2003 health care budget priorities. Last year, we were at peace and had the luxury of budget surpluses. This year, we are waging a valiant war against terrorism abroad, moving swiftly to securing our homeland against future terrorist attacks, and slowly emerging from a recession. We are going to have to set priorities and make some very difficult choices in this budget cycle, and this hearing will help us focus on these challenges.

I share President Bush's and Secretary Thompson's strong commitment to enhanced funding for biomedical research. That has been one of my top priorities since coming to Congress in 1987, and I am pleased that the President's budget includes the final payment to fulfill the promise to double the NIH budget over five years. Funding biomedical research is one of the best investments of taxpayer dollars that we make. It is an investment that pays enormous dividends in improved health and quality of life for millions of Americans and millions across our world and in health care cost savings over the long term. Today, one in twelve Americans is a senior citizen. In just one generation, one in five Americans will be. So we must invest now in research on Alzheimers, Parkinsons, cancer, and other debilitating diseases.

And demographics dictate that act now to modernize and financially stabilize the Medicare program. When we created the Medicare program in 1965, most seniors' greatest fear was developing cancer or having a heart attack and being financially drained by lengthy or frequent hospitalizations. Prescription drugs played a relatively minor role in treatment. Today, millions of seniors are really struggling with the high cost of the prescription drugs they need. No senior citizen should be forced to forego needed medication, take less than the prescribed dose, or go without other necessities in order to afford life-saving medications. I look forward to working with the President and HHS to develop a bipartisan Medicare prescription drug benefit as part of a Medicare modernization package during this session of Congress.

One area that I believe must be a priority and that is unfortunately not reflected in the President's HHS budget is fixing the Medicare physician fee schedule. Fixing the fee schedule is not just a matter of fairness. Unless we act in a timely and thoughtful way to correct the problems that are resulting in significant and unanticipated cuts in Medicare reimbursement to doctors and other health professionals who are paid under the fee schedule, we are going to put both access to care and quality of care for today's and tomorrow's Medicare beneficiaries at very serious risk. Let me talk about the situation in Michigan as an example. Unless we fix the fee schedule problem, Michigan physicians stand to lose $105 million this year, an average loss of over $5,000 per physician. This could well be enough to push physicians already contemplating retiring or cutting back their practices over the edge. Some 47 percent Michigan's family physicians are 50 years old or older, and according to a national survey, about 80 percent of physicians in this age group are already thinking about leaving or reducing their practices. With 13.2 physicians per thousand Medicare beneficiaries, Michigan is below the national average. So mitigating the cutbacks in 2002 and fixing the fee schedule to produce stable and equitable future updates is particularly crucial to continued access to care and quality of care for Michigan Medicare beneficiaries.

Fixing the fee schedule is also particularly critical to access to care and quality of care in the rural areas of my state and across America. Rural populations have higher concentrations of the elderly, and rural elderly Americans tend to be sicker and less well insured than their urban counterparts. This makes health care providers in rural America particularly dependent upon Medicare payments, and particularly venerable to problems in payment policies that result in payments substantially below their true costs of providing care. And when rural communities cannot

recruit doctors, nurses, and other health care practitioners, hospitals close, and not only Medicare beneficiaries, but entire communities lose access to care.

It is important to note that problems in the physician fee schedule affect many other health care practitioners whose reimbursement rates are pegged to that schedule. In many rural communities, nurse practitioners, nurse midwives, nurse anesthetists, and physician assistants are vital to ensuring access to care and quality of care. If these rural communities cannot attract or retain these able health care providers, everyone suffers.

So, again, it is vitally important that we act in a timely and thoughtful way to ensure that Medicare payment policies are fair and reflect the real cost of providing care.

At the same time that we are giving priority to ensuring that Medicare beneficiaries are protected against high out-of-pocket health care costs and have ready access to physicians' services and the services of other health professionals, we must also focus on extending coverage to the uninsured. I was pleased to see that the budget recognizes the vital role that community health centers play in addressing the health care needs of the uninsured and Medicaid populations in my district and across the country. The increased funding in the budget for this program and for the National Health Service Corps Scholarship and Loan Repayment programs will go a long way to helping increase the number of centers and the number of individuals served.

I look forward to working with my colleagues on the Committee and with you, Secretary Thompson, on these priorities. It will not be easy, but we must meet the challenge of balancing competing priorities in a way that strengthens our nation's health care delivery system and commitment to biomedical research.

Mr. BILIRAKIS. Thank you. Ms. Capps.

Ms. CAPPS. Thank you, Mr. Chairman. I also want to thank Secretary Thompson for coming to discuss the health budget with us. I was impressed with the goals and priorities outlined in the President's budget, and I was pleased about the resources that he has requested for some of the priorities.

The administration's $4.3 billion request to address bioterrorism and threats is a good commitment for the coming year, and the $3.7 billion increase for NIH is the proper completion of the effort to double our Nation's health research budget.

These are resources that will make a real difference in the lives of Americans. So I agree with many of the goals laid out in the budget. For example, the commitment to strengthening Medicare.

But the details of this proposal do not substantially move us toward these goals. The President has stated that a prescription drug benefit for seniors is a priority. Yet the funds requested by the administration for this purpose, and the low income assistance program described here are woefully inadequate to meet the need.

It simply leaves out too many seniors. Even the Speaker of the House has said that $300 billion is necessary. The administration's $190 million proposal is just not enough to provide meaningful help to the seniors.

And the budget does not include any resources to assist the physicians and other health care providers facing significant cuts in their Medicare fees this year. This is such a major hole in the budget that you, yourself, Mr. Chairman, circulated a letter asking the budget committee to rectify this problem.

I was pleased to support this effort in the legislation that you introduced last year. Turning to nurses, I have been pleased that Secretary Thompson has expressed support for efforts to address the nursing shortage, and it was good to see a small increase in Federal resources to that end.

With your support and the support of many of my colleagues up here today, both the House and Senate were able to pass versions

of the Nursery Investment Act. I hope that we will be able to count on your further support to move the bill to final passage and then to fully fund its provisions.

Our health care system desperately needs this help, but I was disappointed that the budget cuts nearly 75 percent of the funding devoted to other health professions. In this era, we should be boosting funding for these programs, and not cutting it.

The terrorist attacks have made it abundantly clear how important prepared medical professionals are for our Nation's security. I hope that we can restore that funding before we regret its loss.

There are several other cuts that seem counterintuitive to me as well. The budget eliminates the Community Access Program, and this program helps communities. The budget also cut $57 million from the CDC's chronic disease programs. This is the time that we should be increasing efforts there. These are some of the examples.

Mr. BILIRAKIS. The Chair apologizes, gentlelady, but your time is up.

Ms. CAPPS. I look forward to hearing the Secretary. Thank you.

Mr. BILIRAKIS. Mr. Greenwood for an opening statement.

Mr. GREENWOOD. Thank you, Mr. Chairman. I will take your admonition to be brief, and Mr. Secretary, I look forward to your testimony.

In a time when revenues are way down from what we had hoped they would be because of the economy, it is really extraordinary that we have been able to have a budget here that in fact increases spending for health care programs by 6 percent.

The real challenge for all of us is to try and find ways to save on one piece of the budget so that we can spend more in other places.

And the one place that I am particularly pleased to see your budget is that it recognizes a need to get savings from the average wholesale price of drugs, and you anticipate that we can save $5 billion plus over the next 5 years, and I look forward to working with you both legislatively, and if necessary, administratively, to get that job done.

It is a real place where we are spending money for, and no good result, and we need to fix that, and I yield back the balance of my time, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman for yielding. Mr. Dingell for an opening statement.

Mr. DINGELL. Mr. Chairman, I thank you, and I commend you for this hearing. Mr. Secretary, welcome to the committee. It is a pleasure to see you here, and I thank you for your kindness to us.

All of us are keenly interested in the budget of your department, and the programs that affect so many of this Nation's citizens. I look forward to hearing from you, Mr. Secretary, about the President's proposals to help seniors with the cost of prescription drugs, and to build critical health care research, and provide uninsured children and parents with health care coverage.

I am pleased to note that the President's fiscal year 2003 budget for HHS includes a significant increase in funding for anti-bioterrorism activities, and that is good. Chairman Tauzin and I, along with our committee members, have collaborated on a bill in a bipartisan fashion, which would authorize new resources for hos-

pitals and other health care providers to prepare for potential bioterrorist attacks.

The President's budget includes support for initiatives like those in our bipartisan bill, which is currently in conference with the Senate.

Unfortunately, Mr. Secretary, the remainder of the budget for HHS does not give me much cause for enthusiasm. Lack of access to reportable prescription drug coverage through Medicare is the most pressing problem that seniors and disabled citizens face today.

The President's budget includes no comprehensive Medicare drug benefit at all. The only proposed benefit is for low income seniors, and in this case the benefit is not even defined.

Moreover, the amount that the President's budget allocates for all Medicare for the next 10 years equals 11 percent of the amount of the Congressional Budget Office estimates that seniors will need to spend on prescription drugs during the same time period.

I doubt if anyone would agree that this amount of funding will provide meaningful benefits to our senior citizens. The President's budget also includes some troubling proposals for the uninsured, and I fear will do more harm than good.

The President's budget would allow States to expand Medicaid and CHIP programs to cover more uninsured people through the Medicaid waiver process. But since these waivers must then be budget neutral, the only way States can expand coverage is by cutting the benefits of people already enrolled in Medicaid and CHIP.

And that is hardly a comforting thought in a time when both providers and beneficiaries of these programs are already significantly short of the level of benefits that they in fact need.

Instead of focusing precious Federal dollars where they are likely to do the most good, most of the new money that the budget allocates for the uninsured would go toward tax credits, a doubtful proposition at best.

The majority of uninsured people are below 200 percent of poverty, but the President's proposed $3,000 health care tax credit per family covers first of all less than half of the average cost of a family insurance policy.

Low income families could spend over 15 percent of their total income just to buy such a policy, and then hundreds of dollars more in deductibles and co-payments just to receive services.

Payments to Medicare physicians decreased this year, Mr. Secretary, as you very well know, by 5.4 percent, and are expected to decrease again in 2003 and 2004 as well. This, and the cuts which are afflicting other parts of the health care industry, offer a real threat, not just to the industry, but very frankly to the patients and the beneficiaries of those programs.

The administration has expressed interest in correcting this shortfall, but the President's budget implies that payments to other providers would be cut in order to address physician fees. Again, robbing Peter to pay Paul.

The only increased payments to Medicare providers are for managed care plans, despite the fact that 86 percent of the seniors are enrolled in fee for service programs, clearly a mis-allocation of resources.

Finally, the public health safety net takes a major hit at a time when the demand for these services is increasing. The bill haphazardly cuts, freezes, or inadequately increases the resources for programs that serve unmet needs.

The Centers for Disease Controls' chronic disease prevention programs are cut, as are rural health services, drug abuse prevention, and children's medical education. The nursing shortage has not disappeared, and yet funds for health programs are slashed by over 70 percent.

The Community Access Program, which provides grants to local groups to coordinate services for the uninsured, is eliminated. Funding levels are frozen for the maternal and child health block grant, and family planning services, Healthy Start, and Ryan White AIDS programs.

Mental health activities are frozen, despite the fact that most people, and more than ever, could benefit from these crucial services given the stresses of 9-11. Mr. Secretary, you have my personal sympathy.

I know that you would have liked to have done, but regrettably you have not been able to do so. But Congress certainly wants to do better, and the people certainly expect that better will be done.

And we know that your responsibilities will be multiplied by the Public Health Service System tests that were imposed last fall. You responded well, but all of us know that more needs to be done.

I hope that we can work together to strengthen our Nation's health care programs in the coming years, but the budget seems to stand in the way. Thank you.

Mr. BILIRAKIS. Mr. Deal for an opening statement.

Mr. DEAL. Thank you, Mr. Chairman. Mr. Secretary, welcome to the committee, and I thank you for coming today, and I at the outset commend you for the efforts that you have made in running your department and removing many of the bureaucratic mazes that have perhaps been the highlight of that agency for far too long.

I think you have made tremendous progress in that regard, and we all look forward to working with you to make the process work better in the future.

You know, a 6.3 percent increase, I think for most of the small businesses and employees in my district, if they knew they were going to get a 6.3 percent next year, and in a time of slower economy, they would be very pleased.

I think the challenge that obviously you face, and this committee, and the Congress itself faces, is allocating our priorities within those budget constraints. Certainly we look forward to working with you as to your priorities, and look forward to your message in that regard today.

Some of us obviously recognize that there are some discrepancies. Upper payment limits, for example, in States like mine, we feel we have not been treated fairly, and some of that is due to legislation of this body, and hopefully we can correct that, and others would be due to administration within your agency.

And we look forward to working with you, because when we talk about public funds and benefits to those that are the Medicaid eli-

gible individuals, it ought to be a fair treatment across the Board, and not based on who has the political clout within the Congress.

And we look forward to working with you to resolve some of those issues. Thank you, Mr. Secretary. I yield back the balance of my time.

Mr. BILIRAKIS. Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman. Welcome, Mr. Secretary. I was going to point out in my opening statement the concerns that I raised last week at the PDUFA hearing, and I understand that a report was submitted to you some time ago, and I understand that we received it this morning.

At last week's hearing, I indicated that I was concerned about enforcement action under PDUFA we are under, and in your testimony urging us to quickly approve PDUFA-3. I was concerned about the post-marketing surveillance of drugs, and the reports that were supposed to be completed.

And we were using the figures last week, and about 90 percent of the post-marketings were not completed, and I was concerned about enforcement action, and what enforcement action the FDA and others have in order to make sure that these studies are done in time.

In looking at page 10 of the report, and again I have not had time to read it as it was clearly just given to us today, it shows that in biologics, approximately 14 percent, 301 commitments have been made, and only 44 post-study reports have been completed, and in total under FDAMA, twenty-four hundred total commitments have been made, but only 882 reports have been completed.

And if my math is correct, that is about 14 percent completion for biologics, and about 36 percent for the other prescription drugs out there. Our concern and the concern of the committee was how do you enforce this.

I mean, if you are in FDAMA-2, and he wants to go to FDAMA-3, and if we are not enforcing FDAMA-2, what changes would there be in FDAMA to make sure that there is—I'm sorry, PDUFA, PDUFA, to make sure that there is enforcement, and that these studies are done in a timely manner so you get the reports you want.

As in Serzone, you have been waiting for 6 years for a report, and Accutane, 15 years for a report. What is your remedy and what is your enforcement? So some of us have thought about subpoena power, and also tying the civil penalties into the sales of these drugs while these studies remain not delivered to the FDA.

We are trying to find a way to expedite the process so the safety and effectiveness of these drugs can be given to the American public. So I will be looking forward to your comments on that.

Also, the imports question. You were here last year, and we had a number of questions, and I believe it was in June on drug imports, and I will have a number of questions along those lines about that situation.

And with that, Mr. Chairman, I know that you want to limit our time, and I just want to give some sense of where I am going with my questioning, and I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Dr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman, and thank you Mr. Secretary. The 6.3 percent increase reflects the additional costs of combating bioterrorism and I am glad that the administration is working on that.

We are also fulfilling our commitment to double NIH funding, and I think that is important, too. Now, Mr. Secretary, my points are these. States like Iowa, my home State, are hurting with Medicare and Medicaid. Big time.

Iowa is fiftieth out of fifty States in Medicare reimbursement. Iowa's rural hospitals in particular are hemorrhaging red ink. Iowa's doctors and other providers are telling us that they can't take any more new Medicare patients.

Our Congressional budget and the administration's, I think, must find some additional funding for Medicare and Medicaid. I don't think we can fix this problem in a budget neutral way. We need additional funding if we are going to maintain services.

So where do we find that money? Well, here are a few ideas. How about moth-balling the space station. That is about $50 to $70 billion. Maybe I will get some more bipartisan support on Tim Roemer's and my amendment on that.

How about howitzering the Crusader? That's billions of dollars. There is an awful lot of pork in the budget and President Bush has talked about this. I think we can find some additional funding.

With that additional funding, we need to increase real hospital DRGs, and we need to fix the wage index, and we need to freeze the physician payment to where it was last year, and then fix the formula for future years.

The votes are there for that, both in the House and in the Senate overwhelmingly. And I would say this. I have not even talked about prescription drug costs. I am pleased that the administration incorporated some of the ideas from H.R. 1387, the Drug Availability and Health Care Access Improvement Act of 2001, which I introduced, along with Representative Wynn.

We have bipartisan support for that from across the ideologic spectrum. But I would say this. What good will it due my senior citizens in rural and small town Iowa if they have a prescription drug benefit if they no longer have a hospital and a doctor to go to in their community?

And that is how important this is in terms of funding, and finding some additional funding. I look forward to working with you, Mr. Secretary, and the aqministration, and I don't mean to say that Congress doesn't have a big say in this.

My colleagues on the other side have complained about the tax cut. Well, in response, I think there is a lot of spending items that are wasteful, and that we could do away with, and divert that funding over into the health care side. And with that, I will yield back, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Wynn for an opening statement.

Mr. WYNN. Thank you, Mr. Chairman. Let me also welcome the Secretary. I am looking forward to his comments. I know that we all are, and so I will be brief. But it seems as though the committee has used these opening statements as an opportunity to add their personal indignations, and so I will probably follow suit.

And only to say that everyone talks about additional spending, whether it is prescription drugs, rural hospitals, increasing access to care for uninsured, and the fact of the matter is that we don't have enough money.

You are to be commended for the 6.3 percent increase that you are advocating, and I don't think it is insignificant, but the needs are far greater, and the fact of the matter is that we have made a big tax cut predicated on a surplus.

When we had the surplus the tax cut made sense. The question now before us is that we are now in a deficit, and we don't have a surplus, and we are facing a deficit, and going into the Social Security Trust Fund, and how can we justify continuing this tax cut, and then sit here and bang on you for more of this, and more of that.

And whether it id diabetes, or obesity, prescription drugs, or whatever, these are good issues, and we ought to fund them, and I think we ought to really take a serious look at whether or not we can afford a tax cut at a time or at a level of reduction.

With that, I will conclude my comments, and again, I look forward to your statements.

Mr. BILIRAKIS. Dr. Norwood for an opening statement.

Mr. NORWOOD. Thank you very much, Mr. Chairman, and thank you for the hearing, and, Mr. Secretary, thank you for joining us today. I want to tell you that I think you have one of the most difficult jobs in Washington, DC.

Mr. THOMPSON. I agree with you, more so now than ever.

Mr. NORWOOD. I also think you are doing a wonderful job, and I want to send my compliments to Dr. Crawford, who testified before us last week. He has done a great job, and I thank him personally for producing the agreement for the reauthorization of PDUFA in such lightening speed time.

That to me is a fairly good indication of how well your agency is actually functioning. I know that we all who are sitting here are saying we want more and more money for health care.

And I think the only reason we are doing that is that the American people are saying that to us, and the American people have made it fairly clear that when they get to be 65 that they want free health care, and I don't think anybody on this full committee is ready to vote to abolish Medicare, and Medicaid for that matter.

So that is really sort of where we are coming from, but you have a limited budget in which you must work. But I think that many of us are saying that if we are going to furnish health care, it needs to be decent health care.

It needs to be where a patient actually does have access to a doctor. It needs to be a program where physicians in the country are not trying to get out of as far as they can, because the sooner they get out, the longer it will take them to go bankrupt.

In this program, they can get there pretty fast if they just take on more Medicare patients. I know that your job is to tell us that we have to be budget neutral, and you know what? I agree with that.

I just don't think we have to confine that just to your budget. We all look at the budget of the United States and be budget neutral

in that. There is a great deal of waste in the Federal Government, and not one member here doesn't know that's true.

We need to divert funds from wasteful programs and efficient programs, and put it in health care so we can have a good program. Now, I have not seen a Presidential budget yet that I didn't have concerns about, and this one is the same.

I am concerned that the budget does not do enough to ensure that providers are going to continue to serve Medicare patients, and it is a fact that they are not. It is going to stop. Simply put, asking us to be budget neutral is just not possible to do if we are going to continue with Medicare.

But again we can be budget neutral in your part of the budget, but we also can be budget neutral in the whole budget of the United States, and get some money into these programs.

I am concerned that the budget request on Medicaid, AWP, is going to have a very harmful effect on drug research.

I am concerned about the reductions in health resource services administration, and health care research and quality budget, that particularly impact on health care professionals. We have got to solve this problem, and you have a hard job.

Mr. BILIRAKIS. The Chair thanks the good doctor. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I would like to thank the Secretary for being here again. I don't know about our personal indignation at the budget, but obviously in a process like we have and you had when you were Governor, we all have differences of opinion.

But just like I don't think we ought to mothball the space program. I would hope that we would get some more money out of ethanol, but be that as it may, one man's pork is another person's important project.

And, Mr. Chairman, I would like to thank you for this oversight hearing on the budget, and I am again grateful for our Secretary being here. From the lifesaving research that is done by the NIH, to the Medicare and Medicaid programs, the HHS provides such critical services for every American.

And it is imperative that you receive the resources that you need to continue to improve the health care of all of Americans. This past year, we realized how important our public health system is, and we learned that our system is in dire need of repair.

I am grateful that the President increased his funding for the CDC and other programs through public health so that it is better able to combat bioterrorism. But it seems that we have increased bioterrorism at the expense of other worthwhile programs.

Health care problems facing our country can't be solved by one agency or one division. We need to ensure that all agencies, and not just NIH and bioterrorism, receive adequate funding.

Unfortunately, the President's budget contains significant cuts in programs that combat chronic disease, help the uninsured, and train a new generation of health care providers. I am particularly concerned because the administration's decision now for the second year in a row is to zero the community access program, the CAP program.

CAP enables communities to coordinate and integrate health care for our Nation's 40 million uninsured by improving the infra-

structure and communication among current agencies that we have, both on the local level and on the Federal level.

With the decline in the economy and the subsequent rise in unemployment, more and more Americans are losing their health insurance, and now should not be the time to cut programs that the uninsured need to help get through the system.

I am also concerned that the CDC's chronic disease budget has once again been cut. These programs fund breast and cervical cancer screening, cancer registries, diabetes prevention, heart disease, stroke prevention, arthritis programs, tobacco prevention and cessation, and also obesity prevention.

These diseases account for 70 percent of all of the deaths in our country, and more importantly, they are almost all entirely preventable, and that is what is frustrating.

An ounce of prevention is worth a pound of cure, and I would like to also point out the shortcoming that has been point out before, but on the prescription drug benefit for seniors, and $190 billion creates such a small program for seniors, and most estimates estimate that we need $450 to $750 billion over 10 years.

And it seems like the administration's proposal would only buy seniors one pill, and that is the frustrating part. Mr. Chairman, again, I thank you for the hearing, and I will put my full statement in the record.

Mr. BILIRAKIS. I appreciate that. Mr. Shadegg for an opening statement.

Mr. SHADEGG. Thank you, Mr. Chairman, for holding this important and timely hearing, and thank you, Mr. Secretary, and welcome here. We appreciate you coming to testify before us.

Now, I want to echo the remarks of my colleague, Mr. Norwood, with regard to the difficulty of your job, and with several of the comments by my colleagues on the progress that has been made.

I think that extraordinary strides have been made in the last year and I want to thank you for that. I particularly want to thank you for your advisory committee on regulatory reform.

That committee will be in my hometown of Phoenix as you know next week, and it is expected to announce its initial recommendations on EMTALA. EMTALA, while clearly well-intended, is a law that is not working. It is failing.

And I have worked long hours with the Arizona medical community on trying to improve that law, and in that effort, I was successful in persuading your CMS director, Tom Scully, to come to Arizona in January and spend a day hearing about a variety of issues.

But particularly about EMTALA and the problems that it is causing in Arizona, and in Arizona's hospitals, and particularly in our inner-city hospitals. So I look forward to working with you on that, and I commend you for that effort, as well as many others.

I also want to address the issue of the uninsured. I think that is an issue which our country absolutely must confront. The chairman held an important hearing on that issue just a few weeks ago, and one of the witnesses correctly noted that we are quickly facing a point where our Nation's uninsured may soon jeopardize the care for millions of other Americans who are fortunate to have health care.

We simply must face up to the problem of our uninsured, which is why I am extremely pleased that the President's budget has put forth a reasonable approach to solving that problem through refundable health care tax credits.

I think this is a vehicle that is widely misunderstood in the country, but would give people the ability to choose the health care they need, and would deal with the funding of health care for the uninsured, which simply is being ignored right now.

The reality is for my colleagues who don't believe we can afford to provide refundable health care tax credits for the uninsured, they simply don't know that we are already bearing that cost, and it is being cost-shifted on to those with insurance and cost-shifted on to Medicare and many other programs.

So I commend you for that effort, and I look forward to working with you.

Mr. BILIRAKIS. Mr. Strickland for an opening statement.

Mr. STRICKLAND. Thank you, Mr. Chairman, and thank you, Mr. Secretary. As I reviewed the Department of Health and Human Services fiscal year 2003 budget, I was pleased to see funding increases for bioterrorism preparedness, drug treatment programs at SAMHSA, National Institutes of Health, community health centers, and the National Health Services Corps.

These are important programs that do much to protect and promote the health and safety of all of all Americans. However, I was dismayed to find that the budget lacks in areas that seek to ensure that undeserved communities have access to health care resources.

There are cuts in funding for the Children's Hospital GME program, substance abuse prevention grants, and health professions programs through the Health Resources and Services Administration.

The budget slashes funding for rural health by proposing a 50 percent cut in funding for the State Offices of Rural Health, the agency that assists States in the recruiting and training of health care professionals that serve medically undeserved rural communities, and administers the Medicare Rural Hospital Flexibility Program.

The budget fails to provide for the elimination of the now and necessary, but automatic, 15 percent cut in Medicare rural home health payments, and it fails to eliminate the caps on Medicare disproportionate share hospital payments for small and rural hospitals.

The administration's Medicare budget is grossly inadequate in my judgment, including just $190 billion over 10 years for all aspects of Medicare reform, and just $77 billion is specifically allocated to allow States to provide drug coverage for low income seniors.

In additional to shifting the responsibility for a prescription drug benefit under Medicare from the Federal Government to the States, I find the prescription drug proposal laid out in this budget to be a fraudulent attempt in my judgment on the part of this administration to simply placate seniors who tell me they need a comprehensive benefit plan.

Under the President's plan, there is no guarantee that even those seniors who are under 150 percent of poverty, and are eligible for

the benefits described in the budget, would receive assistance because in this proposal there is no guarantee that the States will act.

It is shameful that this type of proposal has been put forth as real help for seniors. These budget shortfalls should not be tolerated. Instead, we must pass a budget that more closely meets the obligation of the needs and priorities of working and retired Americans.

And, Mr. Secretary, let me say that nothing that I said today reflects on you personally. I am a big cheerleader of Secretary Thompson.

I agree with those who say that you are performing a difficult job admirably, but I felt that I should express these opinions, because I do think that they have merit. And I thank you for what you do, and I yield back the balance of my time.

[The prepared statement of Hon. Ted Strickland follows:]

PREPARED STATEMENT OF HON. TED STRICKLAND, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you, Mr. Chairman, for convening today's hearing.

As I reviewed the Department of Health and Human Services fiscal year 2003 budget, I was pleased to see funding increases for bioterrorism preparedness, drug treatment programs at SAMHSA, the National Institutes of Health (NIH), Community Health Centers, and the National Health Service Corps. These are important programs that do much to protect and promote the health and safety of all Americans.

However, I was dismayed to find the budget lacking in many areas that seek to ensure underserved communities have access to health care resources. There are cuts in funding for the Children's hospitals GME program, substance abuse prevention grants, and health professions programs through the Health Resources and Services Administration (HRSA). The budget slashes funding for rural health by proposing a 50 percent cut in funding for the State Offices of Rural Health, the agency that assists states in the recruiting and training of health care professionals that serve medically underserved rural communities and administers the Medicare Rural Hospital Flexibility Program. The budget fails to provide for the elimination of the now unnecessary but automatic 15 percent cut in Medicare rural home health payments and it fails to eliminate the caps on Medicare disproportionate share hospital (DSH) payments for small and rural hospitals.

The Administration's Medicare budget is grossly inadequate, including just $190 billion over ten years for all aspects of Medicare reform—and just $77 billion is specifically allocated to allow states to provide drug coverage for low income seniors. In addition to shifting the responsibility for a prescription drug benefit under Medicare from the federal government to the states, I find the prescription drug proposal laid out in this budget to be a fraudulent attempt on the part of the Administration to placate seniors who tell me they need a comprehensive benefit. Under the President's plan, there is no guarantee that even those seniors who are under 150 % of poverty ($12,885 for an individual and $17,415 for a couple) and are eligible for the benefit described in the budget would receive assistance because under this proposal there is no guarantee the states will act. It is shameful that this type of proposal has been put forth as real help for seniors.

These budget shortfalls cannot be tolerated. Instead, we must pass a budget that more closely meets our obligation to the needs and priorities of working and retired Americans. Thank you, Mr. Chairman, and I yield back the remainder of my time.

Mr. BILIRAKIS. I thank the gentleman. Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman, in keeping with your wishes, I will be brief. Thank you, Mr. Secretary, for joining the committee today. I have always found your office, and your staff very responsive when we sought to meet with them or ask questions, and we thank you for that.

And we appreciate your efforts to bring efficiency to your department, and the restructuring of the bureaucracy there. We look for-

ward to working with you on a number of issues. Your plate is obviously very, very full, and you have a difficult task.

But we thank you for your track record, and look forward to working with you, especially on welfare reform, in some of the issues that we face. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Ehrlich.

Mr. EHRLICH. I will have mercy, too, Mr. Chairman. I have a statement that I will submit. Just one quick observation, Mr. Secretary. I was looking at your charter and thinking about your charter, and we all have our hot buttons, and you have heard many of these hot buttons today, of course.

And in just looking through the outline that our committee prepares with regard to your testimony, a lot of these issues have been addressed, from low income drug benefits, and all the reimbursement issues, of course, and Medicaid.

AWP has been mentioned, and the discount card and how best to get to the prescription drug benefit, and Medicare solvency, regulatory relief, NIH, work force shortages, the nursing shortage, which is a hot issue with many of us, and particularly myself, as it is with Ms. Capps and the chairman of the Health Subcommittee.

Bioterrorism, genetic non-discrimination, CDC, the uninsured, FDA, community health centers, National Health Corps. Are you sure you still want this job?

We appreciate your thoughtful approach to these issues. This is a very difficult job, and I personally appreciate the attention my office has received, and I look forward to your testimony, and I yield back.

[The prepared statement of Hon. Robert L. Ehrlich, Jr. follows:]

PREPARED STATEMENT OF HON. ROBERT L. EHRLICH, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Chairman, thank you for holding this important hearing on funding priorities for the Department of Health and Human Services for Fiscal Year 2003.

It is our privilege today to have The Honorable Tommy Thompson, Secretary of Health and Human Services, with us today as our sole witness. Mr. Secretary, I wish to add to my colleagues' thanks to you for spending this morning with the members of our Health Subcommittee to discuss your upcoming budget and matters of concern to us.

Mr. Secretary, I would also like to thank you for your service to our country. I view HHS as serving a crucial role in our federal government. Before September 11th, your job was to advance the health of all Americans, increase access to affordable, quality health care, and ensure that proper measures and needed research in all health fields continued. This is a crucial function in our society.

After September 11th, your job is all that and much more. HHS is at the forefront of the War on Terrorism. You are responsible for a $489 billion organization whose mission it is to protect the health and safety of all Americans. The newest component of your mission, Bioterrorism Protection, totaling $4.3 billion in this budget, is crucial to our national security. I look forward to discussing this component with you and how it will work with state and local communities to benefit our safety.

There is one other subject area I look forwarding to hearing you discuss. I know you have been active in providing additional resources to address our nation's nursing shortage, and I appreciate your efforts. As you may be aware, the House passed H.R. 3487, the Nurse Reinvestment Act, which Chairman Bilirakis, Mr. Brown, Mrs. Capps, Mr. Whitfield, and I worked together on last year. This legislation will allow you to provide educational scholarships to nurses who agree to work in medically-underserved areas.

Mr. Secretary, this legislation is needed to address the nursing shortage nationally. One of my concerns is that while this legislation grants you the authority to pursue this program, it may not provide you sufficient resources to provide scholar-

ships for this purpose. I will be eager to hear your view on this important issue and what you think you need in terms of resources to ease the nursing shortage and attract more bedside nurses to the profession.

Mr. Secretary, once again, thank you for your attendance here today. I look forward to your testimony and our dialogue.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman. Mr. Deutsch for an opening statement.

Mr. DEUTSCH. Thank you, Mr. Chairman, and again I join in really direct praise of your work, and your Department's work, in some very specific areas. I think your response in post-911 events has really been excellent, and thoughtful, creative, and really government efficiency at its best, and management at its best, and creative leadership at its best.

I really compliment you and I look forward to working with you in the continuation of that area. I also think that praise in terms of research funding at NIH is a legacy that you can be proud of, and I think we on this committee and subcommittee can really be proud of as well.

I want to know though, and again I know that it is not directly through your efforts, but it is through your department's efforts, and it is really the opportunity that we have to really work with you in terms of the budget as a committee of jurisdiction.

I join with our ranking Democrat on the subcommittee, and the ranking Democrat on the full committee, Mr. Brown and Mr. Dingell, in their very, very specific, and very strong concerns regarding the Medicare prescription drug benefit issue.

I think it is an area where the administration's attempts and budget attempts are really almost effectively zero. Out there in the real world, they really are effectively zero.

And I think that each of us interact with constituents, but this is not a theoretical issue. This is a very real issue, and for literally millions, and tens of millions of Americans, this is a very, very real issue.

It is the difference between lifestyle choices, and in most cases it is not the difference between eating and not eating, but it is clearly the difference between going out, visiting grandchildren, traveling, having electricity or heat at 72 versus 52, and issues like that.

And I think that for us in this budgeting that we are doing, not to address it when we still have the opportunity to address it, is a mistake of tragic proportions. And I think that our job hopefully will be able to give you the opportunity to push dramatically further than what the administration has offered on the table, which I think is a non-starter, and effectively close to a zero for the people who really do need the help.

And with that, I would yield back the balance of my time. Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman, and I think that completes our opening statements. Secretary Thompson, first, I too, want to thank you for the timely furnishing to the committee of the PDUFA performance goals and closure, which we have not had a chance to review, but I imagine that there will be a few questions going forward on that.

Let me ask you, sir, the administration has requested that we find offsets—are you going to make an opening statement, Mr. Secretary?

Secretary THOMPSON. I serve at your pleasure, sir.

Mr. BILIRAKIS. If you want me to go right to questions, I will. It is up to you, sir.

Mr. BROWN. Mr. Chairman, we can make an opening statement for him.

Mr. BILIRAKIS. Feel free to make an opening statement. I will set the clock at 10 minutes. I think this is just not my idea.

Mr. BROWN. Mr. Chairman, for one moment, can I have unanimous consent to enter into the record Ms. Capps' article that she wrote in The Hill and any other extraneous materials other members have?

Mr. BILIRAKIS. Without objection.

Mr. BROWN. Thank you.

Mr. BILIRAKIS. Is that okay with Ms. Capps?

Mr. BROWN. She asked for that.

[The article and additional statements submitted for the record follow:

BUSH HEALTH BUDGET DOESN'T LIVE UP TO PROMISES

By Lois Capps

The President has come forward with a budget proposal highlighting some of the important health care challenges facing our country. I agree with many of his priorities, but am doubtful that the details of his proposals will accomplish these goals.

There are many pieces of this budget that are strong and should be embraced by the Congress. For example, I applaud the Administration's $4.3 billion request to address bioterrorism threats. Many of the priorities raised in bills produced by the Homeland Security Task Force last year are being pursued here.

I am also very pleased the Administration is embracing Congress' long standing commitment to doubling the NIH budget. This funding supports important research that benefits all Americans—from finding cures for Parkinson's and Alzheimer's to determining the most effective medical practices.

But this budget, while setting impressive goals and increasing a few valuable programs, falls woefully short in addressing many other critical health care priorities.

The Medicare prescription drug proposal is one such example. The Administration has declared that adding a drug benefit for seniors is a major priority. But the $190 billion allocated in the budget provides barely half of what Speaker Hastert has claimed is necessary. And the proposal itself—basically offering coverage to only low income seniors—would leave millions of seniors without coverage and still facing enormous drug bills.

In addition, the Administration provides no help to doctors whose Medicare payments were cut by 5.4% this year and will likely see a sizeable cut next year. Just two weeks ago the Energy and Commerce Subcommittee on Health heard testimony on how these cuts will devastate doctors' ability to provide quality care to our seniors. A bipartisan group, led by Chairman Bilirakis, Ranking Member Sherrod Brown and myself, are committed to fixing this problem, but the Administration's budget leaves no room for any solution.

I join the President in trying to ensure we have enough doctors, nurses and other health professionals to bring our public health system up to today's challenges. The terrorist attacks have made abundantly clear how important prepared medical professionals are for our national security. Hospitals cite staffing shortages as a major obstacle to their ability to continue providing quality care. And in my district and across the country, the crisis in long term health care is aggravated by a growing shortage of nurses and nurse assistants.

To address this need, the Administration has correctly proposed increasing the National Health Service Corps and Nurse Education scholarship and loan programs by about $50 million. But at the same time, it has proposed to cut nearly $300 million from the programs that actually train the doctors, physician assistants, pharmacists and lab technicians we need. With the shortages in these critical areas,

these cuts will devastate our public health system. In the interest of national security and public health, we should be boosting funding for training, not cutting it.

We must also improve access to care for the uninsured. The Administration has proposed funding increases for Community Health Centers by $114 million. But it has called for eliminating the Community Access Program (CAP). This $105 million program helps communities coordinate public and private efforts to provide medical care to the underinsured and uninsured. CAP limits redundancy in federal expenditures and leverages private money to provide health care, ensuring the federal government gets more bang for its buck. Killing this program would seriously hurt our ability to wisely use federal dollars to help the uninsured.

The Administration has also appropriately highlighted disease prevention and allocated $20 million in new money for the Healthy Communities Initiative. But it has cut $57 million from the CDC's chronic disease programs, which address illnesses like cancer, cardiovascular disease, and, diabetes. Chronic diseases account for 60% of our nation's health care costs. If we want to prevent disease and its costs, cutting CDC's efforts in this area is a bad idea.

The details of this health care budget often reflect a plan that takes one step forward and two steps back. In many cases I agree with the Administration's stated goals, but this budget would not help us achieve them or improve health care for all Americans. Congress must improve this proposal.

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

In the interest of time, Mr. Chairman, I will get right to the point of my statement.

My primary concern in any budget is its overall effect on rural states. To say that my home state of Wyoming is rural is an over simplification because what we are in fact is "frontier."

According to the Webster's dictionary, "frontier" is defined as a region that forms the margin of settled or developed territory; a new field for developmental activity.

As a region with roughly 100,000 square miles, and 480,000 people, with rugged mountainous terrain, and an unforgiving climate, Wyoming is perhaps this country's last frontier.

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

That is not an exaggeration.

While I am very pleased with the President's budget increases for the National Health Service Corps and Community Health Centers, I am concerned about the cuts to a variety of other rural health programs that directly benefit my state.

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

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

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

PREPARED STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Secretary Thompson, it is a pleasure to have you with us today.

I know from your testimony and the Administration's budget documents that you are here to paint a rosy picture of the Administration budget for HHS. Indeed there are some aspects that are very positive—increases for the national health service corps, increases for the important work of NIH, increases for the support of the Office for Generic Drug review in the FDA, to name a few.

But unfortunately, as I look at this budget, I find the picture is much more one of disappointment than progress.

First and foremost, it clearly does not provide sufficient support for an adequate and comprehensive prescription drug benefit under Medicare. The dollars allocated in this budget fall far short of what is needed—in fact, I would argue four times as much is needed as the amount you have allocated—and certainly will not allow us to construct a decent program that will meet the needs of our senior citizens.

Second, despite the rhetoric about providing coverage for the uninsured, I see a budget that proposes a system of individual tax credits that would undermine the

current employer based system of coverage and rely on an individual insurance market that does not provide affordable coverage for people who are sick or have chronic health conditions—in other words, the very people who need it. And I see a budget that does not make use of the strengths and successes we have had in our public programs of Medicaid and SCHIP. We know those programs work; we know extending coverage effectively reduces the number of uninsured.

Further, this budget fails to provide assistance to the States to maintain and expand their Medicaid programs through endorsement of a higher Federal matching rate or through correction of declining support for disproportionate share institutions, and indeed cuts back on necessary support through arbitrary changes in the upper payment limit programs.

Nothing in the budget takes us forward through expanding coverage for the severely disabled, through removing senseless restrictions that keep States from extending coverage to legal immigrant children, through expanded coverage for severely disabled children and their families, through better dental services, to name just a few.

Instead we see proposals that undermine the protections of the current program through waiver programs that take away from the poorest beneficiaries to support limited expansion to others.

I'm disappointed that in place after place in the budget, you've given with one hand but taken back with another, whether it is the reductions in manpower programs, the elimination of the CAP program, the effective cut in the prevention block grant, the flat funding of the Ryan White AIDS program, family planning, and many traditional public health programs that we know work.

I look forward to hearing from you today, to improving this budget, and to working to expand and strengthen our programs to protect and improve the health of the American people. Thank you.

Mr. BILIRAKIS. Please proceed, Mr. Secretary. I apologize.

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

Mr. THOMPSON. Chairman Bilirakis and Congressman Brown, and members of the committee, I thank you so very much for your hospitality and your willingness to work with me. I appreciate it very much.

I would like to point out that we want to be very responsive to all members of this committee, and to Congress. We are very happy to report that we have been able to reduce the response time from CDC and CMS from 70 days when I first came in here as Secretary, and now down to 20 days, and we are working toward our goal of 15 days.

And if you do not receive a response, and you feel that it is not timely, please call me personally, and I will take care of it.

This budget, Mr. Chairman and members, was sent down with three priorities.

The first one was of course the war that has taken place, the second one was homeland security, and the third one is taking care of the needs of the American public.

So it is an honor to come before you today to discuss the President's fiscal year 2003 budget for the Department of Health and Human Services. Mr. Chairman, it is always good to see you, and thank you for your tremendous leadership in advancing a sound health care agenda for our country.

Congressman Brown, thank you for your deep concern with many of the issues that are facing us today. And to all of you, thank you so very much for your bipartisan support. During the past 13 months we have witnessed some significant achievements in the Department of Health and Human Services.

I will detail some of them in the course of my testimony. The total HHS request for fiscal year 2003 is $489 billion. The discretionary component totals $64 billion, and budget authority, an increase of 3.9 percent over the fiscal year 2002 budget.

Let me begin by discussing our efforts on bioterrorism. After September 11th, I appointed Dr. D.A. Henderson, the physician who spearheaded the successful drive to eradicate small pox worldwide, to head a newly created Office of Public Preparedness.

And about 20 feet away from my office, we have set up a 24 hour a day, 7 days a week, command center, where we receive information from all over the world about possible bioterrorist attacks.

And we have been very aggressive and prudent in our work to prepare for any biological or chemical threat our enemies could use against us. To prepare further, President Bush and I requested an additional $4.3 billion, an increase of 45 percent over the current fiscal year, to support a variety of critical activities to prevent, identify, and respond to incidents of bioterrorism.

We are also requesting more than half-a-billion dollars for our hospital preparedness program, which will strengthen local hospital preparation for biological and chemical attacks, and expand the surge capacity.

We are currently providing the $1.1 billion that Congress on a bipartisan basis appropriated for State governments to strengthen their capacity to respond to bioterrorism and other public health emergencies.

We are also developing a system to connect every major county and metropolitan region with the Health Alert Network. We have the best opportunity, ladies and gentlemen, to develop a public health system that all of us can be very proud of.

The Congress on a bipartisan basis appropriated supplemental money to address immediate public health needs related to bioterrorism preparedness. We have responded by making 20 percent of the total funds immediately available to the States, and the remaining 80 percent will also be distributed expeditiously.

The NIH is researching better anthrax, plague, hemorrhagic fever vaccines. We are purchasing an additional 154 million doses of smallpox vaccine. The result will be that by the end of this year every man, woman, and child, in America will have the vaccine he or she needs.

When it comes to bioterrorism, we are growing stronger in our preparedness each and every day. We are also advancing important biomedical research, and the budget provides $5.5 billion for research of cancer throughout NIH, and a total of $3.7 billion for HIV AIDS related research.

We are also requesting $20 million for a Healthy Communities Initiative. This is a new effort, ladies and gentlemen, that is going to concentrate department-wide expertise on the prevention of diabetes, asthma, obesity, and health disparities in minority communities.

I am deeply concerned, as all of you are, about how obesity is affecting our health as a people. Roughly 3 out of every 5 adults are overweight, and approximately 300,000 U.S. deaths a year currently are associated with obesity and simply weighing too much.

The total direct and indirect costs attributed to being overweight and to obesity amounted to $117 billion in the year 2000. We also have a serious problem with diabetes. Nearly 16 million Americans have diabetes, and 800,000 more fall victims to the disease annually.

This epidemic is witnessing a terrible increase, tripling within the last three decades. Yet, we have got solid research showing that if you exercise just 30 minutes a day, and walking is a perfectly suitable form of exercise, and lose 10 to 15 pounds, your risk of getting diabetes falls by nearly 60 percent.

When you extrapolate that, we spend $100 billion a year on diabetes, and if we were able to reduce the instance of diabetes by 60 percent, that is a savings of $60 billion.

The President and I, and I know you are as well, are absolutely passionately committed to our across the board prevention initiative. Preventive health care saves huge amounts of money, but more importantly can save untold thousands of lives.

We are also helping to prepare low income Americans for their future, and that is why welfare reform remains so important. The good news is that sine 1996, nearly 7 million fewer people are on welfare today than in 1996, and 2.8 million fewer children are in poverty, in large part because welfare has been transformed, and is transforming.

We are calling for a continued commitment to child care, including $2.7 billion for entitlement child care funding, and $2.1 billion for discretionary funding. We are giving the States the flexibility they need to make effective education and job training programs with work, as well as money to strengthen families and reduce illegitimacy.

Strengthening Medicare is another key component of our across the board effort to broaden and strengthen our country's health care system. The 2003 budget dedicates $190 billion over 10 years for immediate targeted improvements, and comprehensive Medicare modernization, including the subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries.

I know that this committee and other members do not believe that is enough, but I think we should work together to find the right amount. The administration recognizes the need to act now to help seniors obtain prescription drug coverage.

Our budget provides $77 billion and $8 billion through the year 2006 for States to expand drug only coverage to low income Medicare recipients whose income is $150 percent of the Federal poverty rate.

And also the Federal Government will pay 90 percent of the costs for drugs for individuals from 100 percent of poverty to 150 percent of poverty. Also this year, HHS will continue to work to implement the President's proposed Medicare endorsed prescription drug card.

The card will give beneficiaries immediate access to manufacturer discounts on their medicines and other valuable pharmaceutical purchases. At the same time, and as was mentioned several times, we cannot ignore the roughly 40 million Americans who lack health insurance.

Since January 2001, we have approved State plan amendments in Medicaid and S-CHIP waivers that have expanded the opportunity for health coverage to 1.8 million Americans, and improved existing benefits to 4.5 million individuals.

I want to point out that we have handed out 1,500 waivers and modifications of State plans, and we are no longer behind. When I came in there were some waivers going back to 1986, and right now we are current, and we get waivers out within 90 days.

The 2003 budget also seeks $1.5 billion to support the President's plan to impact 1,200 communities with new or expanded health centers by 2006. This is a $114 million increase over fiscal year 2002, and would support 170 new and expanded health centers, and provide services to 1 million additional patients.

And last week, we issued 27 grants totaling $12 million under President Bush's Health Centers Initiative to help more Americans gain access to quality health care. In addition, the President's budget includes $89 billion in new health credits to help American families buy health insurance, which will provide health coverage for many low income families.

And I know, Mr. Chairman, and members of this committee, that we have taken some of the suggestions of this committee last year and put it into the new plan. So that an individual can apply and get a number from a regional IRS office, and immediately take that number to an insurance agency, and apply for it.

It also gives States the opportunity to pool the uninsured, which will lower their costs. Mr. Chairman, I know that many members of this committee are concerned about PDUFA reauthorization. FDA and the industry have been negotiating in good faith for many months. We spent last weekend tying up the ends, and today we will have completed our deal.

We have developed a sound plan. The agreement reached several weeks ago calls for increased resources for FDA, including more funding for drug safety after drug approval, a concern that some of you have mentioned already.

The agreement also urges earlier communications between drug and biologic innovators, and the FDA during the approval and review process. Working together with you, and with Chairman Tauzin, and with the other members of this committee, we can reach an accord on PDUFA that will serve our Nation well.

Mr. Chairman, this comprehensive aggressive budget addresses the most pressing public health challenges facing our Nation, from bioterrorism preparedness to coverage for the uninsured in order to ensure a safe and healthy America.

I am confident that working together, we can finish to improve the health and well-being of our fellow citizens. I did a 20 minute speech in less than 10 minutes, and I want to thank you, Mr. Chairman, for letting me come before you today. I look forward now to answering your questions.

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

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

Good Morning Mr. Chairman and members of the Sub-Committee. I am honored to appear before you today to discuss the President's FY 2003 budget for the Department of Health and Human Services. I am confident that a review of the full details

of our budget will demonstrate that we are proposing a balanced and responsible approach to ensuring a safe and healthy America.

The budget I present to you today fulfills the promises the President has made and proposes creative and innovative solutions for meeting the challenges that now face our nation. Since the September 11th attacks we have dedicated much of our efforts to ensuring that the nation is safe. HHS was one of the first agencies to respond to the September 11th attacks on New York City, and began deploying medical assistance and support within hours of the attacks. Our swift response and the overwhelming task of providing needed health related assistance made us even more aware that there is always room for improvement. The FY 2003 budget for the Department of Health and Human Services builds on President Bush's commitment to ensure the health and safety of our nation.

The FY 2003 budget places increased emphasis on protecting our nation's citizens and ensuring safe, reliable health care for all Americans. The HHS budget also promotes scientific research, builds on our success in welfare reform, and provides support for childhood development while delivering a responsible approach for managing HHS resources. Our budget plan confronts both the challenges of today and tomorrow while protecting and supporting the well being of all Americans.

Mr. Chairman, the HHS budget request for FY 2003 totals $488.8 billion in outlays, an increase of $29.2 billion or +6.3 percent over the comparable FY 2002 budget. The discretionary component totals $64.0 billion in budget authority, an increase of $2.4 billion , or +3.9 percent over FY 2002. Let me now discuss some of the highlights of the HHS budget and how we hope to achieve our goals.

PROTECTING THE NATION AGAINST BIOTERRORISM

Mr. Chairman, as you know, the Department of Health and Human Services is the lead federal agency in countering bioterrorism. In cooperation with the States, we are responsible for preparing for, and responding to, the medical and public health needs of this nation. The FY 2003 budget for HHS bioterrorism efforts is $4.3 billion, an increase of $1.3 billion, or 45 percent, above FY 2002. This budget supports a variety of activities to prevent, identify, and respond to incidents of bioterrorism. These activities are administered through the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH), the Office of Emergency Preparedness (OEP), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Food and Drug Administration (FDA). These efforts will be directed by the newly established Office of Public Health Preparedness (OPHP).

On January 31, 2002, HHS announced plans for making $1.1 billion available to States. This funding is available for hospital preparedness, laboratory capacity, epidemiology, and emergency medical response. Approximately 20 percent of this total either has already been provided (or will be provided within the next few weeks) for immediate expenditure to all eligible entities in base awards that will be used to establish core programs and address current needs for bioterrorism preparedness. The remaining 80 percent will be made available for expenditure once the Secretary has approved the States' work plans for their awarded funds. States will submit plans which will be reviewed by the HHS staff to ensure that funding is used wisely for bioterrorism efforts.

In order to create a blanket of preparedness against bioterrorism, the FY 2003 budget provides funding to State and local organizations to improve laboratory capacity, enhance epidemiological expertise in the identification and control of diseases caused by bioterrorism, provide for better electronic communication and distance learning, and support a newly expanded focus on cooperative training between public health agencies and local hospitals.

Funding for the Laboratory Response Network enhances a system of over 80 public health labs specifically developed for identifying pathogens that could be used for bioterrorism. Funding will also support the Health Alert Network, CDC's electronic communications system that will link local public health departments in covering at least ninety percent of our nations' population. Funding will be used to support epidemiological response and outbreak control, which includes funding for the training of public health and hospital staff. This increased focus on local and state preparedness serves to provide funding where it best serves the interests of the nation.

An important part on the war against terrorism is the need to develop vaccines and maintain a National Pharmaceutical Stockpile. The National Pharmaceutical Stockpile is purchasing enough antibiotics to be able to treat up to 20 million individuals in a year for exposure to anthrax and other agents by the end of 2002. The Department is purchasing sufficient smallpox vaccines for all Americans. The FY 2003 budget proposes $650 million for the National Pharmaceutical Stockpile and

costs related to stockpiling of smallpox vaccines, and next-generation anthrax vaccines currently under development.

Another important aspect of preparedness is the response capacity of our nation's hospitals. Our FY 2003 budget provides $518 million for hospital preparedness and infrastructure to enhance biological and chemical preparedness plans focused on hospitals. The FY 2003 budget will provide funding to upgrade the capacity of hospitals, outpatient facilities, emergency medical services systems and poison control centers to care for victims of bioterrorism. In addition, CDC will provide support for a series of exercises to train public health and hospital workers to work together to treat and control bioterrorist outbreaks.

The FY 2003 budget also includes $184 million to construct, repair and secure facilities at the CDC. Priorities include the construction of an infectious disease/bioterrorism laboratory in Fort Collins, Colorado, and the completion of a second infectious disease laboratory, an environmental laboratory, and a communication and training facility in Atlanta. This funding will enable the CDC to handle the most highly infectious and lethal pathogens, including potential agents of bioterrorism. Within the funds requested, $12 million will be used to equip the Environmental Toxicology Lab, which provides core lab space for testing environmental samples for chemical terrorism. Funding will also be allocated to the ongoing maintenance of existing laboratories and support structures.

The FY 2003 budget also includes $60 million for the development of new Educational Incentives for Curriculum Development and Training Program. The goals of this program will be the development of a health care workforce capable of recognizing indications of a bioterrorist event in their patients, that possesses the knowledge and skills to best treat their patients, and that has the competencies to rapidly and effectively inform the public health system of such an event at the community, State and national level.

INVESTING IN BIOMEDICAL RESEARCH

Advances in scientific knowledge have provided the foundation for improvements in public health and have led to enhanced health and quality of life for all Americans. Much of this can be attributed to the groundbreaking work carried on by, and funded by, the National Institutes of Health (NIH). Our FY 2003 budget enhances support for a wide array of scientific research, while emphasizing and supporting research needed for the war against bioterrorism.

NIH is the largest and most distinguished biomedical research organization in the world. The research that is conducted and supported by the NIH offers the promise of breakthroughs in preventing and treating a number of diseases and contributes to fighting the war against bioterrorism. The FY 2003 budget includes the final installment of $3.9 billion needed to achieve the doubling of the NIH budget. The budget includes $1.75 billion for bioterrorism research, including genomic sequencing of dangerous pathogens, development of zebra chip technology, development and procurement of an improved anthrax vaccine, and laboratory and research facilities construction and upgrades related to bioterrorism. With the commitment to bioterrorism research comes our expectation of substantial positive spin-offs for other diseases. Advancing knowledge in the arena of diagnostics, therapeutics and vaccines in general should have enormous impact on the ability to diagnose, treat, and prevent major killers-diseases such as malaria, TB, HIV/AIDS, West Nile fever, and influenza.

The FY 2003 budget also provides $5.5 billion for research on cancer throughout all of NIH. Currently, one of every two men and one of every three women in the United States will develop some type of cancer over the course of their lives. New research indicates that cancer is actually more than 200 diseases, all of which require different treatment protocols. Promising cancer research is leading to major breakthroughs in treating and curing various forms of cancer. Our budget continues to expand support for these research endeavors. The FY 2003 budget also includes a total of $2.8 billion for HIV/AIDS-related research. NIH continues to focus on prevention research, therapeutic research to treat those already infected, international research, and research targeting the disproportionate impact of AIDS on minority populations in the United States.

PRESCRIPTION DRUG USER FEES

As a result of our investment in biomedical research through the NIH, new breakthrough drugs and medical treatments will be discovered to treat and cure serious diseases afflicting millions of Americans. A major mission for the Food and Drug Administration is to determine which of these therapies are safe and effective and to get these on the market quickly. The Prescription Drug User Fee Program known

as PDUFA, enacted by Congress in 1992, has been enormously successful in speeding up drug approval times. This program is due for reauthorization this year and is one of the top priorities of the Administration. I commend you, Mr. Chairman, and the Members of this Committee, for your leadership in this area and we appreciate your bipartisan commitment to act quickly to reauthorize this key program during this fiscal year and to ensure that enactment of this legislation is not put at risk by the inclusion of controversial provisions.

As you are aware, the FDA and the drug and biologics representatives have agreed upon a blueprint containing the proposed specifications for the reauthorization of PDUFA III with input from consumer and patient groups, health professionals, and other organizations. This proposal calls for significant increases in user fees to put the program on sound financial footing and make the collection of fees more predictable. The proposed drug user fee amount would be $222.9 million in FY 2003 with increases in the out years to $259.3 million in FY 2007. The FY 2003 request is approximately a $90 million increase over the $133 million that was collected for FY2001. The PDUFA III proposal includes several important new initiatives. One of the more significant among these is the agreement to use industry fees to significantly expand the capacity of FDA to conduct risk management activities during the first few years after drugs are approved. We expect that this will lead to more targeted and effective drug prescribing patterns by physicians and fewer adverse effects for patients.

SUPPORTING HEALTHY COMMUNITIES

The FY 2003 budget includes $25 million for a Healthy Communities Innovation Initiative—a new interdisciplinary services effort that will concentrate Department-wide expertise on the prevention of diabetes and asthma, as well as obesity. Of this amount, $20 million is available in HRSA. The purpose of the initiative is to reduce the incidence of these diseases and improve services in 5 communities through a tightly coordinated public/private partnership between medical, social, educational, business, civic and religious organizations. These chronic diseases were chosen because of their rapidly increasing prevalence within the United States. In addition there is $5 million in CDC for a national media campaign to promote physical fitness activities, with an emphasis on families and communities.

More than 16 million Americans currently suffer from a preventable form of diabetes. Type II diabetes is increasingly prevalent in our children due to the lack of activity. In a recent study conducted by NIH, participants that were randomly assigned to intensive lifestyle intervention experienced a reduced risk of getting Type II diabetes by 58 percent. HHS plans to reach out to women and minorities to help make this initiative a success.

INCREASING ACCESS TO HEALTHCARE

Of all the issues confronting this Department, none has a more direct effect on the well being of our citizens than the quality and accessibility of health care. Our budget proposes to improve the health of the American people by taking the steps to increase and expand the number of Community Health Centers, strengthen Medicaid, and ensure patient safety.

Community Health Centers provide family oriented preventive and primary health care to over 11 million patients through a network of over 3,400 health sites. The FY 2003 budget will increase and expand the number of health center sites by 170, the second year of the President's initiative is to increase and expand sites by 1,200 and serve an additional 6.1 million patients by 2006. We propose to increase funding for these Community Health Centers by $114 million in FY 2003. Our long-term goal is to increase the number of people who receive high quality primary healthcare regardless of their ability to pay. With these new health centers, we hope to achieve this goal.

In addition to expanding Community Health Centers, we are seeking to expand the National Health Service Corps by $44 million. Currently, more than 2,300 health care professionals are providing service to health centers patients and others in under-served communities.

The Medicaid program and the State Children's Health Insurance Program (SCHIP) provide health care benefits to low-income Americans, primarily children, pregnant women, the elderly, and those with disabilities. The FY 2003 budget we propose strengthens the Medicaid and SCHIP programs by implementing essential reforms in the way we pay for prescription drugs, by extending expiring SCHIP funds, and by testing solutions to barriers in community living for disabled children and adults.

We propose to extend coverage of Medicare Part B premiums for people with incomes between 120 and 135 percent of the Federal poverty level, also known as Qualifying Individuals (QI-1s), for one year until September 2003. Currently, States through the Medicaid program must pay for the Medicare premiums and cost sharing for certain low-income Medicare beneficiaries. The funding to pay for Part B premiums for QI-1s expires in September 2002. This proposal would ensure no interruption of current benefits while discussions take place about how better to integrate the QI-1 programs with other Medicaid programs that also pay Medicare premiums.

For FY 2003, we propose to continue Transitional Medicaid Assistance for an additional year and provide families with an important incentive to work. Currently, States are required to provide up to one year of Medicaid for families who, due to work, would otherwise lose Medicaid eligibility. The provision is due to expire in September 2002. We propose to allow families to continue to take those first steps toward self-sufficiency—often in jobs without health insurance—without fear that their medical bills will leave them worse off than before. The initiative would cost $350 million.

Also, we propose to work with stakeholders to develop legislative proposals that build on the Health Insurance Flexibility and Accountability (HIFA) demonstration in order to give states the flexibility they need to design innovative ways of increasing access to health insurance coverage for the uninsured. The Administration's plan also would allow at State option those who receive the President's health care tax credit to increase their purchasing power by purchasing insurance from private plans that already participate in their State's Medicaid, Children's Health Insurance, or State employees' programs. This could help keep costs down and provide a more comprehensive benefit than plans in the individual market. Further, this will give tax credit recipients a range of choices among insurance products, which the new tax credit program will make affordable.

Additionally, as part of the New Freedom Initiative, a nationwide effort to support community based models of care that help remove the barriers of equality that face individuals with disabilities, we propose four demonstrations to test solutions to many of the barriers to community living for disabled children and adults. Two demonstrations will provide Medicaid respite services to caregivers of disabled adults and to caregivers of significantly disabled children. A third demonstration will allow home and community-based services as an alternative for children receiving care in a residential treatment facility. All three of these demonstrations will help the Administration evaluate the feasibility of providing such services under the Medicaid program. A fourth demonstration will address the shortage of direct service workers.

We also need to make an effort to narrow the drug treatment gap. As reflected in the National Drug Control Strategy, Substance Abuse and Mental Health Services Administration estimates that 4.7 million people are in need of drug abuse treatment services. However, fewer than half of those who need treatment actually receive services, leaving a treatment gap of 3.9 million individuals. Our budget supports the President's Drug Treatment Initiative, and to narrow the treatment gap. We propose to increase funding for the initiative by $127 million. These additional funds will allow State and local communities to provide treatment services to approximately 546,000 individuals, an increase of 52,000 over FY 2002.

STRENGTHENING MEDICARE

The FY 2003 budget dedicates $190 billion over ten years for immediate targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. Last year, President Bush proposed a framework for modernizing and improving the Medicare program that built on many of the ideas that had been developed in this Committee and by other Members of Congress.

That framework includes the principles that:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illness.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened to improve care for seniors.

- Medicare's regulations and administrative procedures should be updated and streamlined, while instances of fraud and abuse should be reduced
- Medicare should encourage high-quality health care for all seniors.

The President's FY 2003 Budget also includes a series of targeted immediate improvements to Medicare, which can be implemented as part of comprehensive Medicare legislation, to provide both immediate benefit improvements for seniors and to help implement a Medicare drug benefit and other long-term improvements more effectively.

The improvements the President and I have proposed include not only a subsidized drug benefit as part of modernized Medicare, but also providing better coverage for preventive care and serious illness. The program's lack of drug coverage is just one example of its outdated benefits and it will have even more difficulty giving beneficiaries modern and appropriate treatment for their health problems in the future. We propose that preventive benefits have zero co-insurance and be excluded from the deductible. We must make these improvements to more effectively address the health needs of seniors today and for the future.

Let me assure you, the President remains committed to framework he introduced last summer, and to bringing the Medicare program up to date by providing prescription drug coverage and other improvements. We cannot wait: it is time to act. Recognizing that there is no time to waste, the President's Budget also includes a series of targeted immediate improvements to Medicare.

As you know, last year the President proposed the creation of a new Medicare-endorsed prescription drug card program to reduce the cost of prescription drugs for seniors. This year, HHS will continue working to implement the drug card, which will give beneficiaries immediate access to manufacturer discounts on their medicines and other valuable pharmacy services. The President is absolutely committed to providing immediate assistance to seniors who currently have to pay for prescription drugs.

Assistance, however, will not come only through the prescription drug card program. The budget proposes several new initiatives to improve Medicare's benefits and address cost. This budget proposes additional federal assistance for drug coverage to low-income Medicare beneficiaries up to 150% of poverty—about $17,000 for a family of two. This policy would eventually expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance, and it will be integrated with the Medicare drug benefit that is offered to all seniors once that is in place. This policy helps to establish the framework necessary for a Medicare prescription drug benefit and is essentially a provision that is in all of the major drug benefit proposals to be debated before Congress. That is, the policy provides new Federal support for comprehensive coverage of low-income seniors up to 150 percent of poverty. And in all the proposals, the Federal government would work with the states to provide this coverage, just as we are proposing with this policy.

In addition, I recently announced a model drug waiver program—Pharmacy Plus—to allow States to reduce drug expenditures for seniors and certain individuals with disabilities with family incomes up to 200 percent of the federal poverty level. This program is being done administratively. The Illinois initiative illustrates how we can expand coverage to Medicare beneficiaries in partnership with the federal government. The program we approved will give an estimated 368,000 low-income seniors new drug coverage.

The President's budget also includes an increase in funding to stabilize and increase choice in Medicare+Choice program by aligning payment rates more closely with overall Medicare spending and paying incentives for new types of plans to participate. Over 500,000 seniors lost coverage last year because Medicare+Choice plans left the program. Today close to 5 million seniors choose to receive quality health care through the Medicare+Choice program. Because it provides access to drug coverage and other innovative benefits, it is an option many seniors like, and an option we must preserve. The President's budget also proposes the addition of two new Medigap plans to the existing 10 plans. These new plans will include prescription drug assistance and protect seniors from high out-of-pocket costs.

Some of these initiatives give immediate and tangible help to seniors. But, let me make clear: these are not substitutes for comprehensive reform and a universal drug benefit in Medicare. They are immediate steps we want to take to improve the program in conjunction with comprehensive reform, so that beneficiaries will not have to wait to begin to see benefit improvements. I want to pledge today to work with each and every member of this Committee to fulfill our promise of health care security for America's seniors—now and in the future.

IMPROVING MANAGEMENT AND PERFORMANCE OF HHS PROGRAMS

I am committed to being proactive in preparing the nation for potential threats of bioterrorism and supporting research that will enable Americans to live healthier and safer lives. And, I am excited about beginning the next phase of Welfare reform and strengthening our Medicare and Medicaid programs. Ensuring that HHS resources are managed properly and effectively is also a challenge I take very seriously.

For any organization to succeed, it must never stop asking how it can do things better, and I am committed to supporting the President's vision for a government that is citizen-centered, results oriented, and actively promotes innovation through competition. HHS is committed to improving management within the Department and has established its own vision of a unified HHS—One Department free of unnecessary layers, collectively strong to serve the American people. The FY 2003 budget supports the President's Management Agenda.

The Department will improve program performance and service delivery to our citizens by more strategically managing its human capital and ensuring that resources are directed to national priorities. HHS will reduce duplication of effort by consolidating administrative management functions and eliminating management layers to speed decision-making. The Department plans to reduce the number of personnel offices from 40 to 4 and consolidate construction funding, leasing, and other facilities management activities. These management efficiencies will result in an estimated savings of 700 full time equivalent positions, allowing the Department to redeploy staff and other resources to advance primary missions.

HHS continues working to improve budget and performance integration in support of the Government-wide effort. Although we work in a challenging environment where health outcomes may not be apparent for several years, and the Federal dollar may be just one input to complex programs, HHS is committed to demonstrating to citizens the value they receive for the tax dollars they pay.

By expanding our information technology and by establishing a single corporate Information Technology Enterprise system, HHS can build a strong foundation to re-engineer the way we do business and can provide better government services at reduced costs. By consolidating and modernizing existing financial management systems our Unified Financial Management System (UFMS) will provide a consistent, standardized system for departmental accounting and financial management. This "One Department" approach to financial management and information technology emphasizes the use of resources on an enterprise basis with a common infrastructure, thereby reducing errors and enhancing accountability. The use of cost accounting will aid in the evaluation of HHS program effectiveness, and the impacts of funding level changes on our programs.

HHS is also committed to providing the highest possible standard of services and will use competitive sourcing as a management tool to study the efficiency and performance of our programs, while minimizing costs overall. The program will be linked to performance reviews to identify those programs and program components where outsourcing can have the greatest impact. Further, the incorporation of performance-based contracting will improve efficiency and performance at a savings to the taxpayer.

WORKING TOGETHER TO ENSURE A SAFE AND HEALTHY AMERICA

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

Mr. BILIRAKIS. Right on 10 minutes. I am really not anxious to get into questions, though it seems like it today doesn't it? I will start. Mr. Secretary, the administration has requested that we find offsets for all new health care expenditures this year, and to pass and provide a payment bill in a budget neutral manner.

At the same time, we will have to fix several very serious Medicaid and Medicare problems, including correcting the formula for setting physician reimbursement, and reducing some of the shortfalls for certain Medicaid providers.

I ask, has the administration been able to identify any areas for potential savings that could be used to offset the costs of these very important initiatives. If they have, and a list is being compiled, when can we have that made available to us?

Mr. THOMPSON. Mr. Chairman, we have worked extremely hard on this, because we know it is a subject that a lot of individuals on this committee and throughout Congress are concerned about, as well as many providers.

It is a very difficult question, and we have been working hard on it. We have come up with several suggestions, and we are responding to Chairman Thomas' letter that was sent to us a couple weeks ago.

And we should have the final decisions made, and the final recommendations made, sometime this week. We expect to give that report to Chairman Thomas, I believe, sometime tomorrow.

And then the rest of the members that have requested it, such as yourself, Mr. Chairman, will receive it, I hope, on Friday morning.

Mr. BILIRAKIS. Friday morning? Okay.

Mr. THOMPSON. And we want to work with you on it, and it is a whole list of recommendations on——

Mr. BILIRAKIS. Are you open to suggestions?

Mr. THOMPSON. We are open to all kinds of suggestions. We know that there is not any easy answer, and I want you to know that all providers are on the table, and that is what has to be done, because you have home help, and you have got outpatients, and you have got the health, and you also have the doctors and the outpatients.

All of these together, and we have got recommendations on all of them, Mr. Chairman.

Mr. BILIRAKIS. Mr. Secretary, given the many problems associated with the existing Physician Payment Formula, we have talked about this time and again, our committee on a bipartisan basis is committed to changing the payment structure legislatively to ensure that 5 percent cuts never happen again.

I know that you are encouraging us to do this legislatively. I wonder, is the administration taking any steps to change that formula and to make suggestions in changes of that formula, and if you are, what might those steps be? Are you trying to address the issue?

Mr. THOMPSON. We are trying to address the issue in total, and my response to Chairman Thomas is that what I want you to know is that any change is statutory and must be made by Congress. We can't do it administratively.

We can make recommendations, but Congress will have to make the final decision on it.

Mr. BILIRAKIS. All right. Are you making recommendations to Chairman Thomas? You have mentioned him 2 or 3 times already.

Mr. THOMPSON. Well, he is the one that precipitated our action by sending us a letter with a whole list of questions that we are trying to respond to, and we hopefully are going to get that information to him sometime tomorrow afternoon.

Mr. BILIRAKIS. Mr. Brown, Mr. Tauzin, Mr. Dingell, and I, have introduced a piece of legislation to make some changes.

Mr. THOMPSON. I know you have.

Mr. BILIRAKIS. If you have any suggestions regarding any of the changes that we propose to make, we certainly would appreciate hearing them.

Mr. THOMPSON. I think the best way to handle that, Mr. Chairman, would be that as soon as this information is made public, that we have a working group to sit down and I will make my staff available at any time that your staff is available, and let's work on your proposal.

And let's work on what Chairman Thomas of the Ways and Means Committee comes up with, and let's see if we can't develop a proposal that is suitable on a bipartisan basis that can pass both Houses of Congress.

Mr. BILIRAKIS. Let me ask you, sir, about the upper payment limit issue, some States are getting a larger break in terms of——

Mr. THOMPSON. I don't think any State is getting a bigger break over another, on the upper payment limit. First off, under President Clinton, he put limits on the upper payment limits for nursing homes and for private hospitals, and the last remaining part of the equation was public hospitals OMB requested the Department of Health and Human Services to draft a rule for public hospitals.

We drafted that rule, and that rule will go into effect on April 15 of this year, and it will put the public hospitals in the same position as private hospitals, and skilled nursing homes that were placed there under the Clinton Administration.

And under that all States were treated the same, and if you had your proposal in, you received it. And I want you to know that somebody mentioned that Wisconsin was treated differently, and I want to point out it was not.

And that Wisconsin was treated before I got here, and the amendment—Wisconsin does not have any public hospitals, and so it does not get any upper payment limits for public hospitals, only fur nursing homes.

Mr. BILIRAKIS. Well, I am not referring to Wisconsin, but I am referring to some of the 7 and 8 year phase-in type of things. They are basically taking advantage, if you can call it, getting rewarded for more years for it.

Mr. GANSKE. Mr. Chairman, that was a statutory thing, and it was an amendment put in by Speaker Hastert, and it was before I got here that that passed and became the law. And I just want to point that out, that it is statutory, and several States lobbied for it.

And Wisconsin, California, and Illinois were three, and I don't know that you can criticize anybody that was able to successfully get the Speaker to introduce it.

Mr. BILIRAKIS. I won't say anything further in that regard, except to say that some of us are very unhappy about it.

Mr. THOMPSON. And I think the power of this body is to pass legislation, and to put other States in the same position.

Mr. BILIRAKIS. Thank you very much. Mr. Brown to inquire.

Mr. BROWN. Thank you, and thanks again, Mr. Secretary. The only increased Medicare provider funding in your budget that I can find is $3.4 billion for Medicare+Choice, and programs over the next 10 years. What goals do you hope to achieve with that $3.4

billion; more prescription drug coverage, or more reduced cost sharing? Where do you go with that?

Mr. THOMPSON. Basically, as you know, Congressman Brown, the Medicare+Choice program has been reducing the number of coverages and the number of people.

Last year, we lost a little over 500,000 and we are down to about 14.4 percent of the Medicare population covered by Medicare+Choice. And we felt that this was the only way that there was going to be able to stem that. In 90 percent of the cases, that reversal, because the individuals that had Medicare+Choice, are very satisfied with it.

But the individual companies that are involved in Medicare+Choice cannot maintain it at the current reimbursement rates, and we felt that it was necessary to try and increase the rates and stem the tide of erosion of the coverage.

Mr. BROWN. There has been legislation offered, and bipartisan in some cases, to require that Medicare+Choice count, and that Medicare HMOs agree once a beneficiary is unenrolled that the Medicare+Choice plan must not for a period of 1, 2, or 3 years, must agree to not cut benefits in any way. Is that something that you would make part of this?

Mr. THOMPSON. It is not part of this, Congressman, and the only—I am not opposed to that. The only caveat is that if a company is losing benefits that they are losing dollars, and is going to either go bankrupt or get out of the market.

And it is pretty hard to continue to force them to keep going.

Mr. BROWN. But are we getting any kind of assurances from these companies as we put in more money last year, and we were putting in this money now, are we getting any assurances from them that they will not cut services, or allow prescription drug coverage to atrophy, or whatever else might happen with managed care——

Mr. THOMPSON. We do not have the legal authority to do so, but we jawbone very effectively and tried to make sure that none of the coverages are dropped. We do everything we possibly an, and we get on the telephone and talk to the insurance carriers, and do everything that we can to possibly keep them in the business. But that is about as far as we can go statutorily.

Mr. BROWN. Are you asking for more statutory authority?

Mr. THOMPSON. At this point in time, no.

Mr. BROWN. I am concerned that-and we have done this before—that this Congress has put more money into provider funding for the 14.4 percent of beneficiaries. Does that mean 85.6 percent beneficiaries don't get help that way?

And that the $190 billion in your budget for—well, the required prescription drug coverage seems pretty inadequate if we are looking at the FEHBP and those calculations for the FEHBP, and to bring coverage to the level of FEHBP, and that Federal employees, and Members of Congress have would cost $750 billion, what kind of prescription drug coverage do you see with this $190 billion, in light of the fact that our numbers that say half the FEHBP coverage for beneficiaries would need $750 billion?

Mr. THOMPSON. These are figures from our actuaries at CMS, Congressman Brown, and we feel that you can deliver the begin-

ning of prescription drug coverage. We know that this Congress last year in the budget bill put aside $300,000 billion over 10 years.

But the President and this administration feels very strongly that if you just do prescription drug coverage that it is going to be a lot more costly.

But if you strengthen it and make some efficiencies, and allow for some cost sharing, you are going to be able to get by with $190 billion. My request of you—and I know that your passionate on this, is to work with you, and try and develop a figure, and try to develop a bipartisan Medicare proposal.

And instead of eroding it, it strengthens it, and makes it financially suitable and financially solvent. This is the President's objective, and it's mine, and I know it is yours. I only hope we can set aside partisan politics, and get on with a bipartisan approach, and I want to work with you to accomplish that.

Mr. BROWN. Well, we wold love to do that, but the problem is not you, but the President has put us in a box where he wants $590 billion more in tax cuts, and yet all you can offer is $190 billion for prescription drugs; when even Speaker Hastert has said $300 billion is what is necessary.

And then I look at what happens with Medicare+Choice, where in 2001 when they get the extra billion dollars, that GAO found that 70 percent of those plans didn't use the money to improve benefits.

So how are we going to take care with the box that you have put us in, where the tax breaks are primarily for upper income people are putting us in a situation where we will have to choose either a generous, or even an adequate, and forget generous, prescription drug benefit, or it is tax breaks for the wealthiest Americans.

Mr. Tauzin said we are not spending the money in a tax cut, and you can say it however you want it. But the fact is that it is a choice. We either do an FEHBP adequate generous level, or what the AARP has said, about $700 billion or whatever number you choose.

But certainly adequate or maybe generous, or we do the tax cut and don't have this kind of money. I mean, I want to work with you, but how do we get out of this box?

Mr. BILIRAKIS. A brief response to that, sir, because we have two votes on the floor.

Mr. THOMPSON. First off, I don't want to put you in a box, and second off, Medicare+Choice, companies are losing money, and we wanted to keep them in the market because the individual subscribers that have them believe in them, and like their coverage, and like their programs.

I want to be able to maintain that, and that is why we are trying to stabilize that. In regards to Medicare, $190 billion, I think that is a giant first step, and I would like to work with you, and I think that just instead of complaining about the dollars—and I can understand your position—I would like to be able to say why don't we start.

You know, instead of saying 750, 300, 190, let's start looking at the whole subject, the Medicare Program, as well as including the prescription drug. I am passionate about it, and I know that you are.

And I would like to be able to come up with a Medicare strengthened bill with catastrophic coverage, with a prescription drug coverage, and also do something about the first dollar coverage, and be able to do something together on a bipartisan basis, but we can't do it unless we start, and I am willing to start.

Mr. BILIRAKIS. All right. The Chair will recess. We have a couple of votes on the floor, and as soon as those votes are over, we will get started again.

[Brief recess.]

Mr. BILIRAKIS. The Chair will yield to Mr. Pallone to inquire.

Mr. PALLONE. Thank you, Mr. Chairman. Mr. Secretary, just as sort of a forewarning, I want to ask about dietary supplements, and I also want to ask about American Indians. So if we get too far into it, I may switch to the other one just so I can get to it if you don't mind.

On the dietary supplement issue, when you were here a year ago, I had asked you a question about the good manufacturing practices, and whether we were going to see those regulations put into place.

And at the time, I believe you said within the next few months, by June or so, and over a year has passed, and they still have not been put into place. And I know that Senator Harkin over in the other body put in $4 million last year for the adverse event reporting.

In other words, if there had been incidents where there had been problems with dietary supplements, that they would be reported. And supposedly we were having the adverse event reporting and $4 million spent on that, and then the FDA was supposed to within 15 days publish the GMPs.

But as far as I know, none of this gas happened, and I would just ask what is happening? Has that $4 million been accepted by the FDA, and what are they doing about adverse reporting, and when are these GMPs going to be published, because they are obviously late?

Mr. HUBBARD. I am Bill Hubbard from the FDA, Mr. Pallone. On the GMPs, those regulations have been drafted, and they are being discussed with the new deputy commissioner at the FDA, who has just arrived. And he is looking at them and discussing them with the Secretary's office.

So they should be done soon we hope; and on the adverse event, the money has come to us, and we are setting a stronger adverse reaction reporting system for dietary supplements.

And we will see results from that as the year flows through.

Mr. PALLONE. Again, I am not trying to be difficult, but it is pretty much the same thing that we heard a year ago, and a year has passed, and we haven't seen any progress to my knowledge.

So I would just stress again how important it is to move quickly on that, because as you know, we do have the incidents in the media where there are things reported and there are some problems.

And I think that those good manufacturers who really are out there doing a good job would like to see these things happen.

Mr. HUBBARD. They would. You are absolutely correct, Congressman, and there has been a lot of discussion and a lot of controversy

developing internally, and we have not had an FDA commissioner, and we now have an individual that I think is outstanding, and Dr. Crawford and I can assure you that we will move very quickly on this thing. And I will keep you personally informed myself.

Mr. PALLONE. I appreciate that, and let me move on to the Native American issue. A couple of things. You mention in your speech about the Homeland Security Funding, and the Anti-Bioterrorism Funding, and I think there is $3.1 billion for homeland security, and $4.3 for Anti-Bioterrorism.

The tribes have been very concerned because they don't know if they can access either pot of money.

Mr. THOMPSON. Yes, they can.

Mr. PALLONE. Okay. If you could just comment on that, because there is no specific language about it in the legislation.

Mr. THOMPSON. Well, what we are doing with the bio-terrorism money is that we have got $1.1 billion to get out. The President signed the bill on January 10, and 21 days later we had the letters out to all the Governors, and we have already sent out 20 percent of the money. And 10 percent, which is to set up their planning, and——

Mr. PALLONE. Mr. Secretary, none of those letters went to tribal governments, and so they are concerned about the——

Mr. THOMPSON. But I talked to the tribal governments at their tribe——

Mr. PALLONE. NCAI?

Mr. THOMPSON. Yes. I talked to them and they gave me an award for——

Mr. PALLONE. It is always helpful when they give you an award.

Mr. THOMPSON. Yes. So I talked to them at that point, and received it, and told them that I want them involved.

Mr. PALLONE. Well, maybe there is some way to notify?

Mr. THOMPSON. And we went across the country, Congressman Pallone, and we set up informational hearings, and we invited all individuals involved. And if you want me to specifically send out letters to them, I would be more than happy to. I contacted them at the conference, at the Congress.

Mr. PALLONE. I would appreciate it if some effort could be made in a proactive way to contact them and say that is available.

Mr. THOMPSON. I would be more than happy to do it. I want them involved.

Mr. PALLONE. All right. And then the last thin—and I want to see how much time is left——

Mr. THOMPSON. What we are really trying to do with this bioterrorism money, Congressman, is really trying to build a strong local and State public health system. We have not done that in America.

Mr. PALLONE. Oh, I agree.

Mr. THOMPSON. And what we are doing is we are sending out templates from what the best programs are in communications to the State Health Departments. We figure it has got to be bought into by the Government and the State Health Departments.

But we are demanding that those individuals go out and find out from the tribes and from the——

Mr. PALLONE. But you know how it is, Mr. Secretary, and I don't have to tell you as you were the Governor of Wisconsin, that——

Mr. THOMPSON. And I had 11 tribes.

Mr. PALLONE. [continuing] they don't deal directly with——

Mr. THOMPSON. I appreciate the advice and we will do a better job.

Mr. PALLONE. One more quick question.

Mr. BILIRAKIS. If it is a quick question and quick answer, and if there is no objection to it.

Mr. PALLONE. I just wanted to ask you that you mentioned diabetes in a major way, and about the new initiatives in your statement.

Mr. THOMPSON. Yes.

Mr. PALLONE. And obviously you know that is a huge problem for Native Americans. How is this new initiative going to help them or have they been taken into consideration in that?

Mr. BILIRAKIS. Can you do that in writing, Mr. Secretary?

Mr. THOMPSON. Yes.

[The following was received for the record:]

The Healthy Communities Innovation Initiative is a proposed demonstration grant program to create healthy environments and to improve health outcomes in areas where asthma, diabetes, and obesity associated morbidity and mortality rates are high. The program will be administered by HRSA and be modeled after the successful Healthy Start community-based demonstration program. Grants will be awarded competitively to public or nonprofit private organizations, including tribal organizations, applying as or on behalf of a community-based consortium. Therefore, tribal organizations will be eligible to compete for these grants to focus on innovative community-level efforts to prevent and treat diabetes, obesity and asthma among Native Americans. In addition, the Indian Health Service receives $100 million annually, specifically for the prevention and treatment of diabetes among Americans and Alaska Natives. Funds are distributed to 318 diabetes programs, primarily located in Indian country, but including 33 programs in urban areas.

Mr. PALLONE. That would be fine.

Mr. THOMPSON. We are doing a lot with the Native American tribes.

Mr. PALLONE. You can get back to me in writing. Thank you.

Mr. BILIRAKIS. Mr. Greenwood.

Mr. THOMPSON. We are doing a lot on it.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. THOMPSON. Congressman, how are you?

Mr. GREENWOOD. I'm fine, Mr. Secretary. The Oversight and Investigations Subcommittee has been looking for some time at the question of importation of drugs. It is a thorny complicated question, because it has multi-facets, and it has to do with people bringing prescriptions in from Canada and Mexico.

Mr. THOMPSON. It is a serious problem.

Mr. GREENWOOD. But that is how we think of it for the most part, but what we did is we went out to Dulles Airport, and we had an airplane come in filled with passengers, and in the belly of that plane was all of its freight.

And we watched as the freight was put through x-ray machines, and then items that looked like they might be drugs were pulled out and opened up, and inspected. And what we discovered was a witches' brew of legal and illegal drugs.

Of course, no prescriptions involved in these drugs coming from all over the world. And it was frightening to think that consumers could go on the internet, for instance, and think that they were ordering some perfectly approved and inspected product from around

the corner, when in fact it might come from halfway around the world.

And it might be bogus, and it might be tainted, and it might make them sick. We had parents of a young man who died from drugs that he had acquired over the internet. I would be interested in your views on what you think can be done about this to protect people from these dangerous products.

Mr. THOMPSON. Very little right now, Congressman, and I want to compliment you on your leadership in this effort.

Dr. Bill Hubbard, who is from the FDA, was just down in Miami, and this was one that just came in by one individual. There were a thousand that day that came in, and this one had all different kinds of drugs and everything like this.

The Customs Office wants to know what they can do, and so Dr. Hubbard went down there, and he brought this back. Now, what he has to do under the law is he has to contact the individual who applied for this thing, and requested it, and ask that person if they want a hearing.

That is all that we can do under the law. Usually when we do this, they don't want a hearing, and then we can dispose of it. But if they want a hearing, then we have to have a hearing, and they have to justify why they are doing this.

It is a serious problem. We would like to be able to have—the Customs Office would like to be able to have the opportunity to return these items, and there is no question in my mind why we should not have that authority.

Right now when we take this, we have to get back a letter within 90 days to the person that applied for it. But there is nothing we can do. What is happening is that we are sure that this individual is reselling it.

We don't know if they are packaged right, and we don't know if they are counterfeits, and we don't know the results of testings. There are syringes in here, and just everything that you can well imagine; a lot of valium, and just everything.

And that was just one and there were a thousand that day that came in.

Mr. GREENWOOD. And what we discovered that day was that even to the extent—in most places these packages are never even looked at.

Mr. THOMPSON. That's right.

Mr. GREENWOOD. They go right to the person to whom they are addressed.

Mr. THOMPSON. There is no law against it.

Mr. GREENWOOD. And to some extent, they may or may not be inspected, but looked at through an x-ray machine. And then when they do find a bucket like that, they will toss it into a cardboard box in a side room and wait for the FDA to arrive.

And someone from the FDA may come by once a week for an hour and look at a few things. So it is really just frightening to think that these kinds of products could get into the bodies of Americans without any protection.

Mr. THOMPSON. Congressman, you have got to realize that we only had 115 inspectors until this year, and thanks to you, and

thanks to the members of this committee on a bipartisan basis, you gave us $98 million to hire more inspectors.

We will have an additional 400 inspectors on the ports of entry and at the airports by the end of this year, and we only had 150 up until this year. So hopefully we will be able to do a much better job, but we should have at least the authority to reject these, and be able to send them back to the manufacturer, instead of sending them on.

Mr. GREENWOOD. Let me get to another issue very quickly. It has to do with mental health, and it has to do with consumer-run services. I am informed that the budget takes the little tiny $2 million that is available for consumers, and consumer/supporter technical assistance centers, and eliminates it.

What this is about is the ability to try to bring people into empowerment who have suffered mental health problems, either individually or within their families, and this little $2 million was helping to provide technical assistance that they could use to be advocates.

I would hope that we could have your support in restoring that, and that $2 million is not a lot of money, but it is pretty important money.

Mr. THOMPSON. We would be more than happy to work with you. As you know, I have appreciated your counsel on many issues before, and I will continue to work with you on them.

Mr. BILIRAKIS. I wondered if we could ask Mr. Hubbard what was the attempt to transport drugs into the country? Were they in suitcases or——

Mr. HUBBARD. No, just in a package.

Mr. BILIRAKIS. Just like that?

Mr. HUBBARD. Here, show him the package.

Mr. BILIRAKIS. Carrying it? Yes, I saw that.

Mr. HUBBARD. That's how it came in.

Mr. BROWN. Would the gentleman yield for a moment?

Mr. BILIRAKIS. I would be glad to yield.

Mr. BROWN. Do you have the same concerns, Mr. Secretary, about Canada, to the same degree?

Mr. THOMPSON. Well, the problem that we have, Congressman Brown, is that we don't have problems with people going into Canada. That is not the concern. But what we are concerned about is if Canada—other countries will send them through Canada, and then get into the United States through other countries.

Mr. BROWN. Canada will allow those drugs to come in? I am a little concerned about the website on this issue that the FDA has. My understanding is that you withdrew the language that was there before, and sort of instructing us on what to do.

I take a bus to Canada every couple of months. It is about an hour or 2 drive from where I live, and we are concerned about the language on what in fact you all might do.

I don't think people are worried that you are going to board the bus and the FDA is going to be there or anything like that, and arrest these people, unless they stop and gamble in Windsor, and buy duty-free alcohol at the border, but that is a whole other issue.

But I guess we are looking for a little more clarity from them on this whole issue.

Mr. THOMPSON. The problem his not been fully defined yet. We are looking at it, but we want to work with you, and we want to work with Congressman Greenwood, who has taken a leadership role in this.

I have asked Les Crawford, who is the Acting Commissioner right now, to really take an in-depth look at this and make some recommendations so that I can bring them back to you.

And bring them back to this committee, in the hope that we can come up jointly with some good legislation. I am just fearful that a lot of our elderly citizens are going to be duped into buying something that may be counterfeit, and that may be harmful to them. And this is a big concern of mine.

Mr. BROWN. Do we know enough about—do we in this country, our government officials, and your agency, know enough about how the Canadians process imported drugs?

Mr. THOMPSON. I think we do.

Mr. BROWN. And if you are satisfied with the way that they import drugs, then there should not be a problem with our importing them from Canada should there?

Mr. THOMPSON. We are certainly satisfied with the Canadian laws and the Canadian manufacturing processes and practices. We are concerned about other countries. In some countries according to my experts at the FDA, 40 percent of the drugs coming out of certain countries are counterfeit.

We are concerned about those kinds of drugs getting into our market in the United States.

Mr. BROWN. As you should be.

Mr. THOMPSON. And causing health concerns, and even death in some cases, and that is our big problem.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Dr. Ganske to inquire.

Mr. GANSKE. Thank you very much. Mr. Secretary, what we are dealing with here is tetracycline, a common antibiotic. Now, what we are really dealing with is the fact that we have a protection measure that gives the drug companies in this country protection against overseas competition for drugs that are made and manufactured in the United States and shipped overseas.

And Congress overwhelmingly passed a law a year or 2 ago saying that we should allow for the reimportation of those drugs that are made and manufactured in the United States.

There was a provision put on the bill that said they could only come back in if they were then relabeled by the drug companies so that they would get to see who buys them wholesale, and have basically a bottleneck.

I think that needs to be fixed. Now, I agree with you that you need to have appropriate inspection. It shouldn't be difficult to determine who are our honest wholesalers. Geneva World, and Farma World, in Geneva, Switzerland, for instance are they okay?

And I am more than happy to support initiatives, and I have in the past, to increase the funding for the FDA to do that type of inspection. But I would point out that this isn't a potential problem just with drugs coming into the country.

How do you know, or how does any person know that the drug they are getting from their pharmacist is the real thing? How often does the FDA inspect the drugs that are in this country?

We have had well-documented examples of dilution, or substitution, for people on expensive drugs in this country. So I think it is a bit of a red herring to bring up a box that some individual citizen has brought into this country for tetracycline.

And what we are really dealing with here is the fact that the pharmaceutical companies do not want to see overseas competition. I am sure that you would like to see a global market on this, because American citizens are subsidizing the rest of the world, in terms of our drug costs.

I mean, I can bring charts here that show that drugs made and manufactured here cost twice as much for the same drugs that are then sent overseas. And our citizens are very, very unhappy about this.

So I will tell you what. If you work with me, in terms of setting up protocols, so that we can implement the law that Congress has passed, I will work with you to make sure that you get the appropriate funding for the inspection.

Mr. THOMPSON. Congressman, as you know, last year I came up here and said, you know, I have a serious problem in the FDA. I have 715 inspectors totally in America. We have to inspect 56,000 places across America.

We have 150 individuals that inspect incoming things from our ports and our airports, 150. And I said we are only inspecting less than 1 percent of all the food that is coming into the United States.

And I said that I am really concerned about that. I asked you, and I asked this committee on a bipartisan basis, to give us more inspectors. We requested $61 million more, and this Congress in their wisdom, and I thank you for it, gave us $98 million, and we are going to now be able to go up to 673 additional inspectors and personnel that are going to help us do the job.

I want to work with you, and the FDA has been under-funded for a long time in this arena, and we need to do more. This is not a red herring, and I don't intend it to be a red herring.

This is 1 day in which a thousand of these packages came into America, and we just took one. There were 999 that were delivered, and only one package was brought up here just to show that there is a problem.

I want to develop protocols, and I want to develop an international market, and I want to work with you to accomplish that, and I will make my staff, and me myself personally, involved in this thing to see if we can't come up with a successful solution.

I do not want to in any way inhibit that elderly citizen from being able to purchase drugs wherever he or she can, and that as long as I have some sort of security and protection, then the remedies will be addressed by the medicine and not in a counterfeit fashion.

Mr. GANSKE. Well, do you think that the funding that you are asking for or that is in the budget for this is adequate?

Mr. THOMPSON. I certainly think that what the Congress did in the supplemental appropriation last year, and giving us the $98

million, was a giant step forward. Am I totally satisfied? No, I am not.

Mr. GANSKE. How much more would you like to see?

Mr. THOMPSON. Well, I think that is something that we need to sit down and discuss, and I need to make sure that I contact OMB.

Mr. GANSKE. Thank you. Thank you, Mr. Secretary.

Mr. BILIRAKIS. Mr. Dingell to inquire.

Mr. DINGELL. Mr. Chairman, I thank you. Mr. Secretary, I am aware of the travails you confront, and I want to commend my friend, Dr. Ganske, for the questions. Food and Drug does not have enough people to address domestic problems?

Mr. THOMPSON. They don't.

Mr. DINGELL. And they don't have enough money to address imports, and they don't have enough money or personnel to address almost any of their functions. And yet you can't get the money out of OMB, and this is not a new thing, as was the case in other administrations.

But you are not able to levy the kind of charges that you do for prescription pharmaceutical clearances, which does work, and which has given you speedy and thorough, and effective clearance of new drug applications?

Mr. THOMPSON. That's true.

Mr. DINGELL. I wonder when the administration and the OMB are going to recognize that the protection of the American public from imports, and from other things, like devices and so forth, is only going to be achieved either by putting out a lot more money, or by bringing forward a system of user fees and charges for the services that the Food and Drug gives.

Mr. THOMPSON. Well, Congressman, as you know, you were very instrumental in the supplemental appropriation on food safety, and I thank you for your leadership. You and I have personally discussed this on many occasions, and I am talking strictly as myself, Tommy Thompson.

I think we should go to the user fee route, and I would support it. I know that I am probably talking strictly to yourself and myself on this issue, and we probably will not be able to pass it.

I don't have a vote and you do, but I certainly think it is the right thing to do, and I think we certainly have to do something. You are absolutely correct that we are looking at inspecting less than 1 percent of the food coming into America.

We are doing a woefully inadequate job as it relates to the inspection of drugs coming into America, and we need to do a better job. But when you only have 750 inspectors, and you have 56,000, and you have over 300 ports of entry, it is impossible to do it with 750 individuals, no matter if they were all as capable as you were, Mr. Dingell, when you went through the airport.

Mr. DINGELL. I would not stand in favor of either effectiveness or courtesy. However, the matter is behind us, and I will observe that I have had better times in dentist chairs.

Mr. Secretary, these questions here are asked with a great deal of respect and affection for you, and I appreciate what you have just said, and I hope that I have not placed you in harm's way. Mr. Secretary, States are required to cover pregnant women in Medicaid today up to 133 percent of poverty.

This coverage includes care for women, and care for the unborn child. States can cover women above 133 percent of poverty. In fact, 39 States already cover women above 133 percent; isn't that true?

Mr. THOMPSON. I am almost certain that it is, yes.

Mr. DINGELL. Now, Mr. Secretary, I believe in California that they cover pregnant women up to 300 percent of poverty; is that correct?

Mr. THOMPSON. If you have got the figures there, I never would question you, Congressman Dingell.

Mr. DINGELL. I got it from the staff and so we can both have faith in it. Mr. Secretary, States do not need then to use a waiver to cover pregnant women above 133 percent.

Section 1902(r) of the Social Security Act allows States to waive income and assets requirements to raise the coverage levels for pregnant women in Medicaid; isn't that right?

Mr. THOMPSON. That's correct.

Mr. DINGELL. So I am coming around, Mr. Secretary——

Mr. THOMPSON. I know what you are coming around to, sir. You are trying to lead me into a trap, Congressman.

Mr. DINGELL. Mr. Secretary, I would never put you in a trap. I just am trying to ask you a question. I am trying to understand that if we have this situation, why is it necessary for us to go the waiver route when the practical result of the waiver route is to require cutbacks in benefits to other persons who have need, while you expand the coverage in other areas.

The net result is that no significant increase in overall care, but a shift in the kind of care and who would be eligible recipients of care because the waiver route is taken.

Mr. THOMPSON. Well, as you probably know, the waiver route has been very successful.

Mr. DINGELL. I have some worries.

Mr. THOMPSON. What are your worries?

Mr. DINGELL. Well, in Utah, the waiver route in fact has caused significant reduction in benefits, while at the same time causing increases in benefits in other areas. And I don't have enough time to go into exactly——

Mr. THOMPSON. Can I respond?

Mr. DINGELL. Of course. Sure.

Mr. THOMPSON. We have issued 1,506 waivers in the past year, and we have been able to give 1.8 million Americans insurance coverage under the waiver process that would not have it.

We have been able to expand benefits by 4.5 million individuals that expanded benefits. Utah wanted to be able to develop a plan to reduce the benefits for some classifications.

Mr. DINGELL. Now you are hitting the point.

Mr. THOMPSON. In order to expand the coverage, they reduced the coverage by 14,000 to what the State employees are receiving under their insurance coverage in order to cover an additional 35,000 individuals.

I looked at the tradeoff and since everybody, even the ones that were being reduced, were still getting the same amount of health insurance coverage that the State employees in the State of Utah were receiving, I thought it was a good tradeoff to get three times as many more people that were not covered by insurance covered.

It was also supported by individuals in the Congress, and in the U.S. Senate from that State, and from the Governor, who has done an excellent job of expanding health insurance benefits in that State, sir.

Mr. DINGELL. I guess my time is up.

Mr. BILIRAKIS. Mrs. Wilson.

Mrs. WILSON. Thank you, Mr. Chairman, and Mr. Secretary, I am very pleased to have you here to talk about what you are doing in Health and Human Services. I particularly wanted to commend the emphasis in your budget on the community health centers, bioterrorism preparedness, and the health research, which has been mentioned by others here this morning.

I wanted to ask you about the State Children's Health Insurance Program, S-CHIP. In your budget, and as you previously announced, your intention to try to continue to extend that program and the State's continued access to it.

And it has been an important program for the expansion of health care benefits for children in many States. But I am concerned though that unless there is more flexibility associated with that program that we may end up as New Mexico is, turning money back in to S-CHIP, close to $200 million, at simultaneously because of the budget crunch in the State, reducing the access of children to Medicaid funds because of a fairly strict requirement in the program for maintenance of level of effort.

In New Mexico, we have 95,000 children who are less than 185 percent of poverty, and because they were already eligible for Medicaid, we cannot use S-CHIP funds for those children. If you go up to 235 percent of poverty, there are only 6,000 more kids that are in that range.

So we have had very little flexibility from your predecessor on what we can use those Federal funds for, and with a State with very high levels of children in poverty, we really encourage you to work with us and what flexibility we can use so that we don't end up reverting funds while we are cutting benefits.

Mr. THOMPSON. Congresswoman, you are absolutely correct, and we want to work with you. First, let me quickly point out that we put in a model waiver for this particular program for S-CHIP.

Second, the President has said that the $3.2 billion that could have been reverted back to the Treasury on S-CHIP is not going to. It is back in the budget so that the States can still use it.

So New Mexico will not have to turn back that $200 million that you were talking about. The third thing is that I started a program when I was in Wisconsin to allow low income parents to be able to sign up with S-CHIP and got a waiver to do it.

And I started that program, and as a result of that program, other States have followed through; Massachusetts, New Jersey, Delaware, New York, Arizona, and California. And we have put in a model waiver so that other States, and hopefully New Mexico would take advantage of that model waiver.

And I think it would probably solve some, if not all, of your problems.

Mrs. WILSON. We would like to work with you on that, because our——

Mr. THOMPSON. I would love to.

Mrs. WILSON. [continuing] waivers have not been approved, and we have not been able to have access to those funds. The State is now considering reducing Medicaid eligibility for children, which will potentially—we may have a situation where we have 6,000 children between 185 and 235 percent of poverty who have great benefits, while we lose 46,000 poorer children who will no longer have health coverage because of the anomaly in the law that says that you cannot—if you were at 185 percent of poverty when you started out, you cannot use any of this money for those children who were already eligible for Medicaid.

Mr. THOMPSON. If we can construct a waiver to help you, and we will not be in the violation of the law, we will do that.

Mrs. WILSON. And if we need to change the law, I think we need to recognize that the current situation with the States is not a circumstance where they are unwilling to continue the level of effort. It is a financial crunch caused by a recession, and we need to take care of those who need help the most.

Mr. THOMPSON. I could not agree with you more, and that's why the President has put forth in his budget provisions that the $3.2 billion, which even as you know certainly could have been used by the Federal Government for other programs, said, no, this is the right thing to do, and leave it in the States, and allow the States to be able to develop their S-CHIP programs.

We want to be able to cover these children. We have found, however, that the best way to cover children is to allow the parents to also sign up. Then they are much more apt to bring their children and to sign up for the program.

And that is what the model waiver does, and I want to work with you, and if we need to change the law, we will tell you that, and will be more than happy to try to attempt to support you in getting that accomplished.

Mrs. WILSON. I appreciate that, because we are in a real bind.

Mr. THOMPSON. The S-CHIP program is a great program and let's use it. I mean, we have got the money there and let's maximize the use, and let's get as many people covered as possible, and that is going back to Congressman Dingell's question.

We were able to use that model waiver to allow for 1.8 million Americans this year to be covered by health insurance.

Mrs. WILSON. Thank you, Mr. Chairman.

Mr. BILIRAKIS. We will also have the opportunity to raise questions in writing to the Secretary. I understand that you do have to leave at one o'clock?

Mr. THOMPSON. Yes, I do.

Mr. BILIRAKIS. Okay. Dr. Norwood to inquire.

Mr. NORWOOD. Thank you, Mr. Chairman. Mr. Secretary, the administration's budget included over $5 billion in savings from Medicare and AWP, and based on the assumption that you would fix the problem administratively if Congress actually failed to act.

Mr. THOMPSON. I would much rather have you act, Mr. Congressman.

Mr. NORWOOD. Well, I think we should, too, and in the proposal developed by the committee to fix this AWP problem, we also included several provisions that would increase physician reimbursement to make up for the loss of the drug revenues.

Would you be precluded from making that similar increase to provide a reimbursement absent specific legislative authority?

Mr. THOMPSON. It is our understanding that we do not have the authority, in fact, to assign it to the physicians. We know that we don't have the authority to do that. Second, there is some question whether administratively we have the authority on AWP.

Mr. NORWOOD. Well, I am actually trying to make the point to this committee that we need to fix this problem, and not leave it up to you to have to fix the problem.

Second, because I know that time is running out on us, the President's budget allows for $4 billion for Medicare+Choice plans. A lot of us have difficulty with that. And in a situation where the rural fee for service provider is seeing Medicare patients, and have nothing to do basically with Medicare+Choice plans.

And we are shorting that group $1.25 billion in the 5.4 percent cut. There are a number of Members of Congress who don't understand that inequity, and why we would so desperately need to put $4 billion into Medicare+Choice, which I would agree is underfunded, too.

But at the same time, and in the same year, and in the same budget, allow a decrease of 5.4 percent, which to tell you the truth, Mr. Secretary, what we are talking about is a cut below what we already pay, which is a round cost.

Why couldn't since we have to be budget neutral here, why couldn't we share the wealth a little bit and just give the Medicare+Choice $2.75 billion, and put the $1.25 billion into the fee for service plans and keep these people from dropping out of the plans?

Mr. THOMPSON. Congressman, you have the power and the authority to do that. We look at it in this situation under Medicare+Choice right now, 14.4 percent of the Medicare recipients are in Medicare+Choice plans. Last year, we lost 550,000 more individuals because the companies could not make a living or make a profit, and they pulled back.

Mr. NORWOOD. But you didn't actually lose them. What they did is they dropped out of that managed care plan.

Mr. THOMPSON. And went into fee for service.

Mr. NORWOOD. And they still had health care.

Mr. THOMPSON. Yes.

Mr. NORWOOD. My concern is about not having health care because the rural doc can't survive.

Mr. THOMPSON. And that is because of the 5.4, but that is also the law that was passed in this Congress in 1998 and 1999, and we have to change the law. CMS can only implement what the law says as you know.

Mr. NORWOOD. I understand that and that is clear to me, but the rules that are being given to us, even though we will change the law, means one or two things. We either have to be budget neutral in the entire budget.

Mr. THOMPSON. Right.

Mr. NORWOOD. Which is totally impractical to be budget neutral just within your budget. I am just telling you that we won't get there. Or we have to put it in the supplemental, because some of

us think that it is an emergency, and to keep the doctors out there treating over 65.

Mr. THOMPSON. It is very serious, and is something that we are very concerned with, and that's why we are working with Congressman Thomas and this committee, and the Ways and Means Committee, to make recommendations, and give this Congress a lot of options, in which they can look at and review.

Hopefully there will be some in there that will be able to be supported on a bipartisan basis.

Mr. NORWOOD. Well, I would ask the administration to give us a signal and we can put it in the supplemental, and that will solve that. Let me thank you on—and this is the last subject, Mr. Chairman—your work on privacy. You and I talked about this.

Mr. THOMPSON. Many times, and I appreciate your concerns.

Mr. NORWOOD. Chairman Tauzin brought it up today, and I just want to say for the record that it is absolutely critical, unless you want to waste millions, and millions, and millions of health care dollars.

Mr. THOMPSON. You are absolutely correct.

Mr. NORWOOD. And you can give us the fix for that.

Mr. THOMPSON. I am happy to be able to report that yesterday I signed the transmittal letter to OMB on these particular things. I am not at liberty under the law to discuss them until we publish them, but hopefully we will be going to the Federal Register relatively soon with recommendations, and I would love to have the opportunity to come up and discuss our changes with you.

Mr. NORWOOD. Well, Mr. Chairman, I hope that you will make that happen, and that then gives us a comment period; is that correct?

Mr. THOMPSON. That is correct.

Mr. NORWOOD. Well, time is of the essence.

Mr. THOMPSON. It is.

Mr. NORWOOD. And people get nervous, and they start wondering will I be able to obey the law, and what is the law.

Mr. THOMPSON. And you are absolutely right. And we want to make sure in the areas of research and consent that doctors and health providers are able to continue to do their business, and be able to do it in a practical way.

Mr. NORWOOD. The HHS Secretary was one heck of a job before 9-11, and it is an unbelievable job now, and I really sincerely thank you for what you are doing.

Mr. THOMPSON. The Governorship of Wisconsin never looked better.

Mr. BILIRAKIS. I would like to ask for unanimous consent to allow all members to submit written questions to the Secretary, and we will keep the record open for 5 days, and without objection, if Mr. Ganske has a quick question, and not a comment, but a quick question that requires a quick answer, we will allow it.

Mr. GANSKE. The Secretary may want to look into that box there. There may be a medicine in there that would help you with your job.

Mr. THOMPSON. Which one.

Mr. BILIRAKIS. Thank you, Mr. Secretary. Thank you so much for your time.

Mr. THOMPSON. Thank you, Congressman Bilirakis, and Congressman Brown, thank you.

Mr. BILIRAKIS. The subcommittee is adjourned.

[Whereupon, at 1 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

RESPONSES FOR THE RECORD OF HON. TOMMY THOMPSON, SECRETARY OF HEALTH AND HUMAN SERVICES

QUESTION SUBMITTED BY REPRESENTATIVE RICHARD BURR:

Question: It is my understanding that HHS has arranged with the Department of Defense to obtain over 218,00 doses of the existing anthrax vaccine, enough for post-exposure immunization of 73,000 individuals and pre-exposure immunization of about 36,000 "high risk workers," or some combination thereof. Is your Department examining the need for increased production of the anthrax vaccine at a second manufacturing site to meet civilian bioterrorism preparedness needs and/or as an insurance policy against a catastrophe or production stoppage at the current sole production site?

Answer: The Department of Defense (DOD) is negotiating with BioPort on behalf of both DOD and the Department of Health and Human Services for the purchase of Anthrax Vaccine Adsorbed, (BioThrax™). Secretary Thompson has requested the purchase of 0.5 million doses in FY02, 1.0 million in FY03 and 1.5 million in FY04 to meet civilian biopreparedness needs.

We have carefully examined the option of increasing production of AVA at a second production facility site and have instead opted to pursue the aggressive development of a second generation anthrax vaccine consisting of a highly purified recombinant component of Bacillus anthracis, the bacterium that causes anthrax. Abundant preclinical evidence is available to indicate that immunization with the recombinant protective antigen (rPA) of B. anthracis generates long-lasting protective immunity against inhalation spore challenge in animal models of the disease. At present, NIH is planning Phase 1 safety and immunogenicity trials in humans for rPA, and has committed significant funds for the accelerated development and manufacturing of this highly promising vaccine candidate. We are confident that accelerated development and production of an improved vaccine will offer significant advantages over subsidizing an additional production site for AVA.

QUESTIONS SUBMITTED BY REPRESENTATIVE JIM GREENWOOD:

Question (1): Congress made it quite clear when it passed BIPA that the so-called "self-injectible" provision was intended in part, to restore coverage for those thousands of Medicare beneficiaries who, up until 1997, had coverage and then abruptly lost that coverage due to a change announced through a HCFA policy memorandum. It has now been over a year since this direction to CMS was enacted and no action has been taken. While I understand CMS's stated concern of ensuring that the implementation of the provision does not have "unintended consequences" for beneficiaries or the trust fund, do you agree that CMS should at least restore coverage for those products that were covered until 1997?

Answer (1): The specific drugs paid for under CMS's policy varied across carriers both before and after the policy clarification that was issued in 1997. CMS's goal now is to implement the BIPA provision to be used by carriers. Considering that BIPA changed the statutory standard for which drugs are to be paid for when delivered incident to a physician's service, we believe the particular drugs that will be paid for under this provision should be determined by the criteria in the new process, regardless of the coverage by carriers prior to 1997.

Question (2): As you know, I have a continuing interest in establishing effective and workable standards for protecting the confidentiality of patient information. As the Department will be issuing modifications to the HHS privacy regulation through new rulemaking, I believe the Department should issue these changes expeditiously.

I am concerned that the research provisions of the final rule could disrupt vital health research efforts. Over 140 academic research institutions, medical specialty doctors, hospitals and others recently wrote you and warned of the potential problems caused by the rule. "[The rule] will seriously impair our ability to conduct clinical trials, clinicopathological studies of the natural history and therapeutic responsiveness of disease, epidemiologic and health outcome studies, and genetic research."

While there are problems that need to be addresses in many areas of the rule, a few key changes to the research provisions would go a long way toward instilling patient confidence that information about them will be used appropriately.

The requirement in the regulation that written consent be required for routine health care activities is clearly unworkable. What specifically will the new rulemaking propose for fundamentally fixing this provision? Will the NPRM give health care providers the flexibility they need by giving providers the discretion to decide when consent for use of information for treatment, payment and health care operations is needed?

What other changes will be made to the regulation to ensure that research will not be adversely affected? Will the Department change the de-identification standards so that researchers do not have such a high hurdle to reach and therefore end up using identifiable data, rather than de-identified data?

Answer (2): The Department published proposed improvements to the Privacy Rule in the Federal Register on March 27, 2002. President Bush and I believe strongly in the need for federal protections to ensure patients' privacy. The changes that we have proposed will allow us to ensure strong protections for personal medical information while improving access to care. They are common-sense revisions that would eliminate serious obstacles to patients getting needed care while, for the first time, providing federal privacy protections for patients' medical records.

The proposal is intended to ensure strong privacy protections while correcting unintended consequences that threaten patients' access to quality health care. The proposed rule includes provisions that would:

- Require a patient's prior authorization before a provider can use or disclose protected health information for non-routine purposes such as marketing or sharing with employers for personnel decisions;
- Protect the individuals' right to access their personal health information, to receive an accounting of disclosures that have been made of their health information, and have a medical record amended, if it contains incorrect or incomplete information, or to have a statement of disagreement included in the record;
- Strengthen the notice requirements that give patients an opportunity to understand and make decisions based on privacy practices, while removing burdensome prior consent requirements for the routine purposes of treatment, payment and health-care operations that created serious obstacles to patients' access to quality care;
- Explicitly prohibit marketing without individual authorization, while allowing doctors and other covered entities to communicate freely with patients about treatment options and other health-related information;
- Clarify that State law governs disclosures about a minor to a parent or guardian;
- Simplify the research provisions to allow for combined permissions and to more closely follow the Common Rule; and
- Provide model business associate contract provisions and allow covered entities up to an additional year to modify existing contracts to be compliant with the Rule. This extension does not apply to small health plans that already have an additional year to comply.

Specifically, with regard to the Privacy Rule's provisions regarding consent and research, the proposal would strengthen the notice requirements that give patients an opportunity to understand and make decisions based on privacy practices, while removing burdensome prior consent requirements for the routine purposes of treatment, payment and health-care operations that created serious obstacles to patients' access to quality care. Under the proposal, health care providers and other covered entities would have the discretion to decide for themselves whether to obtain an individual's consent to use or disclose the patient's information to carry out treatment, payment, or health care operations, and if so, the flexibility to decide how and when it is needed.

On research, the proposal would simplify the research provisions to allow for combined permissions and to more closely follow the criteria in the Common Rule for waiving the individual's consent. In addition, the proposal would permit certain identifiable data elements about an individual, such as zip code and dates of service, to be released for research purposes, while still ensuring that direct identifiers, such as name, address, and social security number, remain protected. As a further protection for the individual, the proposal would condition release of these limited data sets on the researcher's agreement to restrict further access and disclosure of the information.

The Department will take public comment on the proposed changes until April 26, 2002. Thereafter, we will act expeditiously to complete the rulemaking process.

Question (3): Of the many concerns I could raise about funding for mental health services, let me highlight one of the most troublesome. That budget proposes to eliminate altogether funding for *mental health-consumer technical assistance centers.* If our goal is to help mental health consumers around the country achieve independ-

ence through recovery from mental illness, why decimate a program specifically focused on consumers of mental illness and their path to recovery?

Among a number of proposed cuts, the Administration's budget for the Center for Mental Health Services (within the Substance Abuse and Mental Health Services Administration) would end all funding next year for the five centers that provide technical assistance (TA) to help mental health consumers around the country achieve independence through recovery from mental illness. The budget offers virtually no explanation for decimating consumer-support programs, currently drawing only $2 million, or less than 1 percent of the Substance Abuse and Mental Health Services Administration's (SAMHSA) discretionary funding for Programs of Regional and National Significance (PRNS).

Answer (3): The Center for Mental Health Services (CMHS), within the Substance Abuse and Mental Health Services Administration, leads Federal efforts in caring for the Nation's mental health by: providing effective services, generating and disseminating new knowledge as to the effectiveness of treatment, and supporting States and local communities to adopt evidence-based interventions. The involvement of consumers in these efforts is critical to their success. In fiscal year (FY) 2003, CMHS plans to continue support for a number of consumer activities in the States that will help consumers influence the development and adoption of these evidence-based interventions. States are required to have Mental Health Planning Councils, which include consumers, to review and comment on State mental health plans and reports relating to Community Mental Health Services Block Grant funding. SAMHSA supports the National Knowledge Exchange Network, which provides a wide range of information about mental health treatment and services to consumers. SAMHSA will also be continuing its State-wide Family Network Program, over $5 million in grants, which gives adults and families a voice in providing services for themselves and or their children. Among other things that this program supports are conferences and other activities to disseminate what we know works in the treatment of mental illness for consumers. SAMHSA's Consumer Operated Service Program ($5 million) supports the implementation of consumer delivered self-help and related consumer support services in 9 sites across the country to identify expected outcomes when self-help is used as an adjunct to traditional mental health treatment. Additionally, SAMHSA's Circle of Care program ($2 million) provides funds for tribal and urban Indian communities to plan, design, and assess the feasibility of implementing a culturally appropriate system of care for American Indians/Alaskan Natives children and their families.

Continued funding for the technical assistance centers is not included in the President's FY 2003 budget. As the Nation continues to address several critical needs, including relief from the September 11 attacks and subsequent acts of bioterrorism, difficult fiscal choices had to be made in developing the FY 2003 budget request.

However, to allow for an orderly transition to other funding sources and avoid any detrimental effects during the interim period, SAMHSA is proposing to issue a 1-year Guidance for Applicants to fund the existing consumer technical assistance centers for 1 additional year, including support for the Annual Alternatives Conference.

QUESTION SUBMITTED BY REPRESENTATIVE TED STRICKLAND

Question: Last year, the Department of Health and Human Services launched its Health Insurance Flexibility and Accountability initiative to allow states to use the section 1115 waiver process to expand Medicaid coverage to populations that weren't previously covered.

As you know, community health centers are a priority of bipartisan majorities in this Congress and with President Bush. In 2000, Congress passed legislation ensuring that health centers received adequate reimbursement under Medicaid through a prospective payment system. In so doing, Congress explicitly stated that health centers are unique providers, in need of unique payment protections if they are to fill their statutory mission to provide care to the uninsured.

Earlier this year, your Department approved an 1115 HIFA waiver for the state of Utah. This waiver expands care to previously uninsured individuals but also allows the state to waive the PPS requirements for health centers that serve this expansion population.

I am extremely concerned that the department's approval of these waivers will undermine the very public commitment that Congress and the Administration have placed on health centers. It also allows states to exploit the good will and support of health centers through expanded funding for health centers by "robbing peter (Federal appropriations) to pay Paul (Medicaid)."

This is a very important issue to me—Ohio's Medicaid program was under an 1115 waiver and health centers were reimbursed only a fraction of their costs under that approved waiver.

Can you give me assurances, as well as the 80% of the members of this subcommittee that cosponsored the PPS legislation, that the Department of Health and Human Services will not approve future HIFA waivers that waive health centers' PPS reimbursement requirements under Medicaid?

Answer: We certainly do not envision HIFA serving as a vehicle to undermine Congress's intent in establishing a PPS methodology for payment of health centers. While the HIFA guidance mentions the flexibility states may exercise with respect to benefits and cost sharing, waivers of PPS requirement are not mentioned, either in the HIFA guidance or the application template.

As you know, the State of Utah recently received approval to implement a section 1115 demonstration that expands coverage. This demonstration is not a part of the HIFA initiative. It is true that Utah has a waiver of the PPS requirement for services rendered to the expansion population. The administration granted this waiver only after careful consideration of the implications, including the benefit of providing coverage to individuals who were previously uninsured. Any care Federally Qualified Health Centers (FQHC) were previously giving to these individuals was likely not reimbursed.

Any future request for a PPS waiver, whether part of a HIFA or non-HIFA proposal, would be treated in the same fashion. The request would be carefully reviewed, taking into consideration all implications.

QUESTIONS SUBMITTED BY REPRESENTATIVE EDOLPHUS TOWNS

Question (1): I have joined my colleagues, Chairman Bilirakis and Mr. Greenwood, in urging HHS since February 2000 to resolve the issue of coverage for injectable drugs. Can we get this issue resolved through a policy memorandum rather than a long rulemaking process?

Answer (1): As you may know, the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) amended the statute to define drugs covered "incident to" a physician's services as those drugs "which are not usually self-administered by the patient." The prior statutory standard had been drugs "which cannot . . . be self-administered."

Unfortunately, the new wording is not entirely clear. For example, there are several meanings that could be given to the terms "usually" and "by the patient", as well as questions about whether particular categories of drugs should be presumed to meet, or not meet, these criteria. It's a complicated issue and we are committed to getting it right. Without proper guidance to Medicare's carriers, this provision could cost many billions of dollars. It was scored by CBO as costing $100 million in the first year, and $1.1 billion over 5 years, but if defined more expansively than intended, it could cost much more.

We are now looking at data provided by our carriers and consulting with our professional clinical and legal staffs to help us determine how best to write our guidance on this issue. We expect to have a policy decision soon and will continue to keep you informed regarding all of our efforts.

Question (2): I believe that we have a real opportunity to address the issue of genetic non-discrimination this year. The President has voiced his support for it and it also has bipartisan support in this Committee and in the Congress. Can we count on the cooperation of HHS' technical staff so that the Committee can act on a bipartisan bill this year?

Answer (2): The technical staff at the National Human Genome Research Institute (NHGRI) at NIH and the Department have been providing assistance to members of the House, on both sides of the aisle, for a number of years. They have assisted in educating members and staff about the advances in genetic research, the development of genetic tests, and how such tests are used. The President and I agree that genetic discrimination should be made illegal and we will continue to provide whatever level of technical guidance that may be needed.

Question (3): What is your timeframe for appointing Directors for each Institution at NIH to ensure implementation and accountability of the proposed activities in the FY 03?

Answer (3): All appointments of NIH Institute and Center Directors involve a national search to identify individuals with outstanding scientific and leadership skills for the position. A broadly representative search committee representing (including representatives from both inside the NIH and from outside scientific and patient organizations) is charged with identifying candidates, reviewing applications, and rec-

ommending a list to the NIH. Following this process, the (Acting) Director, NIH, interviews the candidates and makes a tentative selection.

National Institute of Biomedical Imaging and Bioengineering (NIBIB)—The Acting Director, NIH, has made a tentative selection for the Director, NIBIB, and the recommendation is being forwarded to the Secretary this week.

National Institute of Neurological Disorders and Stroke (NINDS)—The Acting Director, NIH, has extended an offer to a candidate for the Director, NINDS, and is awaiting a decision from that individual.

National Institute of Mental Health (NIMH)—The vacancy announcement for the Director, NIMH, closed on March 30, 2002.

National Institute on Drug Abuse (NIDA)—The vacancy announcement for the Director, NIDA, closed on April 8, 2002.

It is anticipated that the Search Committees for NIMH and NIDA will start interviewing applicants and completing reference checks mid-April and refer highly qualified candidates to the Director, NIH, by mid-May.

National Institute on Alcohol Abuse and Alcoholism (NIAAA)—The vacancy announcement for the Director, NIAAA, closes on May 1, 2002.

National Institute of General Medical Sciences (NIGMS)—Regarding the vacancy for the Director, NIGMS, the membership of the search committee is being finalized; we anticipate that the announcement will probably be posted late March/early April 2002.

Question (4): What is the status of the Presidential Commission's Report on Complimentary and Alternative Medicine?

Answer (4): The Report was completed by the White House Commission on Complementary and Alternative Medicine Policy and was delivered to the President on March 25, 2002. Copies of the Report were delivered to the House Energy and Commerce Committee and the Senate Health, Education, Labor, and Pensions Committee. The Report is available on the web site for the White House Commission at http://www.whccamp.hhs.gov/finalreport.html .

QUESTIONS SUBMITTED BY REPRESENTATIVE JOSEPH PITTS

Question (1): Mr. Secretary, as you may recall, I raised concern with you late last year regarding Advanced Cell Technology, the company that announced it had succeeded in cloning a human embryo. I wrote to you with my concern that ACT received a federal grant even though it is involved in scientific pursuits that the House has voted to ban and the President opposes. I have enclosed several documents on this issue I would like included in the Congressional Record.

You responded very quickly to my letter and assured me that the Department of Health and Human Services supports the House passed H.R. 2505, "Human Cloning Prohibition Act of 2001," and that you asked the Inspector General at HHS to investigate this matter and report back to you.

Thank you for your prompt response on this matter. I would only ask if you have received a report from your Inspector General and what other steps the Department is taking to make sure that taxpayer funding is not going to groups that are attempting human cloning or creating embryos specifically for research?

Answer (1): The Inspector General informed me that the final report of her audit was issued to ACT on April 26, 2002. I have also received a copy of that report.

NIH grants management and program officials work closely with grantee institutions to assure compliance with all applicable laws, regulations, and policies. Section 510 of Public Law 107-116 (the Departments of Labor, HHS, and Education, and Related Agencies Appropriations Act of 2002), prohibits the use of appropriated funds to support certain human embryo research, including cloning. Quoting this provision, the NIH Grants Policy Statement states that NIH funds may not be used for the creation of a human embryo(s) for research purposes or for research in which a human embryo(s) is destroyed, discarded, or knowingly subjected to risk of injury or death greater than that allowed for research on fetuses in utero under 45 CFR 46.208(a)(2) and subsection 498 (a) and (b) of the PHS Act. The term "human embryo(s)" includes any organism not protected as a human subject under 45 CFR 46, as of the date of enactment of the governing appropriations act, that is derived by fertilization, parthenogenesis, cloning, or any other means from one or more human gametes or human diploid cells.

In addition, the Policy Statement also notes that a March 4, 1997 Presidential Memorandum prohibits NIH from using Federal funds for cloning of human beings.

If a grantee is using non-Federal dollars for research that would be prohibited by Section 510 of Public Law 107-116, it must be able to demonstrate a clear separation between the non-Federal dollars used for that activity and Federal funds awarded for a permissible activity.

Question (2): I have a few questions about the Title X program enforcing compliance with state rape and child abuse reporting laws. Since the Fiscal Year 1999 Labor/HHS/Education Appropriations Bill was signed by President Clinton, and every subsequent year, it has been the law of the land that Title X family planning providers must obey state laws requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape or incest. Current law, signed into law by President Bush states: SEC. 212. Notwithstanding any other provision of law, no provider of services under Title X of the Public Health Service Act shall be exempt from any state law requiring notification or the reporting of child abuse, child molestation, sexual abuse, rape or incest.—P.L. 107-116 (H.R. 3061)

(a) Mr. Secretary, what guidance has your agency developed to inform regional administrators, grantees and providers of these legal requirements which may, for example, require them to notify child protective services agencies if these types of abuse are suspected?

Answer (2a): On January 12, 1999, the Office of Population Affairs (OPA), which administers the Title X Family Planning Program, issued a memorandum to Regional Health Administrators regarding these requirements. This memorandum, which sets out "OPA Program Instruction Series, OPA 99-1: Compliance with State Reporting Laws," was intended to serve as a formal notice to the Regional Health Administrators, Regional Office Family Planning Program staff, and Title X Grantees that Title X providers must report incidents of child abuse, child molestation, sexual abuse, rape, or incest to the appropriate State authority in accordance with requirements imposed by State laws. This Program Instruction remains in effect. Additionally, Regional Offices are encouraged to utilize available resources, such as Title X training centers and technical assistance contractors, to make certain all Title X providers are aware of their responsibilities under individual State laws, and are equipped to handle sensitive situations.

A copy of "OPA Program Instruction Series, OPA 99-1: Compliance with State Reporting Laws" is attached.

(b) Please provide any procedures established by the Office of Population Affairs to monitor compliance with this provision.

Answer (2b): The Office of Population Affairs monitors Title X Family Planning service grantees for compliance with all program requirements through several mechanisms, both written and observational. Written monitoring occurs through annual grant continuation applications, and reviews of written grantee policies and procedures. On-site monitoring of grantees through site visits occurs annually, and comprehensive, on-site program reviews occur every three years.

(c) Do federal confidentiality requirements, or any other requirements, preclude Title X providers from asking a recipient's age or date of birth?

Answer (2c): No—there are not any Federal confidentiality requirements, or any other requirements that preclude Title X providers from asking a recipient's age or date of birth.

DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF THE SECRETARY
ASSISTANT SECRETARY FOR HEALTH
OFFICE OF PUBLIC HEALTH AND SCIENCE
Washington, DC 20201

TO: Regional Health Administrators, Regions I-X
FROM: Deputy Assistant Secretary for Population Affairs
SUBJECT: OP A Program Instruction Series, OP A 99-1: Compliance with State Reporting Laws

The Fiscal Year 1999 Omnibus Appropriations bill (P .L. 105-277) contains new language governing the use of Title X funds. Specifically section 219 states,

> *Notwithstanding any other provision of law, no provider of services under title X of the Public Health Service Act shall be exempt .from any State law requiring notification, or reporting of child abuse, child molestation, sexual abuse, rape, or incest.*

This memorandum is intended to serve as a formal notice to the regional offices, as well as Title X grantees, concerning compliance with State reporting laws. A copy of this memorandum should be provided to all Title X grantees in your region, and Title X providers should refer to this memorandum as needed, if questions in this area arise.

The language of section 219 means that Title X providers must report such incidents to the appropriate State authority in accordance with requirements imposed by State laws. The reporting and notification requirements referenced in section 219

concern State laws; the authority to enforce compliance with such laws lies with the States. It is therefore important that grantees review and be familiar with the relevant reporting requirements in their individual State. Because State laws vary, it is not possible for this office to provide more specific guidance as to the requirements of particular States' laws; grantees are urged to consult with their own attorneys for specific guidance.

Identified instances of child abuse, child molestation, sexual abuse, rape, or incest present serious medical and psychological situations for patients and their families. Findings of such instances coming within the applicable State law should be documented in the medical record and reported as required by the applicable State requirements. The Office of Population Affairs encourages efforts to augment existing training programs for Title X providers to ensure optimal medical assistance in such situations. Grantees should fully understand their obligations under State law related to reporting when such acts or actions are disclosed, and they should review current protocols for responding to such reports. We also encourage enhanced counseling and education efforts targeted to the unique needs of adolescents. Title X providers are encouraged to continue to work at the local level in an interdisciplinary manner with other local health care providers who may also have reporting obligations under State law, law enforcement officials, child protective services, social service experts and others in order to explore how best to respond to these situations. To accomplish this, regional offices and Title X grantees are encouraged to utilize resources available through the regional training centers and the technical assistance contractor, as well as other available resources.

We appreciate your continued cooperation in assuring that grantees are aware of their obligations and hope this memorandum provides clarification on this matter.

cc: Regional Program Consultants, Regions I-X

PREPARED STATEMENT OF COLLEGE OF AMERICAN PATHOLOGISTS

The College of American Pathologists (CAP) is pleased to submit this statement for the record of the Energy and Commerce Health Subcommittee hearing on the Department of Health and Human Services' fiscal 2003 budget request. The College is a medical specialty society representing more than 16,000 board-certified physicians who practice clinical or anatomic pathology, or both, in community hospitals, independent clinical laboratories, academic medical centers and federal and state health facilities.

As Congress considers the HHS budget request for the next fiscal year, the College asks that lawmakers give special attention to two issues important to ensuring quality health care for all Americans and access to that care.

BIOTERRORISM PREPAREDNESS

The nation's clinical laboratories and the pathologists who provide medical direction in those facilities form the front line in the battle against bioterrorism. Because these laboratories often serve as the point of entry for specimens that may be infected with biological agents, it is essential that laboratory personnel be adequately educated, trained and prepared to rapidly respond.

The College applauds President Bush for his administration's efforts during the past six months to support this goal and improve the nation's ability to prepare for and respond to the bioterrorism threat. The College also appreciates the efforts of Energy and Commerce Chair Billy Tauzin, ranking member John Dingell and other committee members for their bipartisan efforts last year in support of the Public Health Security and Bioterrorism Response Act of 2001, H.R. 3448.

This legislation would expand education and training for medical personnel, enhance controls of biological agents and waive certain Medicare requirements during public health emergencies. Further, the bill would make grants available through HHS to professional societies and private accrediting organizations to educate and train medical personnel and develop proficiency testing programs that, using nonlethal samples of biological agents, help laboratories hone their ability to detect infectious agents likely to be used in bioterrorist attacks. This approach is commendable, as these professional organizations are frequently best suited to assess and meet the education and training needs of their members.

The bill tightens regulatory control of biological agents without imposing undue burdens on clinical laboratories that diagnose and verify the presence of these agents in the course of patient care. Also, H.R. 3448 contains a provision crucial to the ability of laboratories to respond swiftly to acts of bioterrorism: authority for the HHS Secretary to waive certification requirements for clinical laboratories in the

case of a national emergency. Under the Clinical Laboratory Improvement Amendments of 1988 (CLIA), certain requirements are established for the inspection and certification of laboratories. In times of national emergency, it may be necessary to waive these requirements to ensure adequate access to clinical laboratory services.

The College urges the subcommittee to ensure that HHS funding for fiscal 2003 include support for bioterrorism preparedness as provided for in Public Health Security and Bioterrorism Response Act of 2001.

MEDICARE PHYSICIAN PAYMENTS

On January 1 of this year, Medicare's annual update to physician payments produced a 5.4 percent cut that may jeopardize physician participation in the program and, ultimately, beneficiary access to care. Despite evidence that a flawed formula behind the annual update caused this reduction, the administration budget request for fiscal 2003 contemplates no additional spending to correct the problem.

The CAP thanks Health Subcommittee Chair Michael Bilirakis, ranking subcommittee member Sherrod Brown and other committee members for their introduction last November of legislation to substantially reverse the January 1 reduction and replace the flawed "sustainable growth rate" (SGR) system behind Medicare's annual updates with a formula that more accurately reflects physicians' practice costs. The College greatly appreciates the subcommittee's early efforts to address this problem and urges passage of legislation this year to mitigate the harmful effects of the January 1 reduction and improve the payment formula for coming years.

This year's 5.4 percent reduction affects pathologists profoundly and exacerbates existing financial pressures brought on by increasingly complex and costly regulatory requirements and rising liability insurance rates. The January 1 reduction in payments is the fourth payment cut—and the largest—since Medicare instituted its physician fee schedule a decade ago. Since 1991, Medicare physician payment rates have risen an average of only 1.1 percent annually, or 13 percent less than the annual increase in practice costs, as measured by the Medicare Economic Index. Further, the January 1 reduction comes on top of cuts to pathology services made in the transition to resource-based practice expenses, such as an 11.5 percent drop in payment over four years for the diagnosis of breast cancer, prostate cancer and malignant melanoma.

Pathologists and other physicians cannot continue to sustain the financial pressures the Medicare program has placed upon them. Compounding the current problem of falling payment rates are numerous new administrative requirements imposed on Medicare providers in recent years. For example, documentation requirements necessitated by Medicare program integrity initiatives and various provisions of the Health Insurance Portability and Accountability Act of 1996 have created substantial new paperwork burdens in laboratories and physician offices, and more are expected in coming years. These requirements raise the cost and complexity of providing care, but come with no additional compensation. We appreciate this Committee's commitment to reducing regulatory burdens, as well as the efforts of the Centers for Medicare and Medicaid Services. Yet, this relief cannot serve as a substitute for what is really needed: an alternative payment approach that meets the needs of Medicare patients and better reflects the costs of their care. Further adding to the burden on providers are rising professional liability insurance rates and the cost of technological advances critical to maintaining state-of-the-art medical care.

The 2002 payment cut stems from the flawed SGR formula. This system inappropriately reflects downturns in the general economy and that, along with data errors by the Centers for Medicare and Medicaid Services, have short-changed physicians by $15 million since 1998. The Medicare Payment Advisory Commission (MedPAC) warned last year that significant cuts in 2002 "could raise concerns about the adequacy of payments and beneficiary access to care." MedPAC adopted a recommendation that Medicare replace the SGR with a system based on estimated changes in physician practice costs less an adjustment for growth in multifactor productivity (labor, supplies and equipment—not just labor, as is now the case).

MedPAC's concerns regarding access must not be taken lightly. Experiences with Medicare+Choice disenrollment and Medicaid patient access give ample evidence of the need to maintain adequate payment to ensure adequate access. This year's reduction and future cuts that are likely absent immediate changes to the update system will force some physicians to discontinue accepting new Medicare patients, switch from participating to non-participating provider status, reduce administrative staff, retire early or take other actions to limit their Medicare liability. It is unfortunate that those same actions likely will jeopardize Medicare patients' access to care.

The College thanks the Subcommittee on Health for the opportunity to present its views on these important issues and offers its support and continued assistance

as the administration and Congress work to address these pressing issues in coming months.

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
March 14, 2002

The Honorable TOMMY G. THOMPSON
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

DEAR SECRETARY THOMPSON: Thank you for participating in the House Energy and Commerce Committee Subcommittee on Health hearing on March 13, 2002. During the hearing we discussed whether the American Indian and Alaska Native (AI/AN) tribes would be included in the methodology for the $25 million for Healthy Communities Innovation Initiative, which includes a new initiative on diabetes. I would like to take this opportunity to follow up on our discussion.

As you know, one of the fastest growing, most costly, and most deadly diseases is diabetes, with an estimated 800,000 new cases diagnosed every year. At a general population growth rate of almost 6% per year, the Centers for Disease Control (CDC) is calling diabetes "the epidemic of our time." Diabetes currently costs the U.S. approximately $100 billion and kills approximately 200,000 people every year. If we do not take immediate and dramatic steps to reverse this trend, over the next decade diabetes will cost this country $1 trillion and claim over 2 million lives.

Diabetes, in the last half of this century, has severely impacted American Indian/Alaskan Native (AI/AN) communities. In some AI/AN communities, 60% of the adults have been diagnosed with diabetes (Position Statement from Indian Health Services National Diabetes Program). A recent Indian Health Service (IHS) study shows a steady increase in the rate of diagnosed diabetes in AI/AN adolescents and young adults. (Interim Report to Congress Special Diabetes Program for Indians, January 2000)

Traditionally, AI/AN communities were not susceptible to diabetes due to the traditional food sources they consumed. However, their lifestyle has shifted to a decrease in physical activity and an increase in high calorie-high fat diet. If the general population is experiencing a diabetes epidemic, then the AI/AN people are in an even more serious diabetes health situation.

Given such realities, I would like to know if the methodology for the $25 million Healthy Communities Innovation Initiative will include AI/AN tribes for diabetes prevention? According to your written testimony to the House Energy and Commerce Committee Subcommittee on Health (3/13/02), you state that five communities will participate in this initiative. I am hopeful AI/AN communities will be considered for participation in this initiative. Clearly, such funding is necessary to support continued diabetes research and prevention activities in AI/AN communities.

I look forward to your response.

Sincerely,

FRANK PALLONE, JR.
Member of Congress

U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
March 15, 2002

The Honorable TOMMY G. THOMPSON
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

DEAR SECRETARY THOMPSON: Thank you for participating in the House Energy and Commerce Committee Subcommittee on Health hearing on March 13, 2002. During the hearing, we discussed whether American Indian and Alaska Native tribes have access to the homeland and bioterrorism security funds available to the Department of Health and Human Services. I appreciate your statement that Indian tribes are eligible for both homeland and bioterrorism security funds, and that you will notify them of their eligibility. I would like to take this opportunity to follow up on this discussion.

Due to the events of September 11, 2001, the need for both state and tribal governments to have established and viable emergency management services is very apparent. I have spoken with numerous American Indian tribal representatives during the past six months, and have learned that they are very concerned that their governments will be left out of this homeland and bioterrorism security initiative.

As you may know, the 10th U.S. Circuit Court of Appeals recently ruled that, "Indian tribes are neither states, nor part of the federal government, nor subdivisions of either. Rather, they are sovereign political entities possessed of sovereign authority not derived from the United States, which they predate." In addition, the United States Government committed to a trustee relationship with the Indian Nations. Defined by treaties, statutes and interpreted by the courts, the trustee relationship requires the federal government to exercise the highest degree of care with tribal and Indian lands and resources. Given these legal factors, I believe Indian tribal governments need to be included in the homeland and bioterrorism security plan and adequate funding needs to be made available to support such efforts.

I learned from you during the hearing that once the President signed into law the homeland and bioterrorism legislation on January 10, 2001, a letter was sent to all governors entailing the homeland security funds available to states. I also recently learned that the Bush Administration has given State governors 60 days to meet with their state and local health services officials concerning development of homeland and bio-terrorism security preparation plans. The governors are then to submit their plans to the federal government for funding support. Unfortunately, American Indian tribes and their health departments are not specified in this plan, and thereby appear to be completely left out of the important process of securing our entire nation from terrorist threats. Similar to state governments, Indian governments have citizenry to protect as well and should have access to the available funds.

Given this current situation, I respectfully request that letters be sent to tribal leaders nation wide to inform them that these homeland and bioterrorism security funds are available to them. This is crucial to ensuring that our homeland is secure from bioterrorist activity.

Please provide me with a timeline of when you will be notifying the Indian tribes regarding their eligibility to access homeland and bioterrorism security funds.

I look forward to your response.

Sincerely,

FRANK PALLONE, JR.
Member of Congress