

**PRESIDENT'S FISCAL YEAR 2008 BUDGET
(MEDICAID AND MEDICARE PROPOSALS)**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED TENTH CONGRESS
FIRST SESSION

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FEBRUARY 7, 2007
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**PRESIDENT'S FISCAL YEAR 2008 BUDGET
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WEDNESDAY, FEBRUARY 7, 2007

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

The hearing was convened, pursuant to notice, at 10:03 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Rockefeller, Bingaman, Kerry, Wyden, Schumer, Stabenow, Cantwell, Salazar, Grassley, Hatch, Snowe, Kyl, Smith, and Roberts.

**OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR
FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE**

The CHAIRMAN. The committee will come to order.

The prophet Ezekiel admonished his nation's leaders: "Woe to the shepherds of Israel. The weak you have not strengthened, nor have you healed those who were sick, nor bound up the broken."

Mr. Secretary, you at the Department of Health and Human Services and we at the Committee on Finance have a similar duty. We have a duty to be good shepherds. We have a duty to strengthen the weak, to heal the sick, and to bind up those who are broken.

The budget is where we do that. The budget answers the questions: will we strengthen the Nation's poor, will we heal children, and will we care for the Nation's elderly?

This year, Congress has a once-in-a-decade opportunity to strengthen the health of our Nation's children, improving and expanding the State Children's Health Insurance Program, or CHIP, the committee's top health care priority this year.

Here are my five priorities for CHIP. First, we must give CHIP enough money to maintain coverage for those whom it already serves. Second, we must work to reach the 6 million uninsured children now left behind, those who are eligible for CHIP or Medicaid, but not enrolled. Third, we must support State efforts to use CHIP to cover more children. Fourth, we must improve the quality of health care under CHIP. Fifth, we must not increase the number of Americans without health insurance.

The administration's budget would not achieve these goals. The budget for CHIP is not that of a good shepherd. The budget provides for \$5 billion in new funding for CHIP, and that is only about a third of what we will likely need just to maintain current services.

Equally troubling are the budget's policy changes. Many States are employing CHIP to expand access to all children, but the administration's policies would undermine these efforts. The budget would do so by lowering funding rates for children and families with incomes more than twice the poverty level.

Today, a family of three with an income of twice the poverty level makes a little more than \$34,000 a year, but an average family health care plan costs about \$12,000. The budget would put health coverage out of reach for low-income working families. In effect, the budget would tell them that they should spend more than a third of their income on health insurance.

The budget's proposals threaten the remarkable success of the CHIP program. If Congress were to enact these proposals, more than one million children and 600,000 of their parents, caretakers, and other low-income adults could lose health coverage.

In my own State of Montana there are more than 37,000 uninsured children, and across the Nation, nearly 9 million, but the administration's proposals would do little to help States respond to this growing crisis. It says to States like Montana that are trying to do the right thing and expand coverage: we are not with you.

And by short-changing CHIP on funds and lowering the Federal share for children above 200 percent of poverty, this budget could actually contribute to even more children becoming uninsured.

The administration's budget would also make it harder to heal the Nation's poor. I have deep concerns about the budget's more than \$26 billion in Medicaid cuts.

The budget calls for \$14 billion in legislative changes to Medicaid. That is twice the size of the \$7 billion of Medicaid cuts that Congress narrowly approved in the last Congress, after a bitter fight, in the Deficit Reduction Act. Cutting Medicaid again so much, so soon, is too big a hit for this critical safety net program.

And the administration's budget would make it harder to care for the Nation's elderly. The budget offers drastic across-the-board cuts in Medicare payments to providers, but those cuts fall only on fee-for-service programs.

The budget would cut payment updates for hospitals, nursing homes, home health care agencies, you name it, by 1 percent indefinitely. This would undermine access to care in a traditional program, especially in States like Montana.

Rural areas would be most hurt by sustained cuts to hospitals. Why? Ninety-five percent of Medicare beneficiaries, at least in my State, choose fee-for-service—they do not have the option of other plans—and I will not turn my back on these seniors.

In addition, the budget exempts the Medicare Advantage program from cuts. The budget shaves 1 percent off of traditional Medicare forever, but the budget does not touch Medicare Advantage plans.

This policy lends credence to those who believe that the administration is attempting to privatize entitlements. The American public has soundly rejected that ideology, witness Social Security privatization.

I share the present concern about rapidly rising health care spending. Health care costs are consuming more of the Federal budget each year, and they undermine our Nation's economic lead-

ership. For the sake of our Nation's elderly and disabled, we need to secure the long-term sustainability of Medicare. I am disturbed by the administration's approach.

Instead, we should roll up our sleeves and enact targeted changes where Medicare is overpaying for products and services. I have been working to identify those areas. Working together with my colleagues on both sides of the aisle, we can make a stronger, more efficient, and more sustainable Medicare.

And the administration has not been a good shepherd for Medicare's prescription drug program. The only change the budget proposes is to raise premiums for high-income beneficiaries. I helped to write that law, that is, to create the Medicare drug benefit, and I still support it. But the law is not perfect, and neither was its implementation.

I believe this committee should work together to make modest improvements to the drug benefit. The program should be more simple, more accessible for all Medicare beneficiaries, and we must do a better job enrolling beneficiaries where eligible for the low-income subsidy.

So, Mr. Secretary, you at the Department and we here at the committee have much work ahead of us. Let us work together to strengthen the Nation's children. Let us work together to heal the Nation's poor. Let us, together, work to care for the Nation's elderly. Together, we have the opportunity to be the good shepherds that our duty and Nation require.

One more final point here. I will tell you what is so disturbing about all of this. This budget cuts. It cuts drastically. I guess the rationale is, well, we have entitlement growth in Medicare and Medicaid, so therefore Medicare and Medicaid should be cut. That is the rationale. It is attacking the symptoms, not the problems.

Why are Medicare and Medicaid going up so much? Why? There are a lot of reasons. One is a big increase in health care costs for everybody, those on Medicaid, those on Medicare, private pay, everybody.

We, therefore, should focus on the underlying causes, not so much the symptoms. I know it is difficult, but I think the administration will be doing this country a much greater service working with this committee and other committees in the Congress to find ways to lower the underlying causes of the increases in Medicare and Medicaid rather than the symptoms, just lopping and cutting off. Lopping and cutting off is going to transfer. It is going to transfer costs someplace else and push up the balloon someplace else, private pay, you name it. If you drop Medicaid, you go to the emergency room. People are getting cared for. It is uncompensated care. It is just not solving the problem here. It is just pushing it off to somebody else.

It looks like the administration is trying to promote an ideology that is to privatize. Rather than attempting to address the underlying causes, you are addressing the symptoms, and you are doing it in a way that privatizes. That is what it looks like, and that is what I find disturbing.

Rather, let us address the underlying causes together in a non-ideological way so that we can care for people who need to be cared

for and do even greater service by cutting the underlying costs for health care.

Senator Grassley?

**OPENING STATEMENT OF HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA**

Senator GRASSLEY. Yes. Thank you very much for holding this hearing, and, taking up where the Chairman left off, I would simply say that I think the administration is trying to do some things in this area with health IT, with the efforts through health savings accounts, with the efforts in the most recent budget of the health insurance program, the taxing of it and using the money that comes from that to help people who do not have health insurance.

There are a lot of other things that need to be done, but I think you are going down that direction. Yet, we still have a very major problem in Medicare and Medicaid. As encouraging as the short-term fiscal outlook may appear, we cannot ignore the discouraging long-term fiscal outlook for these programs.

Earlier this year we had the Federal Reserve head, the Government Accountability Office, the Congressional Budget Office, that have all testified before another committee, the Senate Budget Committee, on the impact of entitlement spending. People like General Walker are going all over the country with another group of people to bring up the siren call of the problems of entitlement spending.

So, I think that Senator Baucus is right about the underlying causes. We can deal with the underlying causes, but we still have terrible entitlement problems, although solving those underlying problems will help solve the Medicare and Medicaid problems.

So we have had all these people raising these alarms about Medicare and Medicaid. In reality, these proposals only slow the growth of Medicare by 2012 by less than one percentage point.

If Congress enacted all of the Medicaid proposals, it would change the annual growth of Medicaid merely from 7.2-percent growth to 7.1-percent growth, one-tenth of one percent.

Now, there is an outcry, and I know how difficult it is to deal with this, because we dealt with it just 12 months ago, to finalize a proposal to save, what, X number of dollars, \$39 billion, maybe, over 5 years, which is kind of a spit in the ocean, and it was difficult. So it is very difficult to do.

But if the average Iowan were hearing us debate about whether we ought to grow Medicaid by 7.2 percent or 7.1 percent and that we were fussing over one-tenth of one percent, they would say, "You guys do not live in the real world. What planet did you come from?"

Yet, when they would say that, they would wonder whether we were really taking seriously the budget problems, and they probably would not understand how difficult it is, at least politically difficult.

But it still is a spit in the ocean compared to what we are talking about. It is clear, as baby boomers become eligible, that the situation is going to get much greater all the time and that Medicaid, Medicare, and Social Security are already 40 percent of the Federal expenditures and 8 percent of GDP. Many of us here will recall,

last year there were efforts to modernize Social Security to help its long-term viability, and we did not get very far in doing that because it is so politically sensitive.

So here we are a year later. I certainly hope that we can work in a bipartisan way to address how entitlements such as Medicare are taking up more and more of the Federal budget. Over the years, efforts have been made to slow the rate of growth of entitlements.

Last year, the trustees of Medicare made an official determination of "excess general revenue Medicare funding," as Congress required in the Medicare Modernization Act, as we call it. If the trustees make a similar determination this year, the Medicare Modernization Act requires the President to propose legislation to address entitlement spending in next year's budget.

During last year's committee hearing on the fiscal year 2007 budget, I do not think that I shocked anyone by saying that any more reductions of a significant scope could be difficult to achieve that year, especially after we had just passed the Deficit Reduction Act.

I do not think I will shock anyone today by saying that any more reductions of significant scope will be very difficult. I think, as you hear the Chairman, you know just how difficult that is going to be.

One area we will probably need to address this year is physicians' payments. That SGR is unsustainable over a long period of time and is a flawed formula.

A key priority of the Senate Finance Committee this year is going to be the reauthorization of the SCHIP program. I want to associate myself with the remarks of the Chairman that he made during the SCHIP hearing last week that puts SCHIP authorization at the top of the agenda in the health area of this committee.

I am interested in learning more about what the President's plan is to reauthorize SCHIP and look forward to working in a bipartisan manner, and with the White House, to accomplish that.

The President's budget achieves a substantial portion of its savings from Medicare provider payment reductions. Many of these recommendations go further than what MedPAC suggested.

In addition to looking at payment updates, I continue to strongly support linking provider payments to quality care as a way to make sure that Medicare is a better purchaser of health care services. Today, Medicare rewards poor quality care. This is just plain wrong, and we need to address that.

I also appreciate President Bush's leadership in putting forward a plan to help more Americans get health insurance. I have addressed that as part of something very important to help the underlying problem that the Chairman has spoken about, because there are 47 million Americans who do not have health insurance.

There is no one-size-fits-all solution to the uninsured problem, because people are uninsured for a lot of different reasons. So, we need new strategies to solve that persistent problem. The President's proposal is a good step in that direction, but even the President would say it does not take care of the needs of all of the uninsured.

We need to make sure that those benefits are being directed wisely, getting the most bang for the taxpayers' buck, as well as the private dollars that are spent on health care.

A plan like the President's could help level the playing field by extending the tax incentives for purchasing health coverage to self-employed and those who purchase health coverage on their own.

It also would make health insurance portable, which is something that is very necessary in this modernized, fast-moving economy that we have, not only in the United States but all over the world.

Before I conclude my opening remarks, there is one more issue that I would bring to the attention of the Secretary. As Chairman of the committee in the 109th Congress, I made many requests of HHS and its related agencies for information and access to people and numerous documents.

Many of the responses to those requests remain long overdue. For example, I discussed with you our longstanding request for a privileged log of the Ketek matter, and I still have not received one. At this point in time it is my understanding that your staff has been instructed to ignore my outstanding committee request, since I am no longer Chairman of the committee.

Consequently, I formally sent a letter to your office outlining my concerns in hopes that some light can be shed on the so-called longstanding policy—and I question whether or not it is longstanding policy regarding responses to outstanding Congressional requests that were made prior to a change in leadership, and what does the change in leadership have to do with things that are made like that?

In fact, just last week I was advised that there was certain information that I would not be provided. I had my staff request a letter articulating the so-called policy in anticipation of this hearing, but yet again I did not receive what I requested.

I think it is important for members of both parties to understand why the administration believes it can simply ignore legitimate requests from Congress as we attempt to conduct oversight.

We cannot, as members of Congress, successfully carry out our constitutional responsibilities to conduct oversight when Congressional requests for access to the executive branch are disregarded.

Mr. Chairman, I am done.

The CHAIRMAN. Yes. Thank you, Senator.

Secretary Leavitt, obviously the last statement by the Senator from Iowa is one I know you will pay attention to. Senator Grassley—in many respects, we are co-chairmen. Senator Grassley, as Chairman, made that request. Many times he has mentioned it to me. He is getting no response.

I think it is an outrage, frankly. I cannot conceive of a situation where the administration, the Department, would not answer the Chairman's request. I am asking you to honor his request and to provide the information to him, and I expect a very timely response.

All right. Mr. Secretary, proceed.

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

Secretary LEAVITT. Thank you.

Mr. Chairman and Mr. Grassley, members of the committee, may I tell you that I am, this morning, moved by your expression from Ezekiel. This is a compassionate Nation.

I believe there is a view, both in the minds and hearts of our people, that we should care for the sick and the downtrodden, and I would like to begin this hearing by telling you the deep privilege I find it to administer the efforts of this Nation in that respect. It is also clear to me that we share the desire to do that, and our purpose today is to talk about how best to accomplish it.

Mr. Chairman, I submitted an opening statement. With your permission, I would like to just submit that and move to perhaps a little different approach that I think might be helpful in terms of our discussion, and get to your questions more quickly. Would that be permissible?

The CHAIRMAN. Yes. Your statement will be included.

[The prepared statement of Secretary Leavitt appears in the appendix.]

Secretary LEAVITT. This is a large and a complex budget. It took hundreds of people the better part of the year to assemble. There are tens of thousands of different decisions that go into it; \$700 billion is a lot of money.

I thought it might be helpful for you to know a little bit about the guidance that I provided to those who were working on it, in terms of the principles that should be followed, and I would like to be able to address many of your questions today in the construct of those principles. I think it will give you some insight into the philosophy that we attempted.

Obviously the President gave us guidance. He made clear he wanted our responsibility to heal the sick and care for the downtrodden to be undertaken. He also recognized the need for this Nation to be a prosperous Nation and for our economy to be strong in order for us to meet those needs and to step in where hands droop down.

He wants, obviously, for our taxes to be low and the taxpayer money to be used as well as it can be used. He has laid out an objective and a priority to balance our budget by the year 2012.

So what you will see here today is a budget that moves towards a balanced budget by 2012, and it has required me, as the Department head, to make some very difficult decisions, to balance priorities, to come with competing noble causes and to make decisions that at times were leaving things that, in otherwise different circumstances, I may have desired to include.

There are new matters that are considered in this budget. I gave my colleagues four principles to look for in anything new that went into this budget. Here they are.

The first is, I wanted to make sure that we had high-demand, highly efficient programs taken care of. You will see, for example, the Indian Health Service and Head Start were protected from any major reductions. You will see CHIP. We agree, Mr. Chairman, that CHIP needs to be reauthorized. I want to make clear to you

that we have no intention in our policy that would remove existing children or existing adults from SCHIP. We intend that they continue. We do intend to focus our interests on CHIP with children, and I am sure we will get into that more later, but I want to assure you that that is part of this budget.

The second principle was presidential initiatives. The President made some commitments that we need to keep. One is for community health centers, for example. The President committed that 1,200 new community health centers would be built. This budget would complete that. Another important initiative was his commitment on HIV-AIDS and on pandemic. All of those are included in this budget.

The third principle is, there are pressing new problems that are not dealt with in existing budgets. I am deeply concerned, as I suspect members of this committee are, about FDA and the need for us to improve drug safety and to speed the approval of generics. We have included provisions that were new to this budget. Then there are some proposals that I think get at the heart of what you were referring to in our need to reduce health care costs overall. One is health information technology. We believe we have not funded that adequately. It is right at the center of all that we want to achieve in cost reduction.

Fraud and abuse. I have been Secretary now for 2 years, and it has become clear to me we can do better there. As we go through, I can see my time is up.

The CHAIRMAN. You can speak a little longer.

Secretary LEAVITT. Well, I would also like to tell you some of the principles that I gave my colleagues as guidance on how we would deal with competing priorities. You will see places in this budget where one-time funds have not been repeated.

One example of that is the Centers for Disease Control. We have had a quite ambitious construction initiative there. Much of it is completed, so we have not repeated it. That will look as though we are reducing funds, but we are simply taking one-time funds off the table that were spent and completed.

The second area would be an emphasis that I have asked them to place on direct services rather than infrastructure. You will see places where—I will give an example. Health professions. In some of our advanced health professions you will see some reductions there, but you will also see increases in community health centers. That is an example of, I want to fund the services, not just infrastructure when I am having to choose between the two.

A third principle will be looking for grant activities that have been completed. An example of that. At the National Cancer Institute, it is the largest investment in all of our centers at NIH, but there is a slight reduction. But what it does not show is that we are moving those monies to have an increase in the number of new grants because we are eliminating non-competing grants.

A fourth principle is eliminating programs whose purposes are addressed by multiple agencies. With the size of HHS and the size of this government, it is not unusual to find problems that are dealt with in many different operating divisions, so I have attempted to consolidate those.

A good example that I think we talked a little bit about last year was the Urban Indian Services clinics. I have again proposed that we consolidate those with the community health centers. They are serving similar populations, and in many cases we have two clinics in the same community that could be served by one.

A fifth principle is looking for under-performing programs. We have looked closely to determine if they are measurable, what the metrics are, and so in some cases you will see a program that has been reduced because of our inability to measure it or our suspicion that it is under-performing.

The sixth principle is that we look for reductions in entitlement growth. You made reference to this. I would just like to say that I am here as Secretary of Health and Human Services, but one of the duties that comes to me as a member of the Cabinet is serving as a trustee of Social Security. The areas that you see reduced here, there is no amputation, this is simply losing weight.

The CHAIRMAN. You do not mean Social Security.

Secretary LEAVITT. I am sorry. And Medicare. That is what I meant to imply. Medicare. The entitlements. We have gone through each of the areas of the entitlement, and to do exactly what you suggested we should do.

Are there places we could reduce the growth where we would not have an impact on the beneficiaries directly? I think we found many of those. And if you add them all up, you can say there is a lot of money there. And there is. In fact, if you project forward 5 years, there is a lot of money.

The sooner we do these things, the more impact we will have to keep it sustainable. If we were able to do all the things that this budget has proposed, we would increase its sustainability from 2018 to 2022, so it is 4 years.

But I think as we go through these—I hope we can go through them one at a time and not just look at them in aggregate and assume that there is some sort of cut. This is a very deliberate effort to try to find places where we could slow the growth.

Mr. Chairman, I know that there are many questions, and I am anxious to have a direct dialogue with you about this.

The CHAIRMAN. Sure. I appreciate that. Thank you, Mr. Secretary.

I am just concerned about the number of children who might lose coverage under the administration's plans. For example, the administration has only prescribed about \$5 billion. Most analysts think it is going to take \$15 billion just to maintain current coverage—\$13, \$14, \$15 billion—that is, about three times what the administration is suggesting.

Second, the administration is shortening the time period in which States have to spend their funds from currently 3 down to 1 year, and also lowering the match for those States covering above 200 percent of poverty. There are other areas here, too.

With all of that, it is more likely there is going to be less coverage for kids—kids will be dropped off—rather than more. Less money, lower match, less time. That sounds to me like there will be fewer kids covered, not more.

Secretary LEAVITT. Let me put this into the construct. There is a widely held aspiration—I am sure you share it, the President

shares it—of having every American have access to an affordable basic insurance policy.

CHIP is a very important part of that. We believe that it will take \$15.4 billion. Let me reconcile those numbers. There is \$5 billion currently in the budget. We would increase that by 4.8 billion new dollars, and then there is an additional \$4 billion that remains on the previous allocations. Our policy would be to not have any children who are covered lost from coverage, nor would we have any adults who are currently covered lost from coverage, but on a going-forward basis we do not believe that CHIP should be the vehicle to cover adults. We think that ought to be a children's program—

The CHAIRMAN. I appreciate that.

Secretary LEAVITT [continuing]. And we ought to continue to build new opportunities.

The CHAIRMAN. Right.

Secretary LEAVITT. And we have proposals that I think will—

The CHAIRMAN. Yes. That may be your policy, but it looks like it is not going to be the effect. Your policy is not to have any more uninsured kids, but the effect is going to be more uninsured kids for the reasons I just indicated. And I am not talking about parents at this point, I am just talking about kids.

Secretary LEAVITT. We are committed to make certain, Senator, that no child who is currently insured—

The CHAIRMAN. And how are you going to do that? What are you going to do for those States that currently cover above 200 percent?

Secretary LEAVITT. We are committed to assure that no child who is currently insured under CHIP loses coverage under the budget.

The CHAIRMAN. But you are shifting the cost onto the States if they want to, and some States are strapped. Very strapped.

Secretary LEAVITT. We do not believe that should, or would, happen. We also believe that there is a need to work with every State to assure that not only children are insured, but we would pursue policies that would allow us to give access to a basic affordable insurance policy to every American, including children and their parents.

The CHAIRMAN. I will not belabor the point here, but it looks to me, just looking at the numbers, that the effect is going to be fewer kids, not more.

The second question. You have all these cuts in Medicare. Why not Medicare Advantage? Many analysts say that is where the money is. That is where the fat is, not fee-for-service, but Medicare Advantage. It just seems to me, at the very least, it ought to be an across-the-board cut. But, rather, the administration is covering fee-for-service but not Medicare Advantage. That seems a little odd. Why?

Secretary LEAVITT. Senator, you referenced your concern that Medicare Advantage was about privatizing the entitlements. May I suggest that Medicare Advantage is about integrating care, it is about finding more efficient care.

What we know is, if we have a person have all of their care in an integrated way, that ultimately the cost savings are substantial. We believe there are good policy reasons for us to be moving to-

ward integrated care, and that is what Medicare Advantage provides.

The CHAIRMAN. Which is a private plan.

Secretary LEAVITT. Well, it is integrated care. Our goal is to find a way to integrate care. That saves money, and it means that we are able to provide better care for more people. It has been a big success. We have 7 million people who are now enrolled, and we hope it will grow.

The CHAIRMAN. I understand. But there are many who think that they are reimbursed at a rate that they do not need. I do not know if it is MedPAC or others who have so said, but I have seen many, many analysts say that they are, in effect, getting more than they need.

I have not seen any analyst who says they are not getting more than they need. If you are going to cut somebody who is certainly not getting more than they need, that is, fee-for-service and hospitals, why in the world are you not also cutting Medicare Advantage?

Secretary LEAVITT. We have clearly adopted a policy of enhancing the amount of integrated care that occurs, and we put into place a means by which we could expand that. In the law already are ways in which, over time, those incentives that we created to build that program will be eliminated. But for the time being, it is important that is available everywhere, even in rural areas, even in Montana.

The CHAIRMAN. Medicare Advantage?

Secretary LEAVITT. Yes.

The CHAIRMAN. There is not much.

Secretary LEAVITT. Well, we want to make——

The CHAIRMAN. I do not know of any.

Secretary LEAVITT. We want there to be more. Important to that is the advantage that you have referenced.

The CHAIRMAN. All right.

Secretary LEAVITT. The second thing that we want to make sure of is that we have the ability to sustain it and that it grows, and we think it will and that it will be good for the overall system.

The CHAIRMAN. Thank you, Mr. Secretary.

Senator Grassley?

Senator GRASSLEY. Yes. Thank you, Mr. Chairman.

Since the transcript of this record or the transcript of this hearing does not show nods of heads, I want to make clear that when the Chairman admonished you to answer my letters you nodded “yes.”

Secretary LEAVITT. Mr. Chairman, I would like to respond directly to the challenge and important statement that you made, and make certain that my assent is understood. There are historic disagreements between the branches of government. I find myself, as a Cabinet Secretary in the executive branch, dealing with policies that were established long before I was there and on disputes that were long before.

Senator GRASSLEY. You do not have to put that on the record. It is on the record elsewhere. That is not the issue. The issue is, those things aside, whether or not I get answers to my questions, that I do not get answered because I am a Ranking Member as opposed

to being Chairman. That is the issue. You nodded “yes” to the Chairman that you were not going to discriminate whether Chuck Grassley is Ranking Member or Chairman. That is what the Chairman asked you to do.

Now, all these other issues, we can argue about those. We were arguing about those when I was Chairman, so we are not going to argue about those when I am Ranking Member. There is just another excuse given by your people in e-mails, that I am not Chairman any more so my questions do not have to be responded to.

Secretary LEAVITT. I know nothing about those e-mails, nor do I know about a policy that would differentiate between you as Ranking Member and—

Senator GRASSLEY. Well, then you do not know what is going on in your Department, and I would like to inform you. But the Chairman knows, and the Chairman says that, if that is what we are receiving from your Department, he is saying that I ought to get an answer to the same inquiry whether I am Chairman or whether I am Ranking Member. I think that is what the Chairman has said.

The CHAIRMAN. Let me just add in here, Mr. Secretary, many times Senator Grassley, over the last year, discussed this, his frustration at not getting responses as Chairman of the Finance Committee to letters that he has sent to the Department. I was stunned that he was not getting responses. For me, I do not care whether he is a Ranking Member, a new member of the committee, or who he is. I expect him to get those answers.

Secretary LEAVITT. I do not believe our longstanding disagreement on what is appropriate for the executive branch to advance to the legislative branch has anything to do with who the Chairman is or the party. These are disputes that I am following as best I can, the policies of the executive branch, and I will continue to do. I want you to know, both of you—all of you—that I view oversight as an important and legitimate part of government, and that we will do all we can to respond within the context of the policies that deal with the ongoing struggles that go back to 1787 between the executive branch and the legislative branch.

Senator GRASSLEY. I hate to spend my 5 minutes educating you on what is going on in the Department.

The CHAIRMAN. You get another 5.

Senator GRASSLEY. But I can tell you this. Since I am Ranking Member, from the FDA we got a statement that we had to have a letter from the Chairman. The Chairman signed a letter for the request.

Then we later were told, well, if we are going to interview the people we want to interview, that the Chairman would have to have somebody there present while the questions were being asked by my staff. Now, there is no point of putting his staff to that trouble. They have enough work to do on their own.

Those are impediments that are unexplainable. They do not meet the common sense test. They do not meet the test of transparency in government. We are a democratic government, and we ought to function like this. The checks and balances ought to function the way the Constitution intended they function. You can have all the

legal arguments you want, but this additional one is nothing but harassment that ought to end.

Secretary LEAVITT. Senator Grassley, we support democracy, we support transparency.

The CHAIRMAN. Do you support answering the letter? That is the question.

Secretary LEAVITT. We will not discriminate between any member of the parties.

The CHAIRMAN. That is not the issue. This committee expects a timely answer to the Senator from Iowa.

Secretary LEAVITT. Thank you. I acknowledge that. You need to know that the answer will not come from me, it will come other places in the executive branch, because this is not a policy I set.

The CHAIRMAN. Now, could you translate that, please? I do not know what that means.

Secretary LEAVITT. What that means is, there are longstanding executive branch policies on what goes forward to a legislative request, and I am in a position of following those guidelines. I will do the best I can to give you that.

Senator GRASSLEY. We have requested those in writing, and we cannot get those policies in writing.

Secretary LEAVITT. I will do my best to—

The CHAIRMAN. This is pretty serious, Mr. Secretary.

Secretary LEAVITT. I understand. I understand.

The CHAIRMAN. Quite serious.

Secretary LEAVITT. If I were in a position to provide an answer to this, I would.

The CHAIRMAN. And I expect an answer from you to Senator Grassley.

Secretary LEAVITT. I will do my best.

The CHAIRMAN. A response.

Secretary LEAVITT. I will do my best.

The CHAIRMAN. Thank you.

Senator ROCKEFELLER. Can I just take this off my time?

Senator GRASSLEY. Sure.

Senator ROCKEFELLER. Mr. Chairman, if the Secretary says that there are longstanding policies and that he cannot change those, and therefore there is no use to write Senator Grassley a letter, I think anybody who does not answer Chuck Grassley's mail is in for a very, very hard life.

Secretary LEAVITT. I have experienced part of that.

Senator ROCKEFELLER. Yes. Chuck Grassley, when he is unhappy, is—

The CHAIRMAN. Well, it is not just Chuck Grassley.

Senator ROCKEFELLER. I know that. But your idea of saying since others have set the policy, that therefore you cannot do anything about it, it feeds into a question that I am going to start off with, what I am going to start off with now, which is, what is your role up there?

The CHAIRMAN. Who are you?

Senator ROCKEFELLER. Do you not fight for the right to be courteous to a co-chairman of the Finance Committee?

Secretary LEAVITT. The issues that we are dealing with today deal with matters related to criminal investigations which involve

the Justice Department. Therefore, I do not handle criminal investigations.

Senator ROCKEFELLER. But then, why could you not write him and say that?

Secretary LEAVITT. I have advocated, and will continue, and I will do my best to respond.

Senator ROCKEFELLER. You mean you cannot, as Secretary of the largest—is it not the largest, except for the Department of Defense, or larger than the Department of Defense—budget, yours, the largest in the Nation, that you cannot answer in a letter? Who is stopping you?

Secretary LEAVITT. Matters that deal in the areas that I have described are coordinated with the Justice Department. Senator Grassley and I have had conversations about this, and he has dealt with the Attorney General directly about it, and I am confident we will continue to do.

Senator GRASSLEY. First of all, the inference is that we are trying to get into a criminal investigation, and that is not true. We are not trying to. So let us go on here.

I am trying to ask some questions here in the 5 minutes that the Chairman gives me—

The CHAIRMAN. Go ahead. You have 5. It starts now.

Senator GRASSLEY [continuing]. That try to be friendly to the administration.

The CHAIRMAN. You can start now.

Senator GRASSLEY. All right. But it makes it very difficult under these circumstances to do anything that is friendly with anybody in this administration if I cannot just get very basic information. But let us go, and I will try to be friendly. [Laughter.]

Secretary LEAVITT. And I will try to be responsive, sir.

Senator GRASSLEY. In regard to the budget and entitlement programs, we have had a lot of people, including yourself, who have said that we have to take these entitlement problems more seriously than what Congress has.

Ben Bernanke said this: “If early and meaningful action is not taken, the U.S. economy could be seriously weakened, with future generations bearing much of the cost.”

Do you agree with Mr. Bernanke’s assessment? What steps do we need to take to avoid the very negative long-term impact on the budget in the economy?

Secretary LEAVITT. Yes. I think we can just start with health care. When I was born in 1951, health care generally was 4 percent of the economy. When my son was born, it was 8 percent of the economy. When my first grandbaby was born, it doubled again, 16 percent.

We are now measuring Medicare alone, as a percentage of the Gross Domestic Product. It will double, and double again in short order. They are not sustainable in their current form. I am a trustee of the Medicare trust fund. Every report, we make that clear.

The reductions in the growth rate that we have proposed would simply keep the system solvent for 4 years. We have to deal with this, Senator, and I think that would be universally felt and understood by everyone on the dais.

Senator GRASSLEY. All right.

Now, the next question: I am going to ask you to fill in something that is not very clear in the budget we received in regard to administrative savings. The quote is, "New efforts to strengthen program integrity in the Medicare payment system, correct for inappropriate provider payments, and adjust payments to encourage efficiency and productivity."

We need more detail. Administrative savings are supposed to bring in \$10 billion of the \$77 billion in Medicare savings over 5 years. That is about 10 percent of what you save. So what is it? Can you give us more detail on these administrative savings?

Secretary LEAVITT. One important one would be the need for us to have more capacity to investigate fraud, for example, in the durable medical equipment area. Not long ago I went to Miami. I spent the afternoon with a group of investigators, walking from spot to spot, looking at businesses that were essentially shams. There was no one there, there was no sign of an ongoing business, and yet they were billing millions of dollars to the Medicare system.

We do not have enough investigators to be able to deal with that. I believe we could save hundreds of millions of taxpayer dollars, and this budget asks for money to be put into our discretionary budget in order to do that.

Senator GRASSLEY. We can give you money for that, I believe, but I am not sure. Do we get savings? We do not get any savings estimated by the Congressional Budget Office if we do that, so it is kind of hard. We have done that in the past and may do it in the future, but just remember, that is a problem for us.

You want us to save money, and we put that in to save money, you score it as saving money and hopefully it will save money, but CBO does not give us any benefit for that.

In my last minute, let me quickly ask this question in regard to, to be eligible for Medicaid a person has to be a citizen or a qualified-aged alien. The DRA included a provision that requires States to more thoroughly document that citizenship.

This provision was developed in response to the Inspector General's report that showed States were not doing a very good job of documenting. In the Tax Relief and Health Care Act we passed last December, we included provisions to improve upon that of what we passed in the DRA.

Specifically, the change gives States flexibility so that a person who had established citizenship for one Federal program would not have to do so again for Medicaid. Do you think documentation enforcement in Medicaid is working properly, and are there areas that could be further improved?

Secretary LEAVITT. It is operating under a new law, which we have attempted, frankly, to interpret to provide the maximum level of flexibility for States. We did not want anyone to be denied coverage simply because they were unable to come up with a birth certificate that was existent, or that there were documentation problems that would create that. We are now implementing it. I think we are doing it successfully. Can it be improved? Yes. Will we get better at it? I am sure we will.

The CHAIRMAN. Thank you, Senator.

Next on the list is Senator Hatch. He has very, very graciously agreed to defer to the Senator from New York, who has a difficult scheduling problem. We all do have difficult scheduling problems, but I want to thank the Senator from Utah very much for his kindness in deferring to him.

Senator SCHUMER. And I want to thank you, Mr. Chairman, the Ranking Member, and my friend from Utah for their courtesy as well.

I have two questions on different areas, so I will ask them both and then ask for the response. The first relates to New York City and New York State and our health care. Your budget is a one-two punch aimed at New York. It would just decimate health care. Basically, in New York it would decimate it. You eliminate two programs that are vital to us where a large percentage of the money goes to New York.

The first is graduate medical education. For years, New York has trained 1 out of every 7, actually, doctors in this country. They get top-notch training. They leave and give great coverage elsewhere. Part of what they do is treat Medicaid patients, so obviously this is a benefit to Medicaid. No administration has opposed eliminating this program. Yours has.

How can you defend that? And what will happen if we eliminate it? We will not have the number or quality of physicians that we have. Medicaid and health care will suffer.

At the same time, while you were doing that, this came on top of the new regulations in terms of the New York City public hospital system, that would lose \$350 million under the Medicaid cuts. That is 20 percent of its revenues, yet CMS has been unable or unwilling to provide information on the impact this rule will have on individual States. I am told that the specific regulation on public hospitals would cost us about 40 percent. Forty percent of it would come from New York.

So how can a budget be drawn up with its different parts without looking at the total effect on health care, which would just send health care in New York reeling, just reeling? It is a one-two punch.

Then on generics, and I will let you answer both and cede my time. Two questions on generics. The proposal for the FDA to impose user fees on drug companies is supposed to speed the approval of generic drugs.

But given that generic drug approval is stalled not so much by the FDA, but by the tactics of the pharmaceutical industry in terms of citizen petitions, authorized generics, it is not money that is the answer.

So in order to speed up new drugs, if your goal is new drugs in the market, it is not to impose user fees, it is really to work with us to put an end to the tactics meant to undermine the 180-day exclusivity rule, which actually my colleague from Utah helped design, I guess it was more than 20 years ago now, and has worked with great success.

In addition, another regulation relating to generics, GAO has determined that payment changes to pharmacies would greatly disincentivize the use of generics. In other words, the way you have

done the payment system, the reimbursement rate would be 36 percent less dispensing generics than prescription drugs.

Pharmacies are going to push the brand drug and cost our taxpayers a ton of money. It seems to me penny wise, pound foolish. How can you justify that? You will make a little money back on this increased fee, and then you will lose \$5, \$10 for every one you save as the pharmacist tries to prescribe the brand-name drug because the pharmacist gets more of a cost reimbursement on that.

Those are my two sets of questions: first, on New York City graduate medical education and the specific cut to public hospitals. My guess is, if these were for-profits in Florida you would not be making the same decision, even though the city hospitals probably do a better job. Second, the two issues on generics, the user fee and the cost to the pharmacists. Thank you.

Secretary LEAVITT. Senator, the regulation you are referring to, your second part on the Medicaid, what was that?

Senator SCHUMER. The regulation is that you are increasing the cost basically. You are decreasing the reimbursement rate to pharmacists. Pharmacists, when they dispense a drug, are given a certain amount. You are going to favor the pharmacist by cutting the generic reimbursements, so you are going to push the pharmacist to prescribe the brand-name drug, which is much more expensive and costs Medicare and Medicaid a lot more money.

Secretary LEAVITT. Let me deal, first of all, with graduate medical education. Obviously there is a need for graduate medical education.

The CHAIRMAN. And I might say, Mr. Secretary, if you could, be somewhat brief because Senator Schumer's time expired. So if you can answer the question briefly, please.

Secretary LEAVITT. We believe Medicaid is to care for low-income people, not just to do graduate medical education. We believe that the graduate medical education system ought to be funded in a means that spreads the burden over all payors of health care, not just Medicaid.

Senator SCHUMER. Medicaid does not just fund that.

Secretary LEAVITT. It is Medicaid and Medicare. In the interest of being brief—

The CHAIRMAN. You can answer it, but briefly.

Senator SCHUMER. To fund a resident or an intern it is not just GME, it is just that Medicaid is paying a certain percentage because Medicaid benefits. It is not solely funded by Medicaid. Of course not.

Secretary LEAVITT. But other payors of health care do not participate, and we think they should.

The CHAIRMAN. Thank you, Senator, very much.

Senator Hatch?

Senator SCHUMER. Mr. Chairman, in all fairness, I asked a few other questions.

The CHAIRMAN. Well, you will have to come back, Senator.

Secretary LEAVITT. I wrote them down.

The CHAIRMAN. In deference to—

Secretary LEAVITT. The next round, I will—or would you like me to respond in writing? I would be happy to do so.

Senator SCHUMER. Thank you.

The CHAIRMAN. In deference to other Senators, you are a minute and a half over your time. Sorry.

Senator HATCH?

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

First of all, I do not know that I have ever seen a Secretary of HHS who has been more forthcoming than this one. I have been around here for, now, 31 years. There are times when even you, as high as this position is, have to live in accordance with Justice Department rules and regulations, whether they are criminal or civil.

Now, I think we should take this up with the Justice Department if they are being overly restrictive in answering the Chairman's, the Ranking Member's, or any member of this committee's questions.

But my experience with Secretary Leavitt, and it is a long, long experience, is that we have never had anybody in this position any brighter or any more capable of doing a great job, and I think he is doing a terrific job. And that is not just because he comes from my home State of Utah. I have seen him in action for most of my Senate life.

I am sure you will answer any question you are able to, and you should. But let me ask you a couple of questions that I have had on my mind for quite a while. And I am going to ask a whole bunch of them in order, and you might want to make notes.

I would like you to update the committee members on Medicare Part D implementation. I have heard all the rigmarole and all the moaning and groaning by those who are critical of Part D implementation. How many Medicare beneficiaries are now enrolled in Medicare Part D? I would like to know that.

What percentage of Medicare Part D beneficiaries ended up in the donut hole last year? Because that is important to all of us up here. Was it more than expected or less than expected? That is a question that I think is an important one.

Has CMS seen significant cost savings in Medicare Part D compared to what was expected when the Medicare Modernization Act was passed by Congress in 2003? Is the Medicare prescription drug program not less expensive than originally thought? At least, that has been the impression that I have had, and from everything I have read it is less expensive than what we originally thought, as we said in those long, interminable meetings coming up with Medicare Part D and the whole Medicare Modernization program.

That is a lot of questions, but hopefully you can answer those for us.

Secretary LEAVITT. Senator, the Part D program has been a robust success. We have 38 million subscribers now.

Senator HATCH. What percentage would that be of those who are eligible?

Secretary LEAVITT. It would be over 90 percent of those who are eligible.

Senator HATCH. Ninety percent? All right.

Secretary LEAVITT. I will add, though you did not ask this, that 80 percent of those that are asked say they are happy with their plan.

Senator HATCH. Right.

Secretary LEAVITT. They are happy with their plan because they have a choice, they were able to get a plan that meets their needs, we do not have just a one-size-fits-all program attempting to stretch over 38 million people.

The cost savings have been profound, both for beneficiaries and for taxpayers. We started off thinking, actuarial estimates, that it would be \$37 a month. Because of competition, it is \$22 a month. That has reflected, for taxpayers, over \$113 billion of savings over what was originally estimated.

Senator HATCH. That is a significant savings. All right.

Let me ask another question on a related issue. Well, how about the donut hole?

Secretary LEAVITT. The good news is that there is a plan now available in every State where people can have coverage in the so-called "donut hole" if they choose to, and we found that more and more people want the lowest cost, more and more people want to have lower co-pays.

Senator HATCH. But most people do not even reach the donut hole.

Secretary LEAVITT. That is right, most do not.

Senator HATCH. Do you know what percentage do not?

Secretary LEAVITT. I do not think I have that information.

Senator HATCH. It is a pretty high percentage, though.

Secretary LEAVITT. It is. It is a high percentage. But the good news is, if a person is in the donut hole and does not want to be, they can get a plan that—

Senator HATCH. Well, we designed it so that it would be about half of what it takes to get to the donut hole. I think it has pretty well lived up to that.

On a related issue, what would be the impact of requiring the HHS Secretary to negotiate Medicare prescription drug prices?

Secretary LEAVITT. Well, it would essentially be a decision to have the government run it. If we had a one-size-fits-all plan you would have, first of all, fewer choices. Beneficiaries, I think, would have less satisfaction with the plan, and I think ultimately you would have costs that would be no lower.

Senator HATCH. All right. I might add, there would be over 4,400 drugs that you would have to negotiate prices for.

Secretary LEAVITT. People would have fewer choices. When you negotiate drug prices there is really only one way to do it: you say, "I am going to take your pill off my plan." If the government starts doing that, suddenly you have the government making choices about who can get what drug as opposed to consumers doing that. Currently, there are over 4,400 drugs available on plans. People can choose a plan that meets their needs, and I think that is exactly why we have 80 percent who are happy. Those who are not, the good news is, we can help find a plan that serves them better. If we had one plan, one formulary, we would have a lot more unhappy people.

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

Thank you, Mr. Chairman. I have some other questions. I will submit them in writing.

[The questions appear in the appendix.]

The CHAIRMAN. Thank you very much, Senator.

Next, is Senator Smith.

Senator SMITH. Thank you, Mr. Chairman.

Mr. Secretary, good to see you.

Secretary LEAVITT. Thank you.

Senator SMITH. Thank you for being here.

Mr. Secretary, in the last 4 years we have lost 3,000 soldiers in Iraq. Now, that is not your area, but I simply cite that number to emphasize a point I want to make. Every year in America, roughly 30,000 Americans commit suicide, 3,000 of those are children. Every year, 3,000, the totality of Iraq, is occurring throughout the neighborhoods and cities of the United States.

I, for one, believe that is an epidemic. One of the best things I have done in Congress is to pass a Youth Suicide Prevention Act, with the help of all of my colleagues here. That program was authorized by the 108th Congress. It was to phase in over 3 years at \$40 million. We are making very good progress towards that.

Two years ago, the 109th Congress funded it at \$27 million, roughly. In the last budget we did in the 109th Congress, the Appropriations Committee fully funded it, \$39.6 million, roughly. I was very proud of that.

Now I am told that the 110th Congress is going to disregard what the Senate did and take the House CR, which flat-funds it at \$26.6 million.

Now, I am not speaking for Oregon because Oregon is already in—I am very proud of them for that—and it is making a real difference. But your budget has essentially an agreement with the House flat funding, which apparently the Senate will accede to without any right to amendment, which will be the basis for my very loud and enthusiastic “no” when it is brought to the floor, among other reasons.

I guess what I am asking is, will the administration oppose an effort to increase it to full funding? Do you have any resources in your Department? I mean, the truth is, \$40 million is a lot to you and me individually. It is a rounding error in the budgets of HHS.

Is there something you can do administratively to fill the gap that the 110th Congress will leave for 2 years running?

Secretary LEAVITT. Senator, the problems you speak of are agonizingly difficult, and I know very few families, in one way or another, that have not been affected. I am fully conscious of the personal loss that you have experienced. We are a supporter of the program.

Senator SMITH. Yes, you are. Thank you for that.

Secretary LEAVITT. We will continue to be supportive. The administration would not object. What influence we have in the negotiations between the House and Senate will be consistent with that.

Senator SMITH. And so you would be for \$40 million?

Secretary LEAVITT. Well, what you asked me is, would we object? The answer is, no, we would not object.

Senator SMITH. I hope we do it. I wish we could do it on an amendment basis on the CR. I mean, it is a life-and-death issue. The problem is not going away, it is growing. I think our Nation needs to put the mental health issue on a parity that it deserves, and it will truly save lives.

So what you have is a silent tragedy in our country that is equal in numbers to Iraq over 4 years, and we ought to be better than that.

Now, the next question I ask is, I do want to ask it in a friendly fashion, and I mean it as your friend. But I am concerned. When we debated the Deficit Reduction Act, a number of items, such as intergovernmental transfers, were debated and roundly rejected by the Congress.

I understand that the Department, the administration, is trying to implement banning intergovernmental transfers through administrative means, even though, at least in my view, there is no Congressional authority to do that.

The CHAIRMAN. Senator, do you expect a response? Because your time is—

Senator SMITH. Yes. If I can get a response, that would be great.

The CHAIRMAN. Yes. Again, briefly, Mr. Secretary.

Secretary LEAVITT. We have pursued a simple policy. The Federal Government pays 57-plus percent of Medicaid. We are partners with the States. What we are looking for is a straightforward partnership where both partners put up real money.

And a lot of States, over time, have found ways to basically use Federal money, and then recycled it and sent it back as the match for our money. There is nothing inherently wrong with an intergovernmental transfer, so long as it is not done specifically with the purpose of matching Federal money for Federal money.

Senator SMITH. It is truly State money.

Secretary LEAVITT. It is truly State money. There is nothing inherently wrong with an intergovernmental transfer.

Senator SMITH. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Mr. Secretary, actually I have just kind of been thinking inwardly. You are a Cabinet officer, and that is a great achievement in life, one which you deserve. You are a very good man. And yet you come before us, really, without any power.

In other words, the testimony which you would have given and which you did submit for the record is not your testimony unless it has been cleared by the Office of Management and Budget. As a Cabinet officer, you do not have the ability to come before us and to give us the benefit of your real thinking.

Now, there are amazing things that happen to the CHIP program and to children losing coverage, States not being able to do what they want to do. So my second point: if you are a Cabinet officer, the judicial model of the Cabinet officer is one who sits around in the Cabinet room and discusses policy, their needs, their views with the President.

Different members of this committee will have different views on this subject. But as we were spending, I do not know, close to a trillion—before it is over it will probably be close to \$2 trillion—on a war which we should not be involved in and not spending enough on a war we should be involved in, which is the war on al Qaeda, Afghanistan, it just grabbed the attention of the Nation.

The President's circle of advisors became very small, maybe three or four people whom he listened to, maybe less, and you watch your programs get decimated because of something called the budget consequences.

Now, people in this room on the dais may have very different views, but I was stunned by the tax cuts. It has nothing to do with the first President in history to cut taxes during a war, although that is pretty relevant, but just the magnitude of them, the freelance nature of them: we won, we reward our friends. You sit there at Cabinet meetings and you watch your budget shrink.

You came to do good work and you are a good man, and you have done good work within your capacity. But people who think that a Cabinet officer has the ability to change the life of the service over which he or she presides are misguided. You are constrained today by the OMB. You cannot answer Chuck Grassley's question. I am no expert on that, so I will not get into that too much.

You do not really have any money to spend. But you have to answer enthusiastically, the President's principles are such and such, that every child will be covered, all people will be covered.

That is not the President's policy. That is not the President's policy. Neither is what he articulated the other night in his State of the Union, and it never has been. To be quite honest, it was not his father's policy. That just was not of interest to them. Many things were, but that was not something which was of interest to them.

Do you ever speak out on these things to the President?

Secretary LEAVITT. Senator, first of all, my testimony was not cleared by anybody but me.

Senator ROCKEFELLER. I will beg to differ on that, but that is not a discussion which we will have.

Secretary LEAVITT. All right.

Secondly, the budget that I am here to discuss today is \$700 billion. So to say I do not have any money to spend, there is 25 percent of the entire Federal budget in this budget, and it has grown by, I believe, about 4 percent this year.

Next, may I say that I have been granted the trust of substantial authority in the area of Health and Human Services. I do my best to do that in a way that is worthy of that stewardship. I do not spend my time enunciating policy on defense. I do not spend my time enunciating policy on justice. I do my best to coordinate with them in ways that serve the President in the best possible way.

Senator ROCKEFELLER. But if you see—

Secretary LEAVITT. I do give the President advice on all of those areas when I have the opportunity. I do it privately, and I do it directly.

Senator ROCKEFELLER. All right.

The CHAIRMAN. Thank you, Senator.

Senator Kyl?

Senator KYL. Thank you, Mr. Chairman.

I just cannot resist, on that last point, when Senator Rockefeller said with regard to the Bush tax cuts, "we won, we reward our friends."

It is pretty interesting that every segment of American society has benefitted as a result of the tax cuts of 2001 and 2003. The

tax code is now more progressive than it was before those tax cuts. We would not have a 10-percent bracket today. We would not have the child tax cut relief, the marriage penalty reform, and a lot of other things that have benefitted all Americans. So, let the record reflect that, if it is true that Republicans and President Bush rewarded their friends after election, their friends are the American people.

Second, let me compliment you, Mr. Secretary, on your availability and the clarity with which you have briefed members of Congress on matters within your jurisdiction, specifically, most recently the proposals of the President enunciated in the State of the Union speech.

I appreciate, again, not just your availability, but the clarity with which you have described those proposals and interacted with members of the Senate, and I appreciate that.

I have two primary questions for you, one of which was essentially asked by Senator Hatch, which established the proposition that the Medicare Part D costs have declined dramatically, even far more than was predicted, as a result of the way that the Medicare Part D negotiation for drugs was written into the law.

I guess the follow-up question with respect to what you said about the savings that Americans are achieving there, is whether you believe that this market-based competition and the success of that in the Medicare Part D program provides lessons with respect to continuing to help reduce costs, while expanding access to care in the broadest sense with respect to some of the proposals that have been made for health care reform.

Secretary LEAVITT. Senator, I think history and economic experience teach us that, when people have access to choices and information about the cost and the quality, they make decisions that drive quality up and costs down. We have seen that no better and with no more clarity than we see it in Part D.

The original estimate, as I indicated, was \$37 a month; this year it will be just over \$22. When you ask the actuaries why, they are very clear. The majority of it, the big share of it, was because there was competition. Given choices, given information, people make decisions that drive quality up and costs down.

Senator KYL. Well, given the fact that there are two basic approaches to reform in health care, one more governmental involvement, the other trying to rely upon the competitive marketplace, it seems to me this is an important lesson to learn with respect to how we develop those new proposals.

The second question I have relates to Medicare Part B premium changes. I was going to ask you to describe in a little bit more detail the premium structure that you envision, and I would like to ask you to do that in writing for the committee since I do not want to take the time here.

The proposal seems to me to be very interesting, but it could stand a little bit more fleshing out, it seems to me.

But it also seems to me that it begs another question, and that is that, since a big part of the Medicare Part B premium goes to physician services and the reimbursement for those services is such a critical part of the overall program, would it not be a good idea for the Congress, working with the administration, to try to reform

the reimbursement of physicians and do that in a way that does not require Congress, every year, to have to come back in and find the funding for what is called a zero update?

Secretary LEAVITT. Senator, it would be, I think, a relief to everyone if we did that. It is clear to me also that some part of that needs to reflect the sentiment you raised earlier. Some part of it needs to be not just on the basis of the quantity of services provided by physicians, but it needs to be focused somewhat on the quality.

Senator KYL. And if I could, just while I have a couple of seconds left, it should also take into account the fact that the most devastating thing we could do to the Medicare program generally would be to inadequately reimburse these providers on whom we all rely—all of us over 65; I will be there some day—for care.

We want to provide the best-quality care for our seniors. The worst thing that we can do, it seems to me, is to rely on a system that will inadequately reimburse that key segment of health care providers.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Salazar?

Senator SALAZAR. Thank you very much, Chairman Baucus, and welcome to the committee, Secretary Leavitt. It is good to see you here.

I have three questions. One, relating to the Visiting Nurse program, second, the rural health programs, and third, the reimbursement to pharmacies, especially rural pharmacies.

Let me first start with CHIP. I have been a strong supporter of the Nurse Family Partnership program in Colorado. It now operates in 22 States and has some remarkable results in terms of what happens to children who are born who are part of that program.

I am very encouraged by the fact that you have included that in the President's budget, and for that I congratulate you. I ask you to just spend a quick minute in responding to what you think about the Nurse Family Partnership program and whether this committee should endorse that part of the program.

But let me ask all my questions, then you can go through all three of them at the same time.

Secondly, I wanted to just ask you about the rural health programs. Perhaps because I come from the fourth poorest county in the United States of America, I have always seen the two Americas in some ways exemplified by what happens in terms of the disparity of care in rural America versus the big cities.

I know you, coming from Utah, know that reality, that when you are 5 hours outside of Salt Lake City, it is a very different kind of health care that you are going to get out in some county 200 miles away than you are if you are in Salt Lake.

So I am troubled by the fact that there have been significant funds eliminated from programs that are important to rural America, including the Area Health Education Centers.

There are five of those in my State, including one in my native San Luis Valley, the rural outreach programs, the rural hospital flexibility programs, the rural and community AED programs. So,

I would just like you to respond to how it is that you justify those cuts in the delivery of rural health care services.

Then, third, with respect to the pharmacy requirements and reimbursements, a simple question is, has the administration considered the impacts on the proposal on the pharmacy reimbursements based on the AMP formulas and the impacts of those changes to pharmacies in rural areas?

So if you will take those three questions and take about 3 minutes to respond to them, I would appreciate it.

Secretary LEAVITT. Yes. First of all, on the nurse home visitation initiative, we agree with you, that is a very important initiative and will, we think, create or foster State-wide collaborations that will support high-quality, evidence-based home visitation programs across the country and that it will pay dividends at many different levels.

With respect to the second point in rural health care, you are right. I come from a State where this is very important. I mentioned earlier that there were places in the budget I was looking for that were served by multiple parts of the budget.

The Medicare Modernization Act increased the amount of funding available to rural health care by \$25 billion over 10 years, and so we have viewed some of those programs as being redundant, and that is the basis on which those decisions were made.

With respect to the average manufacturer price, frankly, Medicaid pharmacy is still the highest reimbursement that any pharmacy receives. I have spent a lot of time behind a pharmacy counter in the last year with Part B, and I understand why they are concerned that those prices are coming down, but they are still substantially higher than they are being paid for by many other payors. So we, frankly, just believe that as a matter of making Medicaid more efficient, we need to undertake that proposition.

We cannot allow rural pharmacies, community pharmacies who people depend on, particularly in some of those same rural areas you have spoken of, to not have business viability. That is something that I am watching very closely.

Senator SALAZAR. Let me push you just on that last comment. The GAO report that was recently released on the AMP issues spoke about the reimbursement to these pharmacies, and it basically said that the current AMP at the higher level that it currently is before the reduction that has been proposed, that it does not cover the actual acquisition costs for the drugs.

So if you already have many of these rural pharmacies that are hanging on by a shoestring, will the reduction by essentially 100 percent of AMP—I think it is from 250 percent to 150 percent—what impact will that reduction then have on those pharmacies?

Secretary LEAVITT. There is a long, detailed answer here. But in the absence of a lot of time, let me just say we do not agree with the GAO report. We just disagree with it. I would be happy to give you a more detailed answer if you would like that when the time allows.

Senator SALAZAR. All right. We will ask for that on the record.

My time is up, but the Chairman is not around, so maybe I can keep going.

Senator WYDEN. I am supposed to sort of crack the whip. But if I do not get too much grief, go ahead and ask one more.

Senator SALAZAR. No. I will save my questions or I will submit them for the record. Secretary Leavitt, thank you for being here.

Secretary LEAVITT. Thank you, Senator.

Senator SALAZAR. Thank you, Senator Wyden.

[The questions appear in the appendix.]

Senator WYDEN. I thank my colleague.

Mr. Secretary, in the name of reconciliation, let me note that, on your Oregon visit, the topic you chose pleased both Democrats and Republicans. Clearly, we can do more in the technology area, and we appreciated your coming out.

I have not gotten to hear every Senator this morning, but I am not surprised at the message that you are getting. What has happened is, despite all the wonderful health care providers and facilities we have in this country, the American health care system is broken.

What we have is, when you try to proceed piecemeal, an awful lot of people get hurt. All those youngsters, for example, whom we need to get covered through the Children's Health Insurance Program and other kinds of services. You have the other people who are hurt by these piecemeal changes come to their Senator, and their Senator tells you, and that is what you are seeing, I think, here today.

What is especially troubling is we are spending enough money in this country on health care. We are not spending it in the right places. For the amount of money we are spending, we could go out and hire a skilled physician for every seven families in the country who would do nothing except care for those seven families. Often when I tell physicians this they say, "Ron, where do I go to get my seven families?" because they would like to practice medicine.

So I think there is an opportunity for bipartisan reform here, and I was glad that the President talked about health care in the State of the Union. We have differences of opinion about what was said, but what are the possibilities of working now in a bipartisan way where Republicans say, we will go further to expand coverage because we know to fix this we have to get people covered, because otherwise the uninsured people send their bills to the insured. And if Republicans move to expand coverage, Democrats like myself say, look, there is a very valid point on the tax code. You can debate how to do it, but the tax code promotes inefficiency and it benefits disproportionately the most affluent.

So wouldn't this be an opportunity to get beyond some of the fighting and the sparring that is inevitable in this broken system and try to get Democrats and Republicans together around something that approaches the vision I have described?

Secretary LEAVITT. Senator, that would be something I personally, and I believe the administration, would welcome. I believe there are at least five primary constructs that we ought to focus on on which I believe there is broad agreement.

The first is that there is a need for every American to have access to an affordable basic insurance policy. The second is that consumers deserve to have an independent assessment of the quality of the care they receive. I think the third is that people deserve to

know and need to know the cost of their care in advance. I think the fourth is that there are things that a person deserves to know, that every decision is being made with high quality and low cost in mind. Lastly, people deserve to have access in a way that is convenient to them, access to their medical records.

I think that within those five constructs is the making of a system that would serve the American people well and on which I would look forward to working with you and others in both parties to achieve.

Senator WYDEN. I thank you, Mr. Secretary. Everybody says it cannot be done. Everybody says the Congress is too polarized, we have to wait for another presidential campaign, it just cannot be done. I am not going to accept that. I think there is a real opportunity here. We have seen the States go forward and innovate. There are good ideas out there. Governor Schwarzenegger and Governor Romney deserve credit. But the States cannot really fix this. They cannot do anything about the tax code. Of course, the Federal Government is the big spender here.

So, I think we can look for ways to encourage State innovation, but I want your take-away message to be that, if you can champion the cause of getting the administration to move to expand coverage, and of course that is real coverage, good-quality, affordable private coverage, not just access but people getting the product, I am going to do everything I can to work in a bipartisan way with the administration, with Democrats and Republicans here to see if we can defy the odds, not just say, wait for another presidential campaign to fix health care, and see if we can get it done now.

Secretary LEAVITT. There is a great opportunity right now, because the States are chomping at the bit to run with this. There are proposals being developed in at least a dozen States that I know of and, frankly, some others that have not yet been announced.

The formula for them is very simple: they need to develop an affordable basic insurance policy or a basic insurance policy, and then between the Federal Government and resources that are available, we need to help, maybe give them tools, to make it affordable.

There is one problem that the States cannot solve that must be solved in order to achieve this, and that is the indefensible tax treatment that those who acquire insurance outside of employment are provided.

It is indefensible that Americans who buy through the employer-sponsored insurance system get a tax deduction and those who have to buy it on their own cannot. We cannot defend that. We have to fix it.

Senator WYDEN. My time has expired, Mr. Chairman.

I thank you, Mr. Secretary.

The CHAIRMAN. Thank you very much, Senator.

Senator Roberts?

Senator ROBERTS. Thank you, Mr. Chairman. I had hoped that Senator Wyden would continue in your absence in terms of the limited time that I have. As the former chairman of the Intelligence Committee, I checked in regards to extra time given to Senator Wyden by myself: it is 2 weeks, 1 day, and 34 minutes. [Laughter.]

In which case I thought I would get a little more time. Perhaps you, sir, who took a great deal of time on our trip to Cuba when we visited with Castro that went 14 hours, could grant me a little bit of leeway.

The CHAIRMAN. That is probably fair, because he did all the talking.

Senator ROBERTS. Right.

The CHAIRMAN. This time you can talk a little.

Senator ROBERTS. It was the world according to Castro. But this is the world according to Roberts.

Secretary Leavitt, thank you for coming. We all share responsibility to get a handle on the growth of Medicare and Medicaid so that these programs are viable and sustainable. I know that, and we are going to cover some ground that my colleagues have already covered. I apologize for not being here.

I do not want to be in the business of tying the hands of our health care providers, especially those in our rural areas. I used to be the head of the posse over in the House on the Rural Health Care Coalition.

We banded together, getting a little tired of beating our knuckles a little bloody on the door of HEW at that particular time—I date back to those days—on harming our seniors and low-income populations by restricting their access to care. I am also on the HELP Committee, so there is a combination there where we can work together, and I look forward to working with you.

We are a rural State. Eighty-eight of our 105 counties are considered rural or frontier. Over 75 percent of our community hospitals are located in rural areas. Eighty-four percent have fewer than 100 beds. Eighty-four percent. We have 82 professional shortage areas all throughout the State.

Two programs, Rural Outreach Grants and Rural Hospital Flexibility Grants, are proposed for elimination, yet they have been absolutely vital to the success of our rural health care delivery system in Kansas. I am not very happy with that, to say the least, and neither are our State people who run the programs.

In addition, the budget proposed that you reduce funding for the National Health Care Service Corps, and nearly eliminate the title VII Health Professions Program. In Kansas, we rely on both of these programs to get doctors and other health professionals to serve in our rural areas. I remember when Joe Califano of HEW said that three doctors had to approve every patient admission in order to be eligible for Medicare.

I was serving in the Congress at that time, and I supported that effort. Of course, it was impossible, because we did not have the doctors. But I thought, if it was a mandate that three doctors go over every patient admission, they might furnish the doctors, so I supported the program. I am being just a little sarcastic here.

I have serious concerns with the lack of proposed funding for the State High-Risk Pools Program. Last year, we worked with my colleagues on the HELP Committee to renew this program. I like to think of it as a bill that I really supported and co-sponsored, and the President signed the measure into law.

With a very small Federal investment, high-risk pools provide health insurance coverage for individuals who would otherwise be

uninsured because of preexisting medical conditions or the inability to afford care.

I do not understand how this budget can justify not extending funding for a program that has been so successful at insuring individuals who would otherwise be unable to gain access to care at this time.

I would like for you to shed a little light on why this budget does not provide funding for the High-Risk Pool Program. I only have a minute to go. I think basically what we ought to do is to have you come up to the office, or I can go down to yours, or whatever, and then we will talk about these concerns that I have raised, because I know we just cannot do it with the time that the Chairman—oh. Nobody. Oh. Sorry, Madam Chairman. We are running out of time.

Pandemic flu. Senator Clinton and I introduced efforts for pandemic flu and bioterrorism planning. You know what is happening around the world, where we have had avian flu spreading in poultry in Japan, South Korea, Vietnam, the Middle East.

There was an outbreak over the weekend in turkeys in England, and two more confirmed human cases in Indonesia just yesterday. I want to know how the budget request does support these efforts in terms of vaccine. We have worked with you in regards to a plan, but we need to know where that is.

Hospital payments. Why on earth, when MedPAC recommended a full update for hospitals in 2008, and we have basically Medicare margins projected to be minus 5.4 percent? This happens every year. Every year we have the Sheep and Cattle Board. Every year the budgeteers pull out the file and say, can't we do better to control Medicare costs?

We go all the way through the year, and hospital administrators and all the people come in from hospitals and say, we cannot do this. Quite frankly, what is happening is we have specialty hospitals now who do not accept Medicare patients but work in the public hospitals. If it does not work in the specialty hospital, they go to the public hospital.

So we have a two-tier system now that is working in regards to public and private with people who say, I cannot do this, I cannot be reimbursed in regards to the Medicare payment with what I am doing. So what we are doing is having triage out there and rationing our health care, and that is not an answer.

Home oxygen. The budget proposes to reduce the rental period for most home oxygen equipment from 36 to 13 months. Senator Reed spoke to this. I will tell you that, in many of my communities, the Home Health Care Agency is the only outfit that sends anybody out there to a home in an outlying area to treat the patient in regards to home health care.

In terms of oxygen, it seems to me we have a rental policy to beneficiary ownership. It does save money, but I believe these savings come at the expense of the senior's safety. Requiring our beneficiary to assume responsibility and ownership of home oxygen equipment is an unreasonable burden.

I know seniors who are very ill, on oxygen. If they do not get that person to come out there and make sure that that equipment is run right—some of them even smoke with the oxygen tank. I mean,

hello! So, consequently we are going to have a lot of people turn blue and then gray if we do not get that back and changed in regards to that support.

Senator Kyl mentioned the physician payment, 10-percent reduction in Medicare physician payments slated in the payment formula. We are just going to exacerbate what I told you about, and I know you know this, that you are going to have a two-tier system here, with people who will take Medicare patients and people who will not. We do not need that. The public hospitals basically now are overwhelmed in terms of the emergency care with the immigration problem, especially in Kansas where we have a large influx of that.

Now, I have gone on a laundry list, if not a rant, in front of you. I look forward to your answers. I am out of time. You do not even have time to respond. But I am looking forward to a personal visit with you. We can go over these things. I do want to work with you in the spirit that Senator Wyden said, in a bipartisan matter.

That is all, Mr. Chairman.

The CHAIRMAN. Thank you, Senator. Fidel would be proud. [Laughter.] Thank you.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

I would like to follow up, I think, on a question that you asked Secretary Leavitt. Good to see you, Secretary Leavitt.

Secretary LEAVITT. Thank you.

Senator CANTWELL. Did you say that you do not think there will be an impact on current SCHIP enrollees?

Secretary LEAVITT. Our policy would be to——

Senator CANTWELL. Could you speak a little louder?

Secretary LEAVITT. Our policy would be to sustain coverage for any child currently on the program, or any adult currently. We would pursue, however, in the future to have a reduced match rate or to not have the enhanced match rate on children over 200 percent in the future.

Senator CANTWELL. So you are saying for the next fiscal year or you are saying for——

Secretary LEAVITT. That would be a principle for the reauthorization of the program.

Senator CANTWELL. I do not understand how, if CRS thinks we need \$15 billion, you have provided \$5 billion. So are you saying you are admitting that there is a \$10 billion shortfall and in the future you would take that gap between 200 and 250 percent of the poverty level and——

Secretary LEAVITT. There is roughly \$4.4 billion left in the allotments from previous years and there is \$5 billion in the base. So you take \$5 billion, plus \$5 billion, plus \$4.4 billion, and that gets you to the funding level.

Senator CANTWELL. And then you want to move forward on a discussion on those, changing the dynamic for that population that is between 200 and 250 percent?

Secretary LEAVITT. That is correct. This is all in the context, however, Senator, of desiring to assure that there is an affordable basic insurance policy available to every American, SCHIP being one of the tools we use to get there. But it requires that we aggres-

sively work with the States to solve the problems they have in being able to reach that objective.

Senator CANTWELL. I think I could go a lot of different ways on that answer, given what I think you know well in our State we had to do in plugging the hole after the Medicare/Medicaid dual eligibility issue and what our Governor worked out with your Agency to cover people who basically already had services, and then were having those services curtailed. So, moving money around from Peter to Paul does not, in my mind, usually provide for continued comprehensive care.

One of the things I wanted to ask is, Washington State was the first in the Nation to cover children up to 200 percent of the poverty level, and did that in 1994, I believe, before this Federal program came into place. Because of that, we were penalized. I am not exactly sure why we were penalized, because several other States who currently were servicing that population were not penalized. But there were several States that were left out of that mix.

Do you support fixing that so that Washington State can use its current backlog of allocated funds to cover those children?

Secretary LEAVITT. I am not sure I know what you are asking, but let me answer two or three things and then we will see if we have covered it.

There are funds that are available to be reallocated right now for the current year. We support that. Going forward, however, we believe reallocation should occur only every year.

We do intend to support having this package continue to cover any child who is currently covered, or any adult who is currently covered, which would include the 200 percent that you currently cover, I believe, in the State of Washington.

Senator CANTWELL. The complication arose in the Act being passed, saying that the Federal Government would not cover any child that was currently covered. So Washington State was already covering 200 percent of the poverty level, so those children were not eligible.

Now, the Chairman has done a great job of trying to help us solve this problem going forward, but it makes no sense to cut those children off of the program for a year, only to say that in the following year that they are now eligible, only because the State of Washington had the foresight to implement a program prior to the rest of the Nation.

As I said, there is inequity between several States. I think there were several States that did get covered that had preexisting programs. So we certainly hope that you would support a level playing field among States on what is being covered.

Secretary LEAVITT. I had the benefit of being here in 1997–1998, not in Congress but as a Governor, and leading and participating in the discussion. The development of formulas is always imperfect, and this one is. To the extent that it can be improved in the reauthorization, I believe everyone would be happy with that.

Senator CANTWELL. You are saying you think all States should be treated the same?

Secretary LEAVITT. Well, we certainly need to have an equitable formula, there is no question. The one we have—formulas always have imperfections, and this one is no exception.

Senator CANTWELL. I see my time is up, Mr. Chairman. Thank you.

The CHAIRMAN. Thank you very much. Thank you, Senator. Senator Stabenow?

Senator STABENOW. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. It is good to see you again. I have many questions and time is limited, so I will move quickly.

First, to health IT. You and I have talked about this on a number of occasions. I understand your commitment. The President spoke about it in the State of the Union. I know that interoperability standards are important.

I also believe that it is critically important that we provide resources so that systems will move ahead, as we have talked before, that people will begin to get the hardware and software and so on.

In the 2008 budget request, there is only \$118 million for a health information technology initiative. What concerns me is that we know that most of the savings on health IT will accrue to us, the Federal Government, Medicare, Medicaid, and so on, and yet we have to have providers, nonprofit and for-profit providers, that are willing to go out, invest the money on hardware, software, and so on to be able to get online so we can accrue those savings.

So we have nothing really in here to provide incentives, and yet at the same time a proposed physician cut of 10 percent for next year, which is not likely to give a physician the incentive to go out and do what they need to do so that we can be successful in saving very large amounts of money and lives.

And you have seen the numbers: \$80 billion to \$100 billion a year, depending on whose numbers you look at. Senator Snowe and I have introduced a health IT bill to focus on incentives.

I wonder if you would just speak to the whole question of why we are not investing more in something that clearly has a huge return to the Federal budget, as well as to quality of health care.

Secretary LEAVITT. We have focused Federal efforts to achieve standards of interoperability that would allow for systems, as they are developed, to act as a system. The point you are making is a valid one, that the benefit is not always proportionate. The doctors are having to make investment and sometimes the benefits go to those who are either served as patients or insurers or payors. That needs to be reconciled, and it will be reconciled in time.

Now we have started, for example, with the way we are using the SGR for doctors' reimbursement in Medicare. A portion of that is paid for information gathering. The same is true with hospitals. We are starting to see the macro-economic model shift to the point that we are reimbursing, in part, to cover that overhead.

There is no question about the fact that the economics will have to change, and I believe they are.

Senator STABENOW. Well, I look forward to working with you, because I believe that they are not moving as quickly and boldly as they should for us to obtain the savings that are necessary.

Switching to Medicare prescription drugs and the hearing that we had on negotiation, we heard, I think, at least a general consensus that in some cases—there was not a general consensus in all cases, but in some cases—regarding, for instance, single-source drugs and so on that the Secretary negotiating can make a real dif-

ference, particularly where there is no competition, or dual eligibles where there were concerns raised about the level of prices and so on.

Do you believe that there are any circumstances under which a U.S. Secretary could do a better job of negotiating a drug price than what is currently happening?

Secretary LEAVITT. Obviously this is not about me or any individual Secretary, it is about the question: is it possible for a person individually, or a government, to do a better job than an efficient market?

Senator STABENOW. Absolutely.

Secretary LEAVITT. It is my belief that an efficient market is the most effective way to negotiate prices, and we have seen it work. As you know, we have seen Medicare Part D prices drop dramatically, and they have dropped because that competition is taking place and because people are happy with, I believe, plans they like and that meet their needs.

Senator STABENOW. I would suggest there are huge differences in numbers, certainly, when we look at one end, which is the VA, versus the lowest end on the prescription drug prices, huge differences in some cases.

But I am wondering. Secretary Tommy Thompson, as you know, negotiated a better price for Cipro. Many of us had to go on Cipro after what happened with anthrax. Do you think that was appropriate for him to use authority to negotiate in that case to get a better price?

Secretary LEAVITT. In that case he was buying it for the government. In the case of Part D, people are buying drugs for their own use. It is a far different role.

Senator STABENOW. So for the government it is all right to negotiate.

Secretary LEAVITT. Well, this is a far different role. We put those into stockpiles and they stay there, and we will dispense them in a time of emergency. That is the government making decisions for government, not government making decisions for consumers.

Senator STABENOW. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Bingaman?

Senator BINGAMAN. Thank you very much.

Mr. Secretary, thank you for being here. I apologize for not being here for your earlier statement. But I wanted to ask about two issues. One is the administration's proposal to limit Medicaid financing mechanisms for public providers.

Since Medicaid was first started, these kinds of mechanisms have always been an important part of allowing State and local government to finance the non-Federal portion of the Medicaid program. The administration proposed these changes last year and sent legislation to the Congress in 2005 to enact these measures. Congress rejected that.

Last year in the budget, the administration indicated its intent to adopt these proposals administratively. I think there were letters sent—300 members of the House, 55 members of the Senate signed those letters—opposing those cuts.

But despite this pretty clear bipartisan opposition to the proposal, the administration nevertheless went ahead with a proposed regulation making fairly sweeping changes in Medicaid along these lines. Why does the administration insist on going forward with its rulemaking on this issue in light of the strong, clear opposition here in Congress?

Secretary LEAVITT. The principle behind our actions stems from the fact that we are partners with the States on these programs. We have already put up 57 percent-plus, depending on the State and the circumstance. We are looking to have a partnership where both parties put up real dollars.

What happens in many cases is that States take Federal dollars, they circulate them in a way that they can then return Federal dollars for the purpose of getting more Federal dollars. We are looking for a partnership where Federal dollars are put up and State dollars are put up, and that we are not creating the kind of creative financing that we have seen in the past.

I want to acknowledge, we have made substantial progress with the cooperation of the States. It is a theme that we will continue to sound because we think it is not only important to the integrity of the program, but we think it is in the best interests of the viability of the program long-term.

Senator BINGAMAN. Has the administration prepared an analysis of the impact on each State of this proposed rule, what you would project to be the impact? I think quite a few States—mine included—have had some concern about how this would impact. There are some ambiguities in the proposed regulation, as I understand it. If you have any State-by-State impact data, that would be very useful for us.

Secretary LEAVITT. One moment. [Pause.] What information I have, I will make available to you. It is partial. It is not complete, but we will make what we have available to you.

Senator BINGAMAN. We would appreciate that. I think that would be very useful. Maybe that will clear up some of the ambiguity. I hope it does.

Let me ask, on one other issue, the President spoke in his State of the Union, I believe, about providing Federal support to State-based efforts to expand health coverage, and I certainly support that. In fact, Senator Voinovich and I both have introduced a bill to try to accomplish that, S. 325.

I am concerned, though, that some of the information that was provided to us accompanying the State of the Union speech indicated that the President's proposal was to pay for this, pay for these initiatives by the States, by cutting funding for the Federal Medicaid Disproportionate Share Hospitals. It seemed to me that this was wrong-headed.

Obviously, the Disproportionate Share Hospitals in my State feel very strongly that the funds that they receive through that provision of the law are extremely important for these safety net hospitals.

Could you clarify what your thinking is there as to whether we should be taking money from safety net hospitals in order to support initiatives, or is there another way we could get this paid for?

Secretary LEAVITT. There are many places in the Federal budget that support the efforts of hospitals in primarily three categories. The first is to pay for uncompensated care, those patients who come to the hospital who need to be cared for who do not have insurance.

The second category would be in supporting public hospitals with capital, equipment, and other measures. Let me just settle with those two. Our view is that, rather than perpetually pay the health care bills of people who are uninsured, at least some part of that could be used to help people get insurance.

Now, there will be always be people who are uninsured because of different circumstances, but if we could dramatically reduce that in a coordinated effort with the State, then perhaps some of that money could be used in a better and more efficient way.

We currently have discussions going with more than a dozen States. In each case, we are working with the hospitals and the Governor to say, if you could dramatically reduce the number of uninsured, does it make sense to have the exact same amount of money going into perpetually paying the bills of the uninsured?

Well, it does not. It would likely make sense to make some of that available to the Governor for the purpose of being able to have an affordable basic health plan available to their citizens.

Senator BINGAMAN. But the way you are describing it, this would be a choice that the State would make.

Secretary LEAVITT. Absolutely.

Senator BINGAMAN. So the State would be able to keep its DSH funding as it currently has it and just not access Federal support for other initiatives if it wanted to.

Secretary LEAVITT. That is right. That is the way we contemplated. I am meeting with a lot of States right now. I have made a commitment to meet with nearly all of the States in the 100 days following the State of the Union, and I have been to about 10 now, and I will be in a dozen in the next couple of weeks.

In most of those cases, the State is already formulating an effort to create a basic plan. We know that there are still going to be people in those States who cannot even afford a basic plan, and so we want to work with the States to develop a plan of affordability.

Part of that plan of affordability could be to work with the hospital to say, if we reduced by half or more, if we could cover every person who is uninsured with a basic insurance policy, we do not need to perpetually pay the bills of people because they will be insured.

So does that free up at least a portion of this money that could be used to help people buy insurance? We are working in a coordinated way with the Governors.

Senator BINGAMAN. Thank you very much. Appreciate it.

The CHAIRMAN. Thank you, Senator.

Thank you, Mr. Secretary. There were many Senators who said they wanted to come back and ask more questions; obviously they were unable to do so. I suspect that they will have questions for you in writing, and I would just ask you to promptly respond.

Secretary LEAVITT. We will do our best, yes.

The CHAIRMAN. Even including the letter to Senator Grassley.

Secretary LEAVITT. To both parties, Senator.

The CHAIRMAN. All right. Thank you.

Secretary LEAVITT. Thank you.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 12 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Statement for the Record
Senator Jeff Bingaman
Finance Committee Hearing, Briefing by HHS Secretary Leavitt
Re: The Administration's FY 2008 Budget
February 7, 2007

Mr. BINGAMAN. I would like to thank Secretary Leavitt for appearing before us to brief us on the President's FY 2008 budget.

I am deeply troubled by many of the proposals in the President's budget and in particular have serious concerns about the aggressive cuts that he has proposed to numerous health care programs such as Medicare, Medicaid, and other public health programs. Nearly 50 million Americans lack health insurance, and that number continues to rise. Instead of focusing on finding ways to provide the uninsured with health care, the White House is primarily focused on proposing deep cuts to a variety of important health care programs. This is very disappointing, and I hope Congress has the will to rise above these proposals and find meaningful ways to improve access to health care for all Americans.

In total the budget includes devastating cuts of \$101 billion to government health care programs. Included in these cuts, the Bush Administration is proposing more than \$75 billion in cuts to the Medicare program, which primarily provides health care to senior citizens and the disabled. These Medicare proposals include significantly increasing premiums to seniors and others as well as significant decreases in payments to hospitals, skilled nursing facilities, hospice care, home health services, and several other critical health care services.

In addition, the Bush Administration proposes nearly \$26 billion in cuts over five years to the Medicaid program, which provides healthcare to low-income children, seniors, pregnant women and others. These cuts would include a proposed Medicaid regulation released in January that would mandate across-the-board restrictions on payments to safety-net providers that could result in New Mexico losing tens of millions of dollars in Medicaid funding annually.

The Bush administration also would eliminate the Community Services Block Grant, which had been funded at \$630 million this year, as well as the Rural Community program. The proposal also includes deep cuts to the Social Services Block Grant. These cuts would result in the loss of millions of dollars of public health funding to New Mexico.

I also am very troubled by the Bush Administration's proposal to eliminate the already underfunded Urban Indian health program, which provides critical funding to First Nations in Albuquerque as well as many other urban Indian health programs. During Secretary Leavitt's comments to the Committee, he highlighted a perceived "redundancy" between the Urban-Indian program and Community Health Centers. I strongly disagree with the Secretary's assertions in this regard.

Indians who live in metropolitan areas retain their tribal identities; as a result of this, the Indian Health Service has the same obligation to serve them as they do the Indians who reside on

reservations. However, service to this Indian population is severely under-funded in the same manner that other components of the IHS system are under-funded. Furthermore, the IHS considers this population within their mission and limited funds for this population are included in IHS appropriations (PL 94-437). Within this context, neither I nor IHS consider these services redundant in relation to Community Health Centers.

The President's Budget also proposes cuts in this year's federal spending for the State Children's Health Insurance Program (SCHIP) by \$223 million, or 4 percent and limits SCHIP to a subset of currently eligible children that may result in as much as 60 percent or more of the children currently enrolled in New Mexico's SCHIP program losing coverage. Such a policy would penalize states like New Mexico that cover children at much higher federal poverty levels than other states through their Medicaid program.

In total, the President proposes \$5 billion in SCHIP funding for the next five year; however, shortfalls in the program needed to cover all individuals currently enrolled in the program are estimated between \$15 to 15 billion. Thus, the President's proposal could result in hundreds of thousands if not millions of children, parents, and adults who currently receive health coverage through the SCHIP program losing coverage.

In the 10 years since passage of the State Children's Health Insurance Program or "SCHIP," the number of uninsured children has decreased while at the same time the ranks of uninsured adults have grown alarmingly. This is a great achievement on behalf of children, by any measure, but there is still more work to do. Six million children remain eligible for Medicaid or SCHIP, but are not currently enrolled. Thus, the re-authorization of SCHIP must build on this past success to expand the program and ensure that all children in America have access to meaningful health insurance coverage.

Medicaid, our gold standard safety net insurance program for children, was designed at a time when people who worked full time could expect to be able to afford health care. This is no longer true. Today, a full time worker earning minimum wage is at 50% of poverty level. Furthermore, two working adults with wages of \$10 per hour do not have enough earning power to afford their health care, yet are at 200% of poverty. Insurance premiums have risen faster than inflation, as have health care costs.

SCHIP priorities for the Nation should be to continue coverage of all currently covered under SCHIP, expand the number of enrollees to capture eligible yet uninsured children, parents and other adults, create incentives for New Mexico and other states to use Medicaid and SCHIP to reduce the number of uninsured, expand coverage to include documented immigrant children and pregnant women, and ensure that Medicaid and SCHIP documentation requirements do not serve as a barrier to U.S. Citizens receipt of SCHIP and Medicaid services.

Finally, I very much support the goals described in the Administrations budget of providing federal support to state-based efforts to expand health coverage. However, I am very concerned about information released vis-à-vis the State of Union that indicates that the President proposes that Federal Medicaid Disproportionate Share Hospital (DSH) would be used to fund, at least in part, these expansions. While state-based health care expansion may provide some relief to safety-net providers that receive DSH funds, it is unrealistic to think that a considerable portion of the individuals served by safety-net institutions would necessarily benefit from state-based expansion efforts. For this reason, I believe efforts to shift DSH payments from safety-net providers could dangerously undermine the financial stability of our health care safety net and, therefore, the access of low-income Americans to critical health care services.

Though we agree about the need for federal support of state-based efforts, we clearly and strongly disagree about the financing of this federal support. I, in conjunction with Senator Voinovich and colleagues in the House have introduced the Health Partnership Act, S. 325, which would provide a mechanism by-which Congress could provide states with this federal support without undermining safety-net providers.

**Opening Statement of Hon. Chuck Grassley, Ranking Member
Senate Finance Committee**

**Budget Hearing with Secretary Michael Leavitt
February 7, 2007**

Thank you, Chairman Baucus.

And thank you, Secretary Leavitt, for coming to discuss the President's spending proposals related to Medicare and Medicaid. I look forward to hearing about the Administration's priorities for the Department of Health and Human Services and discussing the details of the President's budget.

The President's budget proposes substantial savings in the Medicare and Medicaid program. Together, these provisions would decrease spending by almost \$97 billion over the next five years. Altogether the President's budget would erase the budget deficit by 2012.

This budget proposal comes in the footsteps of news of the fiscal year 2006 unified budget deficit actually being lower than originally forecast and also lower than the previous year's budget deficit.

As encouraging as the short term fiscal outlook may appear, we can not ignore the discouraging long term fiscal outlook.

Earlier this year, heads of the Federal Reserve System, the Government Accountability Office and the Congressional Budget Office all testified before the Senate Budget Committee on the impact of entitlement spending on the budget.

Now many have raised alarms about the magnitude of the proposals in the budget for Medicare and Medicaid. In reality, these proposals will only slow the growth in Medicare in 2012 by less than one percentage point. If Congress enacted all of the Medicaid proposals, it would change the annual growth in Medicaid spending in 2012 from 7.2 percent to 7.1 percent.

It is clear that as baby boomers become eligible for Social Security benefits as early as 2008 and Medicare benefits as early as 2011 and medical costs continue to rise faster than the rate of inflation, spending for entitlement programs will become unsustainable. Spending for entitlement programs like Social Security, Medicare and Medicaid already total about 40 percent of federal expenditures or over eight percent of the GDP.

As many of us here will recall, last year there were efforts to modernize Social Security to strengthen its long term viability. Unfortunately, we did not get very far because some from the other side of the aisle justified inaction on Social Security on the grounds that the financial health of the Medicare program was a more urgent issue.

Well, here we are one year later. I certainly hope that we can work on a bipartisan basis to address how entitlement spending such as Medicare is taking up more and more of the federal budget.

Congress faces some tough choices.

Over the years, efforts have been made to slow the rate of growth in entitlement spending. Last year, the Medicare Trustees made an official determination of "excess general revenue Medicare funding" as Congress required in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 or the MMA as we like to call it. If the Trustees make a similar determination this year, the MMA requires the President to propose legislation to address entitlement spending in next year's budget.

During last year's Committee hearing on the fiscal year 2007 budget, I don't think I shocked anyone by saying that any more reductions of a significant scope could be difficult to achieve that year especially after we had just passed the Deficit Reduction Act of 2005.

I don't think I will shock anyone today by saying that any more reductions of significant scope will be difficult to achieve this year. For starters, some of the same challenges we faced last year are still here today.

One area we will probably need to address this year is physician payments. The physician payment sustainable growth rate (SGR) formula is still fundamentally flawed. While the Tax Relief and Health Care Act of 2006 eliminated a five percent cut to physician payments and provided a one-year, zero percent update instead, plus the opportunity to earn a 1.5% bonus for reporting quality measures, physicians will face even more severe payment cuts in 2008.

And over the next five years, Medicare payments to physicians under the SGR are projected to be cut five percent a year and could decline a total of 25 percent during that period. This could threaten access for beneficiaries. At the same time, enrollment in Medicare Part B is expected to grow rapidly over the next several years as baby boomers become eligible for benefits, rising from an estimated 41.4 million in 2008 to 45 million in 2012.

A key priority for the Senate Finance Committee this year will be the reauthorization of the State Children's Health Insurance Program or SCHIP. I want to associate myself with remarks that Chairman Baucus made during the SCHIP hearing last week that put SCHIP reauthorization at the top of the agenda for work in the health arena this year.

I am interested in learning more about the President's plan to reauthorize SCHIP and look forward to working in a bipartisan manner to improve this critical safety net program.

The President's budget includes a proposal for SCHIP that offers about \$6 billion in new funding. Some questions have been raised about this proposal and I hope you will give us more details today.

The President's budget achieves a substantial portion of its savings from Medicare provider payment reductions. Many of these recommendations go further than what the Medicare Payment Advisory Commission has recommended.

In addition to looking at payment updates, I continue to strongly support linking provider payment to quality care as a way to make Medicare a better purchaser of health care services. Today, Medicare rewards poor quality care. That is just plain wrong and we need to address this problem.

Congress passed the first steps for pay for performance in 2003 in the Medicare Modernization Act. Then further steps were taken in the Deficit Reduction Act in 2005. During last year's Tax Relief and Health Care Act of 2006, we took further steps to lay the foundation for pay-for-performance in additional settings by expanding quality reporting to physicians, hospital outpatient departments, and ambulatory surgical centers.

In this year's budget, the Administration proposes the establishment of budget-neutral incentives for high quality hospitals and the creation of minimum benchmarks for low-quality hospitals.

While this proposal is a good step in the right direction, I believe that we should consider even bigger and bolder steps. We have not started all Medicare providers on the road toward value-based purchasing, and I would have liked to see such proposals in the budget.

The reporting of quality data is a good first step towards increased transparency. Just the reporting of quality data has resulted in improvements in quality for hospitals. And, I believe that consumers need access to quality and cost information on providers so that they can become more engaged in their health care decisions.

We need more transparency on health costs because beneficiaries don't know what they are paying for. Data on providers' costs and quality should be publicly available to give consumers an idea of what they're buying.

Giving consumers more direct involvement in paying for their care will prompt them to shop for the best value, ultimately choosing the highest-quality and lowest-cost care. This will increase competition, resulting in improvements throughout the health care system.

I also appreciate President Bush's leadership in putting forward a plan to help more Americans get health insurance. There are now about 47 million Americans without health care coverage.

There's no one-size-fits-all solution to the uninsured problem because people are uninsured for a lot of different reasons. We need new strategies to solve this persistent problem.

The President has correctly identified a flaw in health care tax policy. Similarly situated workers are treated very differently, depending on their employer's choice to provide or forego health coverage. The Joint Committee on Taxation estimates that over the next decade, Americans will receive more than \$1 trillion in tax benefits for health care under our current tax law.

We need to make sure those benefits are being directed wisely, get the most bang for the taxpayer's buck, and help to meet the needs of the millions of Americans without health insurance.

A plan like the President's could help level the playing field by extending the tax incentives for purchasing health coverage to the self-employed and those who purchase health coverage on their own. It also would make health insurance portable as people change jobs.

I look forward to discussing the details of this proposal so we can use it as a starting point as we address these issues in a bipartisan manner to both expand health insurance coverage and contain health care costs.

Before I conclude my opening remarks, there is one more issue I would like to bring to your attention, Secretary Leavitt. As Chairman of the Committee during the 109th Congress, I made many requests to HHS and its related agencies for information and access to people and numerous documents; many of the responses to those requests remain long overdue. For example, I discussed with you our long-standing request for a privilege log in the Ketek matter and I still have not received one. At this point in time, it is my understanding, that your staff has been instructed to ignore my outstanding Committee requests since I am no longer Chairman.

Consequently, I formally sent a letter to your office outlining my concerns in hopes that some light can be shed on the so called "long-standing" policy regarding responses to outstanding congressional requests when there is a change in leadership. In fact, just last week I was advised that there was certain information that I would not be provided. I had my staff request a letter articulating that "so-called" policy in anticipation of this hearing; but yet again I did not receive what I requested.

I think it is important for members of both parties to understand why the Administration believes it can simply ignore legitimate requests from Congress as we attempt to conduct oversight. We cannot, as members of Congress, successfully carry out our constitutional responsibility to conduct oversight when congressional requests for access to the Executive Branch are disregarded.

Mr. Secretary, thank you again for being here today and for sharing more detail on the President's proposals.



Testimony
Before the
Committee on Finance
United States Senate

**FY 2008 Budget Request for the
Department of Health and Human
Services**

Statement of

Michael O. Leavitt

Secretary

U.S. Department of Health and Human Services

February 7, 2007

FY 2008 Budget Announcement

Chairman Baucus and Senator Grassley, thank you for the invitation to discuss the Department of Health and Human Services' budget proposal for fiscal year 2008.

For the past six years, this Administration has worked hard to make America a healthier, safer and more compassionate nation. Today, we look forward to building on our past successes as we plan for a hopeful future.

The President and I have set out an aggressive, yet responsible, budget that defines an optimistic agenda for the upcoming fiscal year. This budget reflects our commitment to bringing affordable health care to all Americans, protecting our nation against public health threats, advancing medical research, and serving our citizens with compassion while maintaining sensible stewardship of their tax dollars.

To support those goals, President Bush proposes total outlays of nearly \$700 billion for Health and Human Services. That is an increase of more than \$28 billion from 2007, or more than 4 percent. This funding level includes \$67.6 billion in discretionary spending.

For 2008, our budget reflects sound financial stewardship that will put us on a solid path toward the President's new goal to achieve a balanced budget by 2012.

I will be frank with you. There will never be enough money to satisfy all wants and needs, and we had to make some tough choices.

We take seriously our responsibility to make decisions that reflect our highest priorities and have the highest pay-off potential. We recognize that others may have a different view, and there are those who will assume that any reduction signals a lack of caring. But reducing or ending a program does not imply an absence of compassion. We have a duty to the taxpayers to manage their money in the way that will benefit America the most.

I would like to spend the next several minutes highlighting some of the key programs and initiatives that will take us down the road to a healthier and safer nation.

Transforming the Health Care System*- Helping the Uninsured*

- The President has laid out a bold path to strengthen our health care system by emphasizing the importance of quality, expanded access, and increasing efficiencies.
- The President's Affordable Choices Initiative will help States make basic private health insurance available and will provide additional help to Americans who cannot afford insurance or who have persistently high medical expenses.
- It moves us away from a centralized system of Federal subsidies; and,
- It allows States to develop innovative approaches to expanding basic health coverage tailored to their populations
- The President's plan to reform the tax code with a standard deduction (\$15,000 for families; \$7,500 for individuals) for health insurance will make coverage more affordable, allowing more Americans to purchase insurance coverage.

- *Value-driven Health Care*

- The Budget provides funds to accelerate the movement toward personalized medicine, in order to provide the best treatment and prevention for each patient, based on highly-individualized information.
- It provides \$15 million for expanding efforts in personalized medicine using information technology to link clinical care with research to improve health care quality while lowering costs; and,
- It will expand the number of Ambulatory Quality Alliance Pilots from 18 sites in FY 2008.

- *Health IT*

- The President's budget proposes \$118 million for the Office of the National Coordinator for Health Information Technology to keep us on track to have personal electronic health records for most Americans by 2014 by supporting our efforts to:
 - Implement agreed upon public-private health data standards.
 - Initiate projects in up to twelve communities based on recommendations of the American Health Information Community. These projects will demonstrate the value of widespread availability and access of reliable and interoperable health information.
 - Develop the Partnership for Health and Care Improvement, a new, permanent non-governmental entity to effect a sustainable transition from the AHIC.

Addressing the Fiscal Challenge of Entitlement Growth

The single largest challenge we face is the unsustainable growth in entitlement programs such as Medicare and Medicaid. The Administration is committed to strengthening the long-term fiscal position of Medicare and Medicaid and to moderating the growth of entitlement spending. The FY2008 Budget begins to address Medicare and Medicaid entitlement spending growth by proposing a package of reforms to promote efficiency, encourage beneficiary responsibility, and strengthen program integrity.

- *Medicaid*

Medicaid is a critical program that delivers compassionate care to more than 50 million Americans who cannot afford it. In 2008 we expect total Federal Medicaid outlays to be \$204 billion, a \$12 billion increase over last year.

The Deficit Reduction Act (DRA) that President Bush signed into law last year has already transformed the Medicaid program. The DRA reduced Medicaid fraud and abuse and also instituted valuable tools for States to reform their Medicaid programs to resemble the private sector.

In FY 2008, we are also proposing a series of legislative and administrative changes that will result in a combined savings of \$25.3 billion over the next five years, which will keep Medicaid up to date and sustainable in the years to come. Even with these changes, Medicaid spending will continue to grow on average more than 7 percent per year over the next five years.

Along with the fiscally responsible steps we are taking with Medicaid, we are following the same values in modernizing Medicare.

- Medicare

Gross funding for Medicare benefits, which will help 44.6 million Americans, is expected to be nearly \$454 billion in FY 2008, an increase of \$28 billion over the previous year.

In its first year, the Medicare prescription drug benefit has been an unparalleled success. On average, beneficiaries are saving more than \$1,200 annually when compared to not having drug coverage, and more than 75 percent of enrollees are satisfied with their coverage. Because of competition and aggressive negotiating, payments to plans over the next ten years will be \$113 billion lower than projected last summer.

We also plan a series of legislative reforms to strengthen the long-term viability of Medicare that will save \$66 billion over five years and slow the program's growth rate over that time period from 6.5% to 5.6%.

Similarly, we are proposing a host of administrative reforms to strengthen program integrity; improving efficiency and productivity; and reduce waste, fraud and abuse—all of which will save another \$10 billion over the next five years.

Promoting Health and Preventing Illness

We are also taking steps in other ways to transform our health care system. Helping people stay healthy longer also helps to reduce our nation's burden of health care costs. The President's budget will:

- Fund \$17 million for CDC's Adolescent Health Promotion Initiative to empower young people to take responsibility for their personal health.
- Strengthen FDA's drug safety efforts and modernize the way we review drugs to ensure patients are confident the drugs they take are safe and effective.
- Enhance FDA and CDC programs to keep our food supply one of the safest in the world by improving our systems to prevent, detect and respond to outbreaks of food borne illness; and,
- Include \$87 million to increase the capacity for the review of generic drugs applications at the FDA and increase access to cheaper generic drugs for American consumers.

Providing Health Care to Those in Need

SCHIP expires at the end of FY 2007 and the President's budget proposes to reauthorize SCHIP for five more years, to increase the program's allotments by about \$5 billion over that time, to refocus the program on low-income uninsured children, and to target SCHIP funds more efficiently to States with the most need.

The President's budget proposes nearly \$2 billion to fund health center sites, including sites in high poverty counties. In FY 2008, these sites will serve more than 16 million people.

We propose increasing the budget of the Indian Health Service to provide health support of federally recognized tribes to over \$4.1 billion, which will help an estimated 1.9 million eligible American Indians and Alaskan Natives next year.

We are also proposing nearly \$3 billion to support the health care needs of those living with HIV/AIDS and to expand HIV/AIDS testing programs nationwide.

In addition, we are requesting that Congress fund \$25 million in FY 2008 for treating the illnesses of the heroic first responders at the World Trade Center.

Protecting the Nation Against Threats

We must continue our efforts to prepare to respond to bioterrorism and an influenza pandemic.

Some may have become complacent in the time that has passed since the anthrax-laced letters were delivered in 2001, but we have not. Others may have become complacent because a flu pandemic has not yet emerged, but we have not.

- The President's budget calls for nearly \$4.3 billion for bioterrorism spending.
- In addition, we are requesting a \$139 million in funding to expand, train and exercise medical emergency teams to respond to a real or potential threat.
- Our budget requests \$870 million to continue funding the President's Plan to prepare against an influenza pandemic. The budget requests funding to increase vaccine production capacity and stockpiling; buy additional antivirals; develop rapid diagnostic tests; and enhance our rapid response capabilities.
- In FY 2008, the Advanced Research and Development program is requested within the Office of the Assistant Secretary for Preparedness and Response (ASPR). Total funding of \$189 million will improve the coordination of development, manufacturing, and acquisition of chemical, biological, radiological, or nuclear (CBRN) Medical Countermeasures (MCM).

Advancing Medical Research

The research sponsored by NIH has led to dramatic reductions in death and disease. New opportunities are on the horizon, and we intend to seize them by requesting \$28.9 billion for NIH.

Our proposal in FY 2008 will allow NIH to fund nearly 10,200 new and competing research grants, continue to support innovative, crosscutting research through the Roadmap for Medical Research, and support talented scientists in biomedical research.

Protecting Life, Family and Human Dignity

Our budget request would fund \$884 million in activities to help those trying to escape the cycle of substance abuse; children who are victims of abuse and neglect; those who seek permanent, supportive families through adoption from foster care; and the thousands of refugees that come to our country in the hopes of a better life.

Our budget request also includes \$ 1.3 billion to help millions of elderly individuals and their family caregivers to remain healthy and independent in their own homes and communities for as long as possible, including the \$28 million for our Choice for Independence initiative that will help states create more cost-effective and consumer-driven systems of long-term care.

Improving the Human Condition Around the World

If we are to improve the health of our own people, we must reach out to help other nations to improve the health of people throughout the world.

Our budget requests \$2 million to launch a new Latin America Health initiative to develop and train a cadre of community health care workers who can bring much needed medical care to rural areas of Central America.

CDC and NIH will continue to work internationally to reduce illness and death from a myriad of diseases, and in so doing will support the President's Malaria Initiative; the Global Fund to Fight HIV/AIDS, Tuberculosis, and Malaria; and the President's Emergency Plan for AIDS Relief.

These are just some of the highlights of our budget proposal. Both the President and I believe that we have crafted a strong, fiscally responsible budget at a challenging time for the federal government, with the need to further strengthen the economy and continue to protect the homeland.

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

Now, I will be happy to take a few questions.

**Responses to Questions for the Record From Secretary Leavitt
Senate Finance Committee Hearing
Fiscal Year 2008 Budget
February 7, 2007**

Senator Grassley

Question on Entitlement Spending

Question: Addressing the spiraling growth in entitlement spending will require drastic measures. In fact, the longer we wait, the more drastic the measures we will have to take. Based on data from the Medicare trustees, if we do nothing to address entitlement spending until 2037, our options will be to increase the Medicare payroll tax by about 270 percent, increase all Medicare taxes, premiums and general revenue contributions by about 87 percent, cut benefits by about 47 percent or a combination of these three. As I said in my opening statement, adopting all of the President's proposals would only have a limited effect on the growth in entitlement spending. At the same time, 47 million people lack basic health coverage. As difficult as it is to tackle these problems, we are going to have to go even further. As a nation, how do you believe we should face the challenge of the uninsured and rising entitlement spending?

Answer: Transforming the health care system, providing health services to underserved populations, strengthening Medicare and Medicaid's long-term financial security, and modernizing the Medicare system are four of eight priorities in the Secretary's plan for helping to fulfill the President's vision of a healthier, safer, and more hopeful America.

The Federal Government's current system of paying for health care results in billions of dollars being spent inefficiently through a patchwork of subsidies and payments to providers. In addition to directly funding the care provided to people enrolled in programs like Medicare and Medicaid, health care entitlement programs finance payments to institutions that either indirectly pay for uncompensated care or subsidize their operating expenses.

The health care system could operate more efficiently if some portion of institutional payments instead were redirected to help people with poor health or limited income afford health insurance. The uninsured often use emergency rooms as a source of primary care, which leads to suboptimal care and spending outcomes. If this public spending were focused on helping the uninsured purchase private insurance, people would receive the care they need in the most appropriate setting. The health care system needs to be transformed in a way that avoids costly and unnecessary medical visits and emphasizes upfront, affordable private health insurance options.

This transformation could happen by subsidizing the purchase of private insurance for low-income individuals. However, any such health care reforms would need to be State-based and budget neutral, not create a new entitlement, and not affect savings contained in the President's Budget that are necessary to address the unsustainable growth of Federal entitlement programs. The Federal Government would also maintain its commitment to the neediest and most

vulnerable populations, while acknowledging that States are best situated to craft innovative solutions to move people into affordable insurance.

The President has asked that I work with Congress and the States on an Affordable Choices initiative to reform the health care marketplace.

At the same time, the Budget includes a set of Medicare legislative and administrative proposals saving \$5.3 billion in FY 2008 and \$75.9 billion over five years. Designed to strengthen Medicare's long-term financial security, these proposals encourage efficient payments, foster competition, and promote beneficiary involvement in health care decisions.

The Budget proposes Medicaid legislative and administrative changes that save \$25.4 billion over five years in order to continue to slow the annual growth in the Medicaid entitlement program.

The President's Budget also proposes to reauthorize SCHIP for five years, increasing the SCHIP allotments by almost \$5 billion over five years. The President's Budget proposes to re-focus SCHIP on low-income, uninsured children at or below 200 percent of the Federal poverty level as the program originally intended.

All of these proposals work together to provide new health care choices for the growing number of uninsured in our country, while helping to contain the growth in entitlement spending in order to promote a longer-term sustainability for these vital programs.

Questions on SCHIP

Question: Mr. Secretary, your proposal for SCHIP reauthorization includes a provision that would shorten a state's allotment availability from 3 years to 1 year. Can you describe the rationale behind this proposal and how you plan to redistribute the funds in FY 08 and in future years?

Answer: The President's Budget proposes to more efficiently target funds to states that need them the most to cover low-income children. Under current law, some states have accumulated large balances of unspent funds.

Question: Mr. Secretary, there are an estimated 6 million uninsured children eligible for Medicaid or S-CHIP who are currently not enrolled. For the past two years, the Administration's budget proposal has included funding for "Cover the Kids," a legislative proposal to provide funding for grants to states, schools and community organizations to enroll and provide coverage to many eligible but unenrolled children in S-CHIP and Medicaid. Mr. Secretary, does your proposal for the reauthorization of S-CHIP include funding for "Cover the Kids?" If not, why not?

Answer: We have had to make difficult choices given limited resources. While the President's budget does not re-propose the "Cover the Kids" initiative, the Budget does increase funding for SCHIP above current law. The President's proposal re-focuses SCHIP on low-income uninsured

children and pregnant women with family income below 200 percent of the Federal poverty level.

Question on Medicaid

Question: In the Deficit Reduction Act, we changed the federal upper limit for reimbursement for prescription drugs to 250% of the lowest Average Manufacturer Price or AMP. The GAO just released a study which seriously questioned the ability of pharmacists to purchase drugs at 250% of the lowest AMP. The budget proposes further lowering the federal upper limit to 150% of the lowest AMP. How do you justify that proposal in light of the GAO report?

Answer: The Deficit Reduction Act of 2005 (DRA) modified several key provision of law concerning Medicaid drug payment. These changes are in part a reaction to a series of reports issued in 2004 by both the Government Accountability Office (GAO) and the HHS Office of the Inspector General (OIG) showing that Medicaid payments to pharmacies for generic drugs were much higher than what pharmacies were actually paying for those drugs. Specifically, DRA changes how the federal government limits payments to state Medicaid agencies for the aggregate costs of prescription drugs when a generic substitute is available. Currently, approximately 600 drugs are subject to Federal Upper Limits (FULs) which are calculated based on 150% of published drug prices. DRA established a new (FUL) that is equal to 250% of the lowest (AMP) for a generic version of a drug.

In regards to the GAO report you mention (*"Medicaid Outpatient Prescription Drugs: Estimated 2007 Federal Upper Limits for Reimbursement Compared with Retail Pharmacy Acquisition Costs"* (GAO-07-239R)), CMS finds the GAO's conclusion unsupported by the report. It uses incomplete and misleading information, as well as non-disclosed pricing data. It also fails to account for rebates and discounts that pharmacies may receive from wholesalers or manufacturers in determining the actual retail acquisition cost. The GAO also failed to account for the differences in the definitions of AMP before and after the implementation of the Deficit Reduction Act of 2005 (DRA). The GAO also did not report on the effect that excluding outlier data would have on AMP-based FULs. The GAO's findings also do not take into account the impact of existing state cost-containment mechanisms such as Maximum Allowable Cost (MAC) programs that result in lower State payments.

The FY 2008 Budget proposes to build on the DRA changes to the federal upper limit (FUL) for multiple source drugs. The Budget proposes to limit reimbursement for multiple source drugs to 150% of the average manufacturer's price (AMP). This will continue efforts to further reduce Medicaid overpayments for prescription drugs. Under current law, states continue to have flexibility to support innovative approaches to lower drug costs, such as paying pharmacists more when they help patients use less expensive generic drugs.

Question on Pay for Performance (Medicaid)

Question: We have made significant progress in implementing Pay for Performance in Medicare, and I appreciate the collaboration we have had with you and your Department. In the budget, there is a proposal to require states to report on Medicaid performance measures and that

Medicaid payment would be linked to performance. Could you describe for us why this is important and how the President's proposals would work?

Answer: The Federal government matches all allowable Medicaid expenditures, regardless of the amount or quality of services rendered. As long as States are not in violation of the law, States are not accountable to the Federal government for how well they deliver, operate, and manage core aspects of their State Medicaid plans. Although no two State Medicaid programs are alike, there are basic programmatic design elements that, when implemented, can help improve the quality, efficiency, and delivery of medical care. The President's Budget proposes to develop a set of universal performance measures and thresholds, and require States to monitor and report on them. After a phase-in period, States that do not meet targeted thresholds for the performance measures would see reductions in their total Medicaid grant award until such States meet the designated thresholds. The Administration looks forward to working with Congress to develop further details on this proposal.

Question on Income-Related Premiums under Part D

Question: Secretary Leavitt, I want to ask a question about the proposal to income-relate the prescription drug premium. I was for the Part B income related premium. But the Part B and Part D programs are a lot different. If higher-income beneficiaries choose not to enroll, that could have implications for plan bids and premiums. They could go up, couldn't they? Do the estimated savings take this into account?

Answer: In general, if higher income beneficiaries have the same distribution of drug expenditures as the general Medicare population, dropping out would have no effect on plan bids and premiums. In the savings estimate, we assumed that high income beneficiaries with low drug expenditures (and with a low risk score) would be more inclined to drop out since they might not find it worthwhile to pay a higher premium. Those with high drug expenditures (and with a high risk score) would be more inclined to keep the drug coverage since they would still benefit from the direct subsidy. This assumption would imply that plans would have higher drug costs in their bids, along with a higher average risk score. Since higher risk scores generally offset higher drug expenditures in plan bids, the effect on the bids and premiums would be small or negligible.

Question on Inflation Indexing of Income-Related Premiums under Part B

Question: The Medicare Modernization Act requires higher income beneficiaries to pay an increased premium for Medicare Part B, beginning this year. An estimated four percent of beneficiaries with annual incomes over \$80,000 and couples over \$160,000 will have their premiums increased over a 3 year period, from 2007 through 2009. Income thresholds after 2007 are adjusted annually for inflation. The President's budget proposes to eliminate the annual inflation indexing of income thresholds for Part B premiums, as of 2008. If income thresholds are not annually indexed for inflation, what percentage of beneficiaries do you estimate would have higher income-related premiums over the next five years?

Answer: The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary (OACT) estimates that, in 2012, 5.9 percent of the approximately 45 million beneficiaries enrolled in Part

B would be affected by the elimination of the inflation adjustment under current law, as compared to the 6.9 percent that would be affected under the President's fiscal year (FY) 2008 Budget proposal. Please see the table below for specific figures over the 5-year period.

Calendar Year (CY)	2008	2009	2010	2011	2012
Total Part B enrollment (in millions)	41.530	42.332	43.112	44.005	45.226
Percentage affected by current law	5.4	5.5	5.6	5.8	5.9
Percentage affected by proposal	5.6	5.9	6.3	6.6	6.9

Questions on Physician Reimbursement

Question: We need to put better incentives into the health care system and motivate providers to provide better quality care. In the last Congress, Senator Baucus and I introduced a bill that moved towards paying providers more for high quality and efficient care. Last year we established a new voluntary quality reporting program for physicians in the Tax Relief and Health Care Act of 2006. In the President's budget, the Administration supports budget-neutral provider payment reforms that encourage quality and efficiency.

Do you think rewarding physicians, hospitals and other providers for high quality care is a good thing for Medicare?

Answer: The Administration supports ways to encourage more efficient and high quality care such as budget neutral payment reforms in Medicare that adjust payments to improve quality and efficiency.

Question: As you know, the Tax Relief and Health Care Act which passed in December eliminated the five percent cut in physicians fees scheduled to take effect in January and froze physicians' fees at the 2006 level. As we all know, the current physician payment sustainable growth rate formula is flawed. The Medicare Payment Advisory Commission, or MedPAC, is due to report to Congress next month on alternatives to the SGR, and we will be studying their report closely. We know that fixing the SGR formula permanently will cost billions of dollars. How do you envision reforming the physician payment formula?

Answer: We are actively engaged with both the Congress and physician community on this important topic. We need to identify ways to align Medicare's physician payment system with the goals of health professionals for high-quality care, without increasing overall Medicare costs. The Administration supports budget neutral payment reforms in Medicare that encourage improved quality and efficiency without increasing costs for taxpayers and beneficiaries.

Questions on Medicare Part D

Question: The Congressional Budget Office has acknowledged that market-based competition and the fact that 2007 bids were 15 percent lower than 2006 bids is the primary reason for the \$136 billion decrease in Part D spending between 2007 and 2013. Do you agree with this CBO finding? (Bids submitted for 2007 are 15 percent below the 2006 bids on average).

Answer: Primarily as a result of strong competition and informed beneficiary choices, the average Part D premium for basic benefits is 42 percent lower than had been projected originally. In January 2007, the HHS actuaries projected a reduction from the previous year's estimation in the baseline of payments to Part D plans due primarily to three factors: 1) lower bid submission due to competition; 2) lower enrollment than originally expected; 3) lower growth in drug costs in general.

Question: The drug plans competing for Medicare beneficiaries have produced greater-than-expected savings from aggressive price negotiation, rebates, and utilization management. Many Part D plans with above-average premiums in 2006 substantially reduced their bids in 2007 in an effort to be competitive. Plans also expect to further increase the proportion of drugs provided through lower-cost, generic equivalents.

The lower-than-anticipated enrollment in Part D, reduced the new Medicare Part D baseline of payments to Part D plans by \$20 billion because many beneficiaries had creditable prescription drug coverage from other sources and did not need to sign up for what would have been duplicative coverage under Part D.

The lower actual growth in drug costs in 2005, compared to mid-session review estimates, resulted in approximately \$13 billion of the reduction in the new baseline. The reduced Part D cost estimates reflect this lower actual growth in drug costs, with a single-digit percentage increase observed for only the second time in more than a decade. Relatively slow growth in actual drug prices and costs is expected to persist over the next few years, as more generic drugs become available and aggressive steps to keep down drug costs continue.

Do you believe that the success of market based competition in reducing Part D spending can be translated to other portions of Medicare?

Answer: In general, yes. The CMS actuaries estimated this in January 2007 that payments to Part D plans are projected to be \$113 billion lower over the next ten years than estimated the previous year. Of the \$113 billion reduction in cost, \$96 billion is a direct result of competition and significantly lower Part D plan bids in 2007. In addition, enrollee satisfaction rates are topping 75 percent. The FY 2008 Budget pursues competition-based savings in other areas of Medicare, which are part of a larger Administration effort to address the unsustainable growth of Federal entitlement programs. The proposal to expand the successful competitive acquisition policy to include clinical laboratory services is a good example.

Question: Secretary Leavitt, many aspects of the Medicare prescription drug benefit work quite well. Pharmacy issues, though, is one area that I think we need to take a good look at. The

Department took some steps last year to address issues. But I continue to hear from pharmacists in Iowa about low payments and “take it or leave it contracts.” Could you please tell me about additional administrative actions the Department might take in this area?

Answer: Contracts between Part D plans and network pharmacies should be as clear as possible in terms of pricing and methods of payment. Their absence and/or inclusion may be accepted and/or rejected in contract negotiations between a Part D sponsor and a pharmacy. Due to flexibility in negotiating these contracts, CMS has been hesitant to assume the role of arbiter between the sponsors and their respective subcontractors. Part D sponsors offering less than satisfactory or unclear contract terms would likely find it difficult to retain enough network pharmacies to meet our network requirements.

Question: In a January 10, 2007 letter CBO stated that HR 4, *Medicare Prescription Drug Price Negotiation Act of 2007* (House noninterference bill), would have “negligible effect on federal spending.” Do you agree with CBO’s assessment?

Answer: Part D drug plans have produced greater-than-expected savings by competing for Medicare beneficiaries and aggressively negotiating with drug companies. Strong, competitive bids and informed beneficiary choices are bringing down premiums, without government interference in drug price negotiations.

Actuaries at the Centers for Medicare & Medicaid Services (CMS) reviewed H.R. 4 and concluded that government negotiations mandated in the bill would produce negligible savings. Although the bill would require the Secretary to negotiate with drug manufacturers regarding drug prices, the inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of this negotiation. Manufacturers would have little to gain by offering rebates that aren't linked to a preferred position of their products, and the actuaries assume that they will be unwilling to do so.

The actuaries expect that the Part D plans will continue to be the source of meaningful negotiations with manufacturers as they will continue to have the authority to establish formularies and define a preferred tier. They would not expect H.R. 4 to have any effect on these negotiations or the prices that are ultimately paid by Part D.

Question: Mr. Secretary, I want to ask about government negotiations for drug prices. Don’t take this the wrong way. You have hard working, dedicated employees. But I don’t think the Department has the capacity or expertise to negotiate drug prices. Can you tell me what it would take budget and staff-wise for the government to negotiate like some people want it to?

Answer: While we are not able to estimate the budget and staff necessary to implement government negotiations for Part D in the absence of specific bill language, it is important to note that government interference with price negotiation in the Medicare prescription drug benefit is unnecessary. The independent Congressional Budget Office has said that government price negotiation would have a “negligible effect on federal spending.”

We already negotiate Part D drug prices through the Part D plans who act as our subcontractors. Medicare regulates the plans that provide the benefit. This means that beneficiaries are afforded maximum protections by government oversight of plans by using network access standards and model formulary guidelines. At the same time, beneficiaries, taxpayers, and the Medicare program benefit from the competitive marketplace as seen in the deep discounts negotiated by plans on behalf of the Medicare program.

Some observers point to the massive buying power of the federal government as the means to exert clout over drug companies. However, private-sector insurance plans and pharmacy benefit managers, who negotiate prices between drug companies and pharmacies, cover about 241 million people, or 80 percent of the population. Medicare could cover at most 43 million.

Question: Secretary Leavitt, one issue that I continue to hear a lot about from Iowans is the Social Security withhold to pay prescription drug plan premiums. I know that CMS and SSA have worked to correct the problems. I know that progress has been made, and I appreciate the updates that CMS has given my staff. That said, it's apparent, based on what I hear from Iowans that more needs to be done to get this option working better. Could please give us update on where things stand in getting this working more smoothly?

Answer: Premium withholding continues to work for the vast majority of the approximately 4.7 million beneficiaries who requested withholding in 2006. While many beneficiaries have experienced some issues with their withholding, CMS is committed to addressing and resolving these issues as soon as possible. The majority of issues were caused by CMS and Social Security Administration (SSA) systems having mismatching data on certain beneficiaries. Has SSA reviewed? Do they concur with this response? Please provide confirmation

CMS, working with SSA and other key stakeholders (plans, pharmacies, etc.), has made tremendous strides to resolve premium withhold issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond.

Question: Mr. Secretary, under the drug benefit, we've gotten lower drug prices, lower premiums, and lower costs. Beneficiaries are satisfied. I've argued against government negotiation.

Two weeks ago, a VA Pharmacy Benefits staff said that the VA offers more drugs than Medicare Part D. But under Medicare, prescription drug plans must meet strict formulary requirements to ensure that beneficiaries have good access to the drugs they need.

Beneficiaries can choose a different plan to get the drug coverage that best suits their needs. How does the VA model for drug coverage compare to Medicare and do you think it should be used for Part D?

Answer: The Department of Veterans Affairs, often cited as an example of how government can negotiate prices, operates an excellent program for veterans, but the two programs are very different. Medicare is a health insurer, whereas the VA is a vertically integrated health system.

In other words, Medicare is a payer, while the VA is the payer, healthcare provider and pharmacy collectively. Comparisons between the two are inappropriate.

Senator Rockefeller

Questions on the Children's Health Insurance Program (CHIP)

Question: Secretary Leavitt, you've been to West Virginia, and I think you know how important health insurance coverage is to the people of my state, particularly children. In West Virginia, nearly half of all Medicaid enrollees (179,300) are children – which is why EPSDT must absolutely be protected. Another 40,000 children are covered by CHIP, and the state is currently expanding to reach additional children.

In my opinion, the most startling aspect of the President's budget is the blatant disregard for the well-being of our nation's children. The Congressional Research Service and independent experts have estimated that states will face a federal CHIP funding shortfall of up to \$15 billion over the next five years. Yet, the President has proposed one-third of that amount – \$5 billion – in new funding for CHIP, which your staff has indicated would lead to an enrollment decline of at least 300,000 children.

Is it the Administration's position that, at a time when 9 million children are without health insurance, it is acceptable to eliminate CHIP coverage for at least 300,000 children?

Answer: The Administration has added approximately two million low-income children to the SCHIP program in the past six years and maintains its dedication to providing governmental funding for low-income children's health insurance coverage. The Administration's proposal refocuses SCHIP on the program's original objective to provide health insurance to low-income children and pregnant women at or below 200% FPL.

Question: Is it also true that your budget provides no new resources for states to reach the 2.2 million children who are currently eligible for CHIP (and the 4 million children who are currently eligible for Medicaid), but unenrolled?

Answer: The President's 2008 Budget proposes to reauthorize SCHIP as well as add funding in order to maintain and strengthen the commitment to providing health insurance to low-income, uninsured children. SCHIP was originally established to provide health insurance to low-income, uninsured children who were not eligible for Medicaid. The President's budget refocuses the program on its original aim, to provide health care to children at or below 200% of poverty. The President's budget proposes to add an additional \$4.8 billion over five years to State allotments.

Question: The President's budget proposal sends a clear message to our working families and to the states that the federal government will not honor its Medicaid and CHIP obligations. The

budget contains over \$26 billion in additional Medicaid cuts, and the CHIP proposal is actually a \$10 billion cut since we need \$15 billion just to maintain current enrollment.

Last year, the West Virginia Legislature passed a bill to expand CHIP coverage from 200 percent to 300 percent of poverty. It has been projected that more than 4,000 children will, over the next several years, enroll in West Virginia CHIP as a result of this expansion – which would increase the percentage of West Virginia children who have health insurance to 97 percent. But, the President's budget pulls the rug out from under West Virginia.

Not only does this budget limit federal funding for CHIP and cause West Virginia to experience a CHIP funding shortfall in 2009; It also restricts my state's ability to receive the enhanced CHIP matching rate (of 81.98%) for covering these additional children.

Secretary Leavitt, is it the Administration's position that West Virginia should not be able to receive enhanced federal matching payments for virtually eliminating uninsurance among children in the state?

Answer: I appreciate West Virginia's efforts to decrease the uninsured rate in the state. The President's 2008 Budget proposes to reauthorize SCHIP as well as add funding in order to maintain and strengthen the commitment to providing health insurance to low-income, uninsured children. SCHIP was originally established to provide health insurance to low-income, uninsured children who were not eligible for Medicaid. The President's budget re-focuses the program on its original aim, to provide health care to children at or below 200% of poverty. The proposal varies the Federal match rate for different populations to focus SCHIP resources on children at or below 200% of poverty. The enhanced Federal match rate will continue to be provided to States to prioritize coverage for children and pregnant women at or below 200% of poverty. In addition, the President's proposed Affordable Choices initiative and health care tax proposal aims at making insurance coverage more accessible and affordable for all Americans.

Questions on health care transparency:

Question: Secretary Leavitt, health care transparency seems to be a major initiative of this Administration. Yet, I find the Administration's push for transparency quite ironic because it only seems to apply in certain contexts. Medicaid doesn't seem to be one of the areas where transparency applies.

This Administration continues to negotiate Medicaid waivers and state plan amendments in secret without meaningful public notice or input.

Senator Baucus and I have introduced legislation on this issue in the past, and I believe it is still a huge problem. So, can you tell the Members of this Committee what your agency is doing to improve Medicaid transparency?

Answer: I agree with you on the need for transparency and broad consultation on waiver proposals and the Administration provides ample opportunity for public input at both the state and federal level. When a state submits a section 1115 waiver application, it must show that it

has adhered to the requirements for public input that are described in the Federal Register, Vol. 59, No. 186, dated September 1994, and, if applicable to the waiver, consulted with American Indian/Alaska Native Tribes. Moreover, we are always open to receiving public comment on the state proposals. Such comments are very helpful in fully understanding the proposals and assists us in our review process.

As you know, I strongly believe in the ability of waiver demonstration projects to permit states the flexibility to explore innovative approaches in operating their Medicaid programs. I share your goal in ensuring that the waiver review process is conducted in a fair, timely, and impartial fashion. The Administration is committed to strengthening transparency and intends to improve communication and collaboration with partners. The Administration will work to add a summary page of pending actions on waivers, including State and Federal contact information, to the CMS website.

Questions on Medicare

Question: Secretary Leavitt, at yesterday's Energy and Commerce Committee hearing, you indicated that there have been "very few problems" with the Medicare prescription drug program. As you might expect, I respectively disagree with this assessment.

Millions of additional seniors will fall into the doughnut hole this year. Dual eligibles continue to have problems getting the prescription drugs they need. In some cases, dual eligibles are enrolled in the drug benefit for months without knowing it. They pay for their drugs out-of-pocket – or forgo their prescriptions altogether – while their prescription drug plans get reimbursed by Medicare for doing nothing. Pharmacies in West Virginia and around the country are still waiting to receive reimbursement for the unanticipated costs they incurred during the first few months of the program. And, some seniors are paying double premiums each month because of ongoing premium withholding problems between CMS and SSA.

Mr. Secretary, I think you would agree with me that these are very real problems, and I would like to know what HHS is doing to address them.

Answer: I do agree, and I can assure you that we are working very hard to resolve problems like these. In the case of ongoing premium withholding problems, for example, CMS, working with the Social Security Administration and key stakeholders (plans, pharmacies, etc.), has made tremendous strides to resolve premium withhold issues encountered in the first year of the program and to lay the groundwork for continued improvements in 2007 and beyond. We will continue to work to address concerns with this issue and others you have identified.

Question: As you know, I have been very concerned that veteran participation in the Medicare prescription drug program is being mischaracterized in the press – to the detriment of the very comprehensive services veterans receive through the VA.

Consequently, Senator Akaka and I asked you and Secretary Nicholson to prepare a consistent set of data regarding veteran enrollment in Medicare Part D. Has CMS been able to conduct a

person-to-person data match with VA files on all 3.8 million veterans to determine the true veteran enrollment figures for Medicare Part D?

Answer: Based on partial year data available in 2006, CMS has conducted such a data match with the following results. The person-level data match focused on the nearly 3.77 million of the 7.63 million veterans enrolled in the VHA who are also Medicare beneficiaries.¹ Specifically, this match revealed the following:

- Nearly 42 percent (1.58 million) of these VHA-enrolled/Medicare beneficiaries are enrolled in a Medicare Part D plan or in employer or union-sponsored retiree drug coverage through the Retiree Drug Subsidy (RDS). About 31 percent of the 3.77 million (1.16 million) are in Part D and an additional 11 percent (419,000) are in former employer or union plans that receive the RDS.
- Of the approximately 1.16 million VHA-enrolled/Medicare beneficiaries who are enrolled in Part D, about 70 percent (813,000) did so on their own. An additional 30 percent (344,000) are receiving the low-income subsidy (LIS). Within the LIS population, beneficiaries who did not choose a plan were enrolled in Part D through CMS “auto-enrollment” or “facilitated-enrollment” processes. Approximately 166,000 of the 344,000 beneficiaries are full-benefit Medicaid dual-eligible individuals. Many of the remainder applied for the Part D low-income subsidy on their own.

(a) If your answer is “no,” can you tell the Members of this Committee when that data match will be completed?

(b) If you have been able to complete the full data match, can you tell us the extent to which veterans who are eligible for prescription drug coverage through both Medicare and the VA are using Part D exclusively, VA exclusively or both programs simultaneously?

Answer: Based on partial year data available in 2006, CMS has some preliminary claims data that address the questions about the extent to which VHA/Medicare Part D beneficiaries are using one or both systems. As plans have several months after the close of the calendar year to send in all of their claims, results may differ when complete files are available.

CMS measures use of Part D based on the claims received to date. Of the 1.16 million VHA/Medicare beneficiaries enrolled in a Medicare Part D plan, we know the following based on claims received as of January 2007.

¹ Approximately 2.6 million of the 7.63 million VHA enrollees do not currently use the VHA’s comprehensive healthcare delivery system. Similarly, approximately 0.6 million VHA enrollees use medical care services, but not prescription drugs. In summary, approximately 3.2 million of the 7.63 million veterans enrolled in the VHA did not use the VHA prescription drug benefit prior to the implementation of Part D on January 1, 2006.

Number of Medicare beneficiaries:	43M
Number of Medicare/VHA enrollees:	3.77M
Number of Medicare/VHA enrollees in a Part D plan or RDS:	1.58M
Number of Medicare/VHA enrollees in a Part D plan using:	1.16M*
Medicare only	0.40M
VHA only	0.28M
Both	0.39M
Neither	0.10M

*Note: Some numbers may not add due to rounding.

Questions on child support enforcement

Question: Secretary Leavitt, the Deficit Reduction Act included a \$1.6 billion cut in child support enforcement. This cut of federal performance based-funding (by two-thirds) would eliminate the incentives for states to invest in this important program. Plus it could undermine effective policies to establish paternity.

CBO estimates that restoring the cuts could help leverage an additional \$8 billion in private dollars to children in support payments, potentially saving money on public assistance.

Why cut a cost-effective program that helps 17 million children, and promotes personal responsibility, especially by establishing paternity? Isn't it better to restore these cuts and maintain incentives to states?

As a former Governor, I can tell you that many states won't be able to fill the gap in child support given all the cuts states are facing in the new budget including sizeable cuts to Medicaid and CHIP.

Answer: Performance-based incentive funds continue to be provided to States as required by the "Child Support Performance and Incentive Act of 1998." The Deficit Reduction Act disallows Federal matching of State expenditures paid for with Federal incentive funding. We understand that the matching of Federal incentive funds was eliminated because Congress considered it inappropriate to use Federal funds to match Federal funds. Despite this change, the Child Support Enforcement Program remains among the most generously funded, open-ended entitlement programs that aid families.

DRA provisions improve collection of medical child support, strengthen existing collection and enforcement tools, and allow States the option to provide additional support for families who need it most. Over the five years starting in FY 2006, it is estimated that the Federal government will provide over \$20 billion in federal funds for State child support costs, including more than \$2 billion in federal incentive payments to states. Furthermore, estimates also predict collections will still increase significantly over the next ten years, even though overall collections may be lower than they would have been prior to enactment of the DRA provisions. The Federal Office

of Child Support Enforcement is working closely with States to minimize the impact on families and State resources of these funding changes, through streamlining and automating more Child Support Enforcement functions.

States also can choose to reinvest their share of retained child support collections or otherwise act to reduce the impact of these changes. If States want to spend more on their child support programs, they only have to come up with one-third of the additional amount they want to spend, and the federal government will pay the remaining two-thirds per current law which calls for the federal government to pay 66% of State costs to operate child support enforcement programs.

The Centers for Disease Control and Prevention's (CDC) Seasonal and Pandemic Influenza Vaccine Tracking Activities

Question: Where is HHS in its vaccine tracking efforts for seasonal and pandemic influenza vaccines? How will the budget request support these efforts?

Answer: Following discussions at the 2006 Annual Meeting of the National Influenza Vaccine Summit, CDC convened a meeting in April 2006 to begin planning for influenza vaccine tracking for the 2006-07 influenza season. Participants discussed data needs, uses, and limitation, so that data users (public health) and data holders (manufacturers, distributors) would better understand each other's perspective. Outcomes of the meeting included an agreement on the part of all licensed manufacturers and major distributors to provide data and to update the data on a weekly basis throughout the distribution period. Participants also agreed that CDC would provide a national overview on distribution for dissemination to the National Influenza Vaccine Summit over the course of the 2006-07 influenza season. Finally, participants agreed that if a severe vaccine supply shortfall were to occur, all manufacturers and distributors would share additional information with CDC to facilitate redistribution.

Influenza vaccine distribution data were reported weekly beginning in September 2006 and were updated for the final time in February 2007. CDC has just conducted analysis of data use by state and local public health officials and will summarize this guidance to share with state and local public health officials in preparation for the 2007-08 influenza season. Flu Vaccine Finder, which is currently a stand-alone application, will be integrated into the Vaccine Ordering and Distribution System (VODS), which is currently being developed to support the distribution of publicly purchased pediatric vaccines and for which a module is also being developed to support the centralized ordering/distribution of pandemic influenza vaccine, when that system is implemented.

CDC, in cooperation with federal, state, and private sector partners, is developing and drafting a plan to track the distribution of pre-pandemic and pandemic vaccine to project areas (states, territories, Los Angeles County, New York City, and Chicago). The vaccine will be shipped to project area-designated ship-to sites capable of receiving and storing the vaccine, and repackaging and redistributing the vaccine to administration sites. Because pandemic influenza vaccine distribution is likely to be quite distinct from distribution of seasonal influenza vaccine, CDC is working with partners to create a system to support centralized ordering, distribution, and distribution tracking of pandemic vaccine that would exist within the VODS systems. The

current timeline for completion of the development and implementation of this system is December 2008.

Funding to support these activities has come from the following sources:

- Tracking of seasonal influenza vaccine – routine funds used to support CDC’s Immunization Program; and
- Development of a module to distribute and track pandemic influenza vaccine – initially provided by HHS as Pandemic Influenza Emergency Supplemental funding.

Additional pandemic influenza funds have been requested to support completion of development and maintenance of the pandemic module.

Detailed Information

1. Tracking Seasonal Influenza Vaccine

A. 2004-2005 Influenza Season

CDC began tracking seasonal influenza vaccine in October 2004, to provide state and local public health officials with information about influenza vaccine distribution. This system was developed following a dramatic shortfall of seasonal influenza vaccine precipitated by Chiron’s announcement that the company would be unable to deliver any of the 50 million previously anticipated doses to the U.S. market due to regulatory issues. Tracking during the 2004-05 season focused on inactivated (injectable) influenza vaccine produced and distributed by sanofi pasteur (formerly Aventis Pasteur), which represented approximately 95 percent of the doses available that season. In addition to vaccine tracking, this application also had an ordering capacity. Access to the system was provided for a limited number of state/local health officials per jurisdiction and was accomplished by placing the application (FluFinder) CDC’s Secure Data Network (SDN).

B. 2005-2006 Influenza Season

As part of contingency planning for the 2005-06 influenza season, CDC reached out to sanofi pasteur as well as Chiron’s seven major influenza vaccine distributors to enlist their participation in CDC’s data tracking activities for inactivated influenza vaccine. Because it was not anticipated that Flu Vaccine Finder’s ordering capacity would be needed, a more simplified approach was chosen, making state-specific spreadsheets with vaccine distribution data available to state and local health officials via CDC’s Secure Data Network. In response to a significant delay in vaccine distribution by Chiron in 2005, CDC activated Flu Vaccine Finder in December. Data were updated a limited number of times throughout the season as new information was submitted to CDC. A key lesson learned during this season was the need for public health officials to have access to vaccine distribution data as early in the distribution process as possible.

C. 2006-2007 Influenza Season

Following discussions at the 2006 Annual Meeting of the National Influenza Vaccine Summit, CDC convened a meeting in April 2006 to begin planning for influenza vaccine tracking for the 2006-07 influenza season. This meeting included public health participants (representatives of state and local public health officials from the Association of Immunization Managers, the Association of State and Territorial Health Officials, the National Association of City and County Health Officials, all four licensed U.S. influenza vaccine manufacturers (including MedImmune, who produces the live, nasal spray influenza vaccine), five of the seven major influenza vaccine distributors, two distributor trade organizations, and CDC staff. The purpose of this meeting was to discuss data needs, uses, and limitations, so that the data users (public health) and the data holders (manufacturers, distributors) would better understand each other's perspective.

Outcomes of this meeting included an agreement on the part of all licensed manufacturers and major distributors to provide data [including size of order, product information (NDC code), name of manufacturer, state/zip code to which order was distributed, and provider type to which order was distributed] and to update the data on a weekly basis throughout the distribution period. In addition, it was agreed that a national overview on distribution would be provided by CDC for dissemination to the National Influenza Vaccine Summit with its members over the course of the 2006-07 influenza season. Finally, in the event of a severe vaccine supply shortfall, such as occurred in the 2004-2005 influenza season, all manufacturers and distributors agreed to share additional information with CDC to facilitate redistribution.

D. Current Status and Future Plans

(a) CDC's influenza vaccine distribution tracking application (Flu Vaccine Finder) was activated on September 8, 2006 with a one-time report of selected influenza vaccine ordering information. Weekly reports of distribution data were posted for the first time on September 13, 2006 and were updated on subsequent Wednesdays until the end of January 2007. This time-line was developed to address the need for data early in the distribution process that was highlighted by the 2005-2006 season.

(b) Vaccine distribution data were updated for the final time on February 2, 2007. CDC has just conducted analysis of data use by state and local public health officials and will summarize this guidance to share with state and local public health officials in preparation for the 2007-08 influenza season.

(c) Flu Vaccine Finder, which is currently a stand-alone application, will be integrated into Vaccine Ordering and Distribution System (VODS), a system currently being developed to support the distribution of publicly purchased pediatric vaccines and for which a module is also being developed to support the centralized ordering/distribution of pandemic influenza vaccine, when that system is implemented. The data inputs for tracking seasonal influenza vaccine in the new VODS will continue to come directly from our influenza vaccine manufacturer and distributor partners.

2. Tracking and Distribution of Pandemic Influenza Vaccine

CDC plans to track pandemic influenza vaccine through the Vaccine Ordering and Distribution System (VODS), an application being developed to support CDC's routine vaccine management activities. In conjunction with a recently implemented contract for centralized distribution, this system is currently being designed to function as the ordering, distribution, and grantee monitoring system for the Vaccines for Children (VFC) program, and the Section 317 Immunization program that provide vaccine across the country.

Working with state and local partners, CDC has identified system requirements to support the federal program, the systems responsibilities under the Department of Homeland Security's Project Matrix, and the grantee community. With the perspective of both the current state and desired "end state" in mind, the system will achieve the following during routine functioning:

- (a) The centralizing of vaccine distribution and the tools for order entry and order processing increase visibility for vaccine accountability and improve efficiency through reduction of operating/inventory/distribution costs.
- (b) Provider orders, when collected with the "CDC-required" supporting data, will be compared to a set of standards, or "business rules."
- (c) Business rules will be developed to encourage the optimal vaccine management practices – limiting order frequency and order size where needed.
- (d) Provider orders that reach the system will either be (1) approved and fulfilled, or (2) placed on hold for review by the grantee.
- (e) Grantees will have the power to determine whether to approve an order. CDC awarded a task order to Northrop Grumman via CDC's Consolidated Information Technology Services Contract (CITS) for the development of VODS. Northrop Grumman is using a solution that involves the configuration of SAP enterprise application software to meet the VODS requirements.

CDC, in cooperation with Federal, state, and private sector partners, is in the process of developing and drafting a plan for tracking the distribution of pre-pandemic and pandemic vaccine to the project areas (50 states, DC, 8 territories, LA County, New York City, and Chicago). The vaccine will be shipped to project area-designated ship-to sites, which need to be capable of receiving and storing the vaccine, and repackaging and redistributing the vaccine to administration sites. Specific details about the distribution process are currently under discussion with HHS, with a goal of how distribution and tracking could be conducted if an immediate need arose and how these activities could be implemented using a second approach that is currently under development.

The immediate approach is to use the system that is currently being used to distribute and track the distribution of seasonal influenza vaccine. Distribution approaches, which vary by manufacturer, are being explored to determine how those approaches would work in a system in which project areas (rather than individual providers) are the end users. In terms of tracking distribution, as described above, the system for tracking seasonal vaccine could be used with only minor modifications to provide information about distribution by date of distribution, product type, order size, provider type, and zip code.

For the longer term, because pandemic influenza vaccine distribution is likely to be quite distinct from seasonal influenza vaccine distribution, we are also currently creating a system module to support centralized ordering, distribution, and distribution tracking of pandemic vaccine that would exist within the VODS systems currently being developed to support the routine distribution of publicly purchased pediatric vaccines. The current timeline for completion of the development and implementation of this system is December 2008 (thus the need for the immediate approach described above). CDC has added a new task to the CITS contract (the same contract being used for the VODS implementation) to support the addition of specific functionality related to pandemic influenza vaccine tracking. CDC will continue to work with vendor to develop the additional functionality for pandemic influenza vaccine distribution and tracking as part of VODS.

3. Funding for Systems to Distribute and/or Track Seasonal and Pandemic Influenza Vaccine

Funding to support these activities has come from several sources. Tracking of seasonal influenza vaccine is supported from the routine funds used to support CDC's Immunization Program. Development of a module to distribute and track pandemic influenza vaccine was initially provided by HHS as supplemental funding. Additional pandemic funds have been requested to support completion of development and maintenance of the pandemic module.

Senator Hatch

Question: The Finance Committee passed legislation to set a timeframe and deadline for adoption of ICD-10 in the US, but the HIT legislation unfortunately did not make it to the President last year. I hope that we will move it again this year and urge you to work with CMS and Congress to support updating our current coding system by 2011.

Answer: I agree that updating the current coding system is important. As you know, the International Classification of Diseases, 9th edition, Clinical Modification (ICD-9-CM), which is a clinical classification system consisting of diagnosis and procedure codes, was developed in the 1970s and implemented in 1979. These clinical codes are used for many purposes including reimbursement, quality reporting, pay for performance, benchmarking, healthcare policy, public health reporting and research.

Dramatic advances in medicine have occurred in the 28 years since ICD-9-CM was first implemented. In 1990, the National Committee on Vital and Health Statistics (NCVHS) noted concerns in its annual report about the ICD-9-CM classification system.

Question: The budget details savings you expect to derive from a demonstration program on competitive bidding for lab services. Last year, I sponsored legislation to address competitive bidding for DME because I have serious concerns about the implications of this program. What protections will be included in your outline that will ensure patients maintain access to critical technologies and services under a competitive bidding program? What measures will you take to avoid disruptions in the care that beneficiaries receive today?

Answer: The Clinical Laboratory Competitive Bidding Demonstration was mandated by Section 302(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. An Initial Report to Congress (RTC) describing the proposed demonstration design was submitted in April 2006. The Office of Management and Budget (OMB) approved the key design elements in March 2007, and operational details are currently under development within the Centers for Medicare & Medicaid Services (CMS).

As noted in the Initial RTC, several protective elements are built into the program's design to ensure access to needed laboratory services. A key selection criterion for the demonstration sites is assurance that each area includes sufficient numbers of laboratories to provide for both successful competitive bidding and assured access for beneficiaries. Multiple winning laboratories will be awarded so they will have sufficient capacity to serve all beneficiaries in their area. Capacity and geographic coverage will also be considered in the selection of successful bidders under the competition.

The Initial RTC also noted demonstration elements designed to protect quality of care. In addition to quality standards under the Clinical Laboratory Improvement Amendments (CLIA), the demonstration will include further quality measures such as test turn-around time, log-in error rates, and the number of lost and/or unusable specimens. Participating labs will be required to designate a quality assurance staff member to serve as a point-of-contact for CMS, physicians, and beneficiaries. CMS will also maintain a toll-free hotline to receive any complaints about the demonstration from beneficiaries, physicians, or laboratories, in addition to working closely with existing CMS survey and certification quality monitoring programs, 1-800-Medicare, and the Medicare Ombudsman. Winning laboratories will be required to submit information on their service and quality standards. Finally, quality (along with access) will be considered in the selection process. The choice of multiple winners will help to assure quality since laboratories will compete with each other on the basis of quality testing and service. We anticipate that protections such as these could be applied if competitive bidding were implemented more broadly, as was proposed in the 2008 Budget.

Senator Bingaman**Questions on the State Children's Health Insurance Program (SCHIP)**

Question: There are nearly 50 million Americans that are uninsured and that number continues to grow. The SCHIP program has proven very successful at providing coverage to low-income Americans that have too many resources to qualify for Medicaid but, nonetheless, can not afford to finance their own health care coverage. Ensuring that we reauthorize and provide robust funding for this very important program is a key goal for me and many other democrats this year. Such reauthorization must continue efforts to reach uninsured children who are already eligible for SCHIP or Medicaid, but are un-enrolled. Reauthorization must also support states in their efforts to move forward in covering more children and must guarantee that no American loses health insurance coverage as a result of SCHIP reauthorization.

The President's Budget proposed an increase of only \$5 billion dollars in SCHIP funding over the next five years. However, current estimates are that at least \$13 billion to \$15 billion are need to ensure that all individuals currently enrolled in SCHIP continue to receive coverage.

In developing the \$5 billion recommendation, did the administration determine how many Americans currently receiving SCHIP coverage will be thrown off of the program because of lack of funding?

Answer: The President's Budget was formulated under the assumption that in order to maintain the current coverage for both children and adult populations over the next 5 years a total of \$34 billion would be needed. This total would be funded with \$25 billion, representing the \$5 billion per fiscal year assumed under current law, plus \$4 billion in unexpended SCHIP allotments projected to be available at the end of FY 2007 for a total of \$29 billion. The \$5 billion number being asked about represents the difference between the \$34 billion projected funding needs and the \$29 billion in other available funds which is being added as new funds in the President's Budget. Under current law 1 million kids would lose coverage by 2012 but the President's Budget prevents this from happening.

Question: In addition, current estimates are that less than 10 percent of all SCHIP coverage is to adults. Thus, isn't it true that even if parents and other adults were stripped out of the program, we would still have to dis-enroll many thousands of children to deal with the shortfall in funding proposed by the President?

Answer: The FY 2008 President's Budget proposes to reauthorize SCHIP for 5 years, consistent with submission of a five-year Budget to the Congress, and focuses each of the program elements on SCHIP's original objective to provide health insurance coverage for uninsured, low-income children at or below 200 percent of the Federal poverty level. Toward this end, the President's Budget actually provides an increase in funding of approximately \$4.8 billion over 5 years. The Administration is also committed to ensuring SCHIP funding is preserved for low-income children and to that end is working to transition adults from SCHIP to Medicaid as State waivers expire.

The President's Budget lays out new approaches to expanding access to affordable health care. For example, the combination of the President's Affordable Choices initiative and health care tax policies will provide new opportunities for Americans, including parents of SCHIP-eligible children, to purchase affordable health insurance.

Question: The Administration's budget proposes to focus SCHIP funding on "core populations" – that is uninsured children at or below 200 percent of the federal poverty level. Such a "focus" would appear to conflict with the many SCHIP waivers granted over the last few years by your Agency to states including New Mexico to cover "non-core" populations. However, during a briefing of Senate staff Monday, HHS representatives indicated the President's proposal intends to limit states that cover children and adults outside the "core population" to a Medicaid matching rate instead of an enhanced SCHIP matching rate – even though these states will be utilizing their SCHIP allotment to pay for this coverage. Such a policy would contravene the purpose of enhanced SCHIP match, which is intended to incentive states to cover individuals with greater resources not covered under a state's Medicaid program. In addition, such a policy would penalize states like New Mexico that cover children at much higher federal poverty levels than other states through their Medicaid program.

How would you reconcile this shift in SCHIP policy with the many waivers that you've provided to states over the years?

Answer: The President's 2008 Budget proposes to reauthorize SCHIP as well as add funding in order to maintain and strengthen the commitment to providing health insurance to low-income, uninsured children. SCHIP was originally established to provide health insurance to low-income, uninsured children who were not eligible for Medicaid. The President's Budget re-focuses the program on its original aim, providing health care to targeted, low-income children below 200% of poverty.

Because of the important reforms in the Deficit Reduction Act of 2005, Medicaid is now a more viable option for states to use to serve parents who are low-income but in the workforce and we are directing states to that option rather than to SCHIP. We will not approve any new waivers that cover adults under SCHIP or renew any waivers for adults. The Administration is currently working with States to transition adults from SCHIP to Medicaid as their SCHIP waivers expire.

Question: Is it fair to penalize these states as they attempt to expand health insurance coverage?

Answer: The Administration does not believe that these states will be penalized

Question: In addition, under the proposal, states must limit public providers to cost while private providers may continue to receive UPL payments up to the Medicare payment rates. To the extent that UPL is being used to support public providers with razor thin margins who are the only source of care to many low-income Americans, how do you justify such a policy?

Answer: I am concerned by the perception that the rule related to cost limits for governmental providers and other provisions to ensure the integrity of the Medicaid program (CMS-2258-F), is

intended to harm public providers; in fact, I understand it to protect health care providers. Governmentally-operated health care providers are assured the opportunity to receive full cost reimbursement for serving Medicaid-eligible individuals, instead of being pressured to return some payment to the State. And, non-governmentally operated health care providers, including many of the “public” safety net hospitals, are not affected by the cost limit provision of the rule.

Questions on Medicaid Proposed Regulation:

Question: During the hearing, I expressed to you that I am very troubled by the Administration's proposal to limit Medicaid financing mechanisms for public providers. Since inception of the Medicaid program and by design, such mechanisms have always played an important role in permitting state and local governments to finance the non-federal portion of the Medicaid program. The Administration proposed these changes last year, submitting proposed legislation to Congress in the summer of 2005 to enact these measures. Congress rejected the proposal. In last year's budget, the Administration then indicated its intent to adopt the proposal administratively. 300 Members of the House and 55 Senators went on record opposing the administrative cuts. Despite the clear, overwhelming and bipartisan opposition to the proposal, the Administration nevertheless issued a proposed regulation making sweeping policy changes in Medicaid.

During the hearing I asked you, given Congress' clear message that we do not believe this is an appropriate policy change to implement by regulation, why is the Administration insisting in going forward with its rulemaking in this area?

Answer: In being a responsible steward for the Medicaid, Medicare and SCHIP programs, I believe it is important to promote transparency and accountability in financing and support efforts to maintain the integrity of the programs. Over the last few years, CMS has been closely examining reimbursement state plan amendments and their associated funding arrangements due to agency concerns about questionable methods of State Medicaid financing. The General Accountability Office (GAO) and the Office of the Inspector General (OIG) have expressed similar concerns about Medicaid financing practices, and in 2003 the GAO placed Medicaid on its list of “high risk” programs. We have worked with a number of states to put questionable financing practices to an end, but these changes need to be made permanent so they cannot slip back into practice in the future. The proposed regulation will ensure that States will fully understand applicable rules, and will know that the same rules apply nationwide. By setting out clear tests that States can apply and monitor, this regulation will permit States to evaluate potential financing and payment methodologies in advance. Moreover, this regulation will give CMS new enforcement and monitoring tools to ensure compliance.

Question: Also, given the attempt in 2005 to make these changes legislatively, under what authority do you believe you may act to attempt these changes administratively?

Answer: This regulation is part of the Secretary's Federal oversight responsibility to ensure that Medicaid payments are consistent with statutory requirements. The Secretary is exercising that authority through the rulemaking process, as required under the Administrative Procedure Act. The regulation interprets and implements statutory provisions enacted by Congress requiring that

payments by States to providers for covered services must be “consistent with efficiency, economy and quality of care” (Section 1902(a)(30)(A) of the Social Security Act). The regulation reflects the need to ensure that payments are actually retained by providers to cover the costs of covered services. The absence of legislation mandating the current approach did not eliminate the Secretary’s authority or responsibility to ensure compliance with existing statutory provisions.

Question: I also highlighted during the hearing that the proposed rule included several ambiguities and many states are having enormous difficulty predicting the impact of the rule. Further complicating the issue, several states report getting conflicting or incomplete information from CMS about how the rule should be interpreted. I asked you if, given this level of uncertainty, the Administration had prepared an analysis of the state-by-state impact of these cuts. You indicated that the Administration had a limited impact analysis of the rule on states. You also indicated that you would share this impact with the Committee. I anxiously await this information.

Finally, what assurances can you provide that critical medical services relied on by Medicaid and uninsured patients through the safety-net will continue to be available?

Answer: All States could be affected by the rule if the State currently:

- reimburses governmentally-operated health care providers in excess of the cost to provide services to Medicaid individuals;
- accepts funds from non-governmentally operated health care providers to help fund the non-Federal share of Medicaid payments; and/or,
- requires the return of Medicaid payments.

The CMS Office of the Actuary does not prepare estimates on a state-by-state basis or by class of facility; however, CMS has limited information on states’ use of intergovernmental transfers and recycling gained from its state plan amendment review process. I have enclosed this information.

I appreciate that Medicaid is a vitally important program that serves very vulnerable populations. I am concerned by the perception that this Medicaid rule is intended to harm public providers; in fact, I understand it to protect health care providers. Governmentally-operated health care providers are assured the opportunity to receive full cost reimbursement for serving Medicaid-eligible individuals, instead of being pressured to return some payment to the State. And, non-governmentally operated health care providers, including many of the “public” safety net hospitals, are not affected by the cost limit provision of the rule and therefore may continue to receive Medicaid payments in excess of cost of providing services to Medicaid individuals within existing Federal requirements.

Senator Stabenow

Question: According to the Medicare Payment Advisory Commission (MedPAC), the physician “SGR” payment formula will result in substantial payment cuts to physicians and other health professional through at least 2015. The cut scheduled to go into effect next January is an enormous 10% – twice the level we would have seen this year had Congress not acted.

MedPAC does not support the impending payment cuts and is concerned that cuts could threaten access to physician services, particularly primary care services.

Rather than supporting cuts, MedPAC recommends physicians receive an update to payments in 2008 equal to the Medical Economic Index (MEI).

Although MedPAC has recommended repeal of SGR and positive updates for years, and although the President has signed into law provisions overriding the SGR formula for the last 5 years, the President’s Budget assumes continuation of the current payment formula, and the 10% cut in 2008 and future cuts that the formula provides.

Do you disagree with MedPAC that physicians should receive a payment update? Why doesn’t the budget include any resources for a payment level for physicians that accurately reflects the cost of providing care to Medicare beneficiaries?

Answer: We are actively engaged with both the Congress and physician community on this important topic. We need to identify ways to align Medicare’s physician payment system with the goals of health professionals for high-quality care, without increasing overall Medicare costs. The Administration supports budget neutral payment reforms in Medicare that reward improved quality and efficiency without increasing costs for taxpayers and beneficiaries.

Senator Smith**Questions on Changing Medicaid through Administrative Maneuvers:**

I am concerned that the Administration consistently attempts to use its administrative authority to rework the Medicaid program in a manner that is inconsistent with the intent of the Congress. During debate over the Deficit Reduction Act, many of the administrative proposals contained in your budget were debated and roundly defeated by Congress, yet you continue to try to circumvent the will of the Congress and advance them outside the legislative process.

For instance, I, along with many of my colleagues, remain opposed to your efforts to limit the use of intergovernmental transfers. You try to paint them as fraud and abuse, when those of us who know the program recognize that these functions are being used by states to generate much needed funding to cover millions of poor, elderly and disabled Americans. What’s more, the plan amendments that allow the states to operate were approved by your agency.

Question: Your agency estimates that its proposal to restrict the use of IGTs will generate \$5 billion in savings to the federal government, which likely amounts to close to \$9 billion in total lost funding for the program. How will this money be made up within Medicaid so as not to result in lost coverage and access for persons currently on Medicaid?

Answer: The provisions of the regulation were actually designed to protect health care providers, including the safety net providers. Under the provisions of the regulation, governmentally-operated health care providers are assured opportunity to receive full cost reimbursement for serving Medicaid individuals. Nongovernmentally-operated health care providers, including many of the “public” safety net hospitals, are not affected by the Medicaid cost limit provision of the regulation and therefore, may continue to receive Medicaid payments in excess of the cost of providing services to Medicaid individuals within existing Federal requirements. Moreover, the rule provides that payments to these health care providers cannot be diverted, but must be retained by the providers and available to support provider services.

Question: Has your agency evaluated the impact this change will have on the number of people who lose coverage on a state-by-state basis given this loss of revenue? If not, I would like those numbers.

Answer: The regulation presents no changes to coverage or eligibility requirements under Medicaid but clarifies statutory financing requirements and allows governmentally operated providers to be reimbursed at levels up to cost. Federal matching funds will continue to be made available based on expenditures for appropriately covered and financed services delivered to Medicaid eligible individuals. Governmentally-operated health care providers can receive Medicaid revenues up to the full cost of providing services to Medicaid individuals and private health care providers may continue to receive Medicaid revenue in excess of Medicaid cost. Under these circumstances we do not anticipate that the actual services delivered by governmentally-operated health care providers or private health care providers will change.

Questions on Funding for the AIDS Drug Assistance Program:

I appreciate the Administration’s budget proposal to increase the US’ contribution to the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis. However, proposed funding for domestic AIDS programs, particularly the AIDS Drug Assistance Program or ADAP, was far short of what is needed to meet existing demand for services.

Question: I plan to reintroduce the Early Treatment for HIV Act in the coming weeks. This bill would allow states to provide Medicaid coverage for low-income individuals diagnosed with HIV. I believe this is the long-term solution needed to solve ADAP’s problem of being historically under funded. As I continue to work to pass this bill, what sort of assistance can the Centers for Medicare and Medicaid Services provide states to create demonstration projects to provide Medicaid coverage to individuals living with HIV?

Answer: CMS works with states on a variety of different types of demonstration projects (both comprehensive health systems reform and targeted interventions for specific populations) and has in the past worked with states on demonstration projects that specifically address the needs of

individuals with HIV/AIDS. In both Maine and the District of Columbia, CMS worked with our state partners to accomplish this type of program. The program is premised on the concept that intervening earlier decreases the costs to the state (and Federal government) over the longer term.

The Maine HIV/AIDS Demonstration provides a comprehensive set of services to those who are both HIV positive and at or below 250 percent of the FPL. The Demonstration expands access to those without health insurance and who are otherwise ineligible for MaineCare, the State's Medicaid program. The Demonstration is designed to provide more effective, early treatment of HIV disease by making available a limited but comprehensive package of services, including anti-retroviral therapies. The District of Columbia HIV/AIDS Demonstration extends Medicaid benefits to HIV-positive individuals.

CMS often replicates a concept in one state that has been tested in others, and is willing to provide technical assistance to any state that wishes to develop a program that provides services to this population. As always with demonstration projects, CMS works with the states in advance to establish a budget-neutral spending cap which it then monitors over the life of the demonstration to ensure that costs to the Federal government do not exceed what costs would have been in the absence of the demonstration.

Senator Salazar

Question: Please explain in detail the reasons why the Department of Health and Human Services disagrees with the Governmental Accountability Office's findings set forth in GAO-07-239R, Medicaid Federal Upper Limits, regarding Medicaid pharmacy reimbursements.

Answer: CMS finds the GAO's conclusion in "Medicaid Outpatient Prescription Drugs: Estimated 2007 Federal Upper Limits for Reimbursement Compared with Retail Pharmacy Acquisition Costs" (GAO-07-239R) unsupported by the report. The study uses incomplete and misleading information, as well as nondisclosed pricing data. It also fails to account for rebates and discounts that pharmacies may receive from wholesalers or manufacturers in determining the actual retail acquisition cost. The GAO acknowledged in their final report that it was difficult to identify rebates and other discounts.

The GAO also failed to account for the differences in the definitions of AMP before and after the implementation of the Deficit Reduction Act of 2005 (DRA). Effective January 1, 2007, the DRA revised the definition of AMP to exclude customary prompt pay discounts to wholesalers and required manufacturers to include sales of authorized generics when they report their AMP.

The GAO also did not report on the effect that excluding outlier data would have on AMP-based FULs. We have proposed by regulation to exclude outlier AMP data when calculating the FUL. The effect of this method for establishing FULs is not reflected in the GAO results.

The GAO's findings also do not take into account the impact of existing state cost-containment mechanisms such as Maximum Allowable Cost (MAC) programs that result in lower State payments. Although the final GAO report recognizes State MAC prices as a "valid comparison," they state that the issue was beyond the scope of their report which centered on AMP-based FULs only.

As reflected in the GAO report, FULs apply to state Medicaid program expenditures in the aggregate, thus, states may reimburse for some drugs in excess of the FULs as long as these higher reimbursements are offset by others that are below the FULs. However, the report does not analyze how the effects of the FULs could be mitigated by States through higher payments when acquisition cost exceeds the FUL.

CMS expects the provisions of the DRA to drive prescribing and filling practices to lower-priced generic versions of drugs, which will decrease costs overall. However, the GAO provided no analysis of how States and pharmacies can mitigate the effect of the lower FULs by filling prescriptions with low cost generic equivalent drugs. The final GAO report recognizes that "to the extent that the cost-containment measures of the AMP-based FULs influence retail pharmacies to acquire lower cost therapeutically equivalent versions of drugs or negotiate lower prices from manufacturers and wholesalers, the gap between AMP-based FULs and acquisition costs could be narrowed or offset."

Per the GAO, "only after AMP-based FULs are implemented in 2007 will there be an opportunity to determine the extent to which these FULs facilitate both cost-effective Medicaid drug expenditures and adequate reimbursement for retail pharmacies."

Prior Office of the Inspector General reports have outlined the need for reform in Medicaid pharmacy reimbursement. Using 250 percent of the lowest reported AMP rather than the current methodology of 150 percent of the lowest price published in national compendia will result in billions of dollars of savings to States and the Federal Government. The GAO also acknowledges that they "agree with CMS that changing the basis of the FUL from average wholesale price to AMP was a step in the right direction toward achieving savings for the federal government on Medicaid expenditures for multiple-source outpatient prescription drugs."

Senator Roberts

Question on High Risk Pool

Question: Can you shed some light on why this budget does not provide funding for the high risk pool program?

Answer: The FY 2008 Budget includes several initiatives to restructure health insurance markets and help people with poor health or limited income afford health insurance. This budget includes a State-based and budget neutral initiative to foster affordable choices in the health care system. Through this initiative HHS would work with States to craft innovative solutions that

move people into affordable insurance. The budget also re-proposes the establishment of association health plans. These plans would allow small employers, civic groups, and community organizations to band together and use their purchasing power to negotiate lower-priced coverage for their employees, members, and their families.

Question on Hospital Payments:

Question: The President's budget proposes serious reductions in Medicare reimbursement to hospitals. Recently, MedPAC recommended a full update for hospitals for FY 2008. One of the reasons they are recommending a full update is that overall Medicare margins are projected to be minus 5.4% for FY 2007. Can you explain how the administration can rationalize reducing payments for hospitals given this finding?

Answer: The Medicare Payment Advisory Commission (MedPAC) has noted that hospitals have been able to reduce costs under tighter price pressures and that hospitals with negative Medicare margins tend to have less pressure to control costs due to higher payments from private payers. Factoring productivity into payments will encourage these hospitals to improve their efficiency and control their costs. A modest reduction in the update of 0.65 percentage points (one half of the 10-year Bureau of Labor Statistics productivity average of 1.30 percent per year) would encourage efficiency, while maintaining access to care. As a Trustee of the Medicare Trust Funds, it is vital that we do everything we can to maintain the solvency of the program and pay as efficiently as possible.

Further, since the implementation of the inpatient prospective payment system for acute care hospitals, the average actual increase in the market basket has been approximately 1.3 percentage points less than the average projected market basket increase (or only 66 percent of the average projected market basket increase). In light of these historical findings, and given hospitals' ability to adjust to market conditions, an on-going adjustment for productivity would likely not affect the ability of hospitals to furnish high quality inpatient services to Medicare beneficiaries.

We have great faith in the market's ability to adapt without reducing access. Since 2002, more hospitals have opened than closed each year, suggesting that access to care is still improving.

Questions on Home Oxygen:

Question: The budget proposes to reduce the rental period for most home oxygen equipment from 36 to 13 months. I have serious concerns with this proposal. In fact, I introduced legislation last year with Senator Jack Reed to strike the beneficiary ownership requirement of home oxygen equipment after 36 months of rental included in the Deficit Reduction Act.

Answer: Under the President's fiscal year (FY) 2008 Budget proposal, once the beneficiary owns the equipment after 13 months (36 months for new technology equipment), the Centers for Medicare & Medicaid Services (CMS) will make separate payments for all necessary items and services to support a beneficiary's use of oxygen equipment, as is the case under the current policy for all such equipment (i.e., after 36 months). CMS will make separate payments for general maintenance and servicing visits every six months, delivery and refilling of stationary and portable oxygen contents, reasonable and necessary repairs, and replacement supplies and

accessories. Beneficiaries have the option of having their original or another supplier provide maintenance and servicing and repairs of their oxygen equipment.

The Department of Health and Human Services Office of Inspector General (HHS OIG) issued a report in September 2006 that provided important information on cost, servicing, and maintenance issues. The HHS OIG report recommended that CMS work with Congress to further reduce the rental period for oxygen. We agreed with their recommendation and, as you know, proposed to reduce the rental period for oxygen from 36 to 13 months.

More specifically, the HHS OIG report provided vital information on the suppliers' purchase price, reuse, and maintenance and servicing of oxygen concentrators. The OIG report found that concentrators cost about \$587, on average, to purchase. The report also found that suppliers rented used concentrators to about 73 percent of the sampled beneficiaries. The used concentrators were 2.5 years old, on average, but there were cases of concentrators that were over 10 years old.

In addition, the report provided details on the maintenance and servicing that is actually done during a supplier's visit. The report found that minimal servicing and maintenance is necessary for concentrators and portable equipment. This is an important finding because the report was based not only on reports from suppliers, but also on actual on-site observation accompanying suppliers on their visits to beneficiaries' homes. In addition, the report found that these servicing tasks take minimal time to perform. More specifically, the report stated that "when we accompanied suppliers on their visits to beneficiaries' homes, we observed that routine maintenance for a concentrator consists of checking the filter to make sure it is clean and checking the oxygen concentration and flow rate with handheld instruments, tasks that can be performed in less than 5 minutes."

We found this information to be valuable in better understanding the cost of equipment, and the maintenance and servicing of oxygen concentrators. Accordingly, the information was an important consideration in developing the FY 2008 Budget proposal.

Question: I realize changing from a rental policy to a beneficiary ownership model might save money. However, I believe these "savings" come at the expense of seniors' safety. Requiring beneficiaries to assume responsibility and ownership of home oxygen equipment is an unreasonable burden and worry for these seniors who are often very ill and vulnerable. Mr. Secretary, can you address this issue? Has your agency done any sort of impact studies on how further reducing the rental period to 13 months could affect these Medicare beneficiaries?

Answer: The President's fiscal year (FY) 2008 Budget proposes to reduce the rental period from 36 to 13 months for oxygen equipment (other than new technology equipment). Once the beneficiary owns the equipment after 13 months, Medicare will make separate payments for all necessary items and services to support a beneficiary's use of oxygen equipment, as is currently the case after 36 months.

CMS issued a final rule in November 2006 that implemented Section 5101 of the Deficit Reduction Act (DRA), which required suppliers to transfer title of oxygen equipment to the beneficiary after 36 continuous months. The final rule established supplier requirements to safeguard beneficiaries, and also established new payment classes for oxygen and oxygen equipment to reflect new technology and adequate compensation for delivery and refilling of portable contents.

Most importantly, the final rule established additional safeguards for beneficiaries now that beneficiaries will own their oxygen equipment, such as requiring that a supplier who furnishes rented oxygen equipment/capped rental to the beneficiary must continue to furnish that item throughout the whole rental period except in certain circumstances specified in the final rule. In addition, suppliers may not switch out equipment at any time during the 36 month rental period except in certain circumstances specified in the final rule. CMS is also requiring that the supplier disclose to the beneficiary its intentions regarding assignment of all potential monthly rental claims for oxygen equipment/capped rental DME items.

The DRA required that Medicare make payments for reasonable and necessary maintenance and servicing of beneficiary owned oxygen and capped rental equipment for parts and labor not covered by the supplier's or manufacturer's warranty. The final rule states that all reasonable and necessary maintenance of beneficiary owned capped rental or oxygen equipment, which must be performed by authorized technicians, would be covered. CMS will also make payments for general maintenance and servicing visits every six months, beginning six months after ownership, in addition to reasonable and necessary repairs, for beneficiary-owned oxygen equipment. Separate payment will also be made for replacement of supplies and accessories (e.g. cannulas, tubing) will continue after ownership of the equipment transfers to the beneficiary.

With regard to studies, the Department of Health and Human Services Office of Inspector General (HHS OIG) issued a report in September 2006 that provided important information on cost, servicing, and maintenance issues. More specifically, the report provided details on the maintenance and servicing that is actually done during a supplier's visit. The report found that minimal servicing and maintenance is necessary for concentrators and portable equipment. This is an important finding because the report was based not only on reports from suppliers, but also on actual on-site observation accompanying suppliers on their visits to beneficiaries' homes. Ultimately, the HHS OIG report recommended that CMS work with Congress to further reduce the rental period for oxygen.

Question on Physician Payment:

Question: The budget does not include any proposal to reverse the 10% reduction in Medicare physician payments slated in the payment formula for next year. Can you discuss how you think doctors – especially doctors in our rural areas who serve large proportions of Medicare patients – can sustain a 10% reduction in Medicare payments?

Answer: We are actively engaged with both the Congress and physician community on this important topic. We need to find ways to align Medicare's physician payment system with the goals of health professionals for high-quality care, without increasing overall Medicare costs.

The Administration supports budget neutral payment reforms in Medicare that reward improved quality through value-based purchasing.

Question on HIT:

Question: Your budget embraces the goals of HIT. As you know, I am a big believer in HIT and want to work on enacting legislation this year. One specific beneficial technology that can truly and directly improve patient care is remote monitoring technology. As you know, many conditions require immediate and timely monitoring by their physicians for conditions such as congestive heart failure, cardiac arrhythmia, and diabetes and sleep apnea. Remote monitoring by a physician can reduce travel time, improve care management, and provide better patient outcomes. Do you think we need to adjust the physician fee schedule to ensure that physicians have the proper incentives to provide these services to manage some of the most costly chronic conditions?

Answer: Medicare covers some remote monitoring services such as some types of remote cardiac monitoring. Other remote monitoring services such as automated monitoring of weight or blood pressure do not have a Medicare benefit category and thus are not covered services. When services are covered, payment is made under the physician fee schedule.

Additional Questions:

Question: The rule issued January 18, 2007 by the Department of Health and Human Services threatens to cut a large hole in the safety net that provides health care for thousands of residents of Kansas. The rule is entitled "Cost Limit for Providers Operated by Units of Government and Provisions to Ensure the Integrity of Federal-State Financial Partnership." Has your Department prepared an estimate of the impact of the rule on the citizens of Kansas?

Answer: No, CMS' Office of the Actuary, which prepares these estimates, does not prepare estimates on a State-by-State basis or by class of facility.

Question: Here is our assessment of the impact in Kansas: in Fiscal Year 2006, Medicaid beneficiaries came to the University of Kansas Hospital (KUH) for care more than 37,000 times (4,573 inpatient discharges and 32,431 outpatient encounters) and uninsured patients more than 17,000 times (1,185 inpatient and 15,873 outpatient). Total uncompensated care for FY 2006 approached \$81 million. One feature of the rule would be to change the definition of a public hospital in such a way that KUH would lose \$20 million in Medicaid funding. What is the Department's plan to replace this lost funding for Kansas and for similarly situated public hospitals throughout the country?

Answer: While we do not have facts relating to the particular situation of KUH, the rule was designed to protect health care providers, including safety net providers. Governmentally-operated health care providers would be assured the opportunity to receive full cost reimbursement for serving Medicaid-eligible individuals. Non-governmentally-operated health care providers, including many of the "public" safety providers would not be affected by the cost limit provision and could continue to receive payments in excess of the cost of providing services

to Medicaid individuals, within applicable Federal aggregate upper payment limit requirements. To protect providers, the rule reaffirms that all health care providers must retain the total Medicaid payment to which they are entitled. This ensures that Medicaid funding will be available to cover the provider's Medicaid costs and is not required to be diverted by the State for other purposes.

Question: Can you explain why the Department chose to exclude from receiving matching funds, contributions to Medicaid by public hospitals, like the University of Kansas Hospital, that do not receive general appropriations or have independent authority to levy taxes to support their mission?

Answer: The Federal Medicaid statute permits the non-federal share of Medicaid expenditures to be contributed by "units of government within a State" when "such funds are derived from State or local taxes (or funds appropriated to State university teaching hospitals)." The rule would implement this statutory provision. To the extent that a hospital does not have "funds derived from State or local taxes (or funds appropriated to State university teaching hospitals)," then the hospital would not meet these statutory requirements to contribute the non-federal share. The State would then need to contribute the non-federal share, and the hospital would have the full benefit of the resulting federal-state Medicaid payment, which could result in the hospital having more funding rather than less funding. This would bolster the hospital's "public" mission in the delivery of health care services to the nation's most vulnerable populations.

Question: How many public hospitals nationwide would similarly be excluded because they do not receive general appropriations or lack the authority to levy taxes?

Answer: The CMS Office of the Actuary does not prepare estimates on a State-by-State basis or by class of facility.

Question: Even if the proposed rule did not change the definition of a public hospital, it would propose to limit reimbursement for KUH's 37,000 Medicaid patient encounters to the actual cost of care. KUH is a safety net hospital, and this limitation would severely undercut the hospital's ability to provide care for the 17,000 uninsured patient encounters. Even if the Administration's proposals to expand coverage to more uninsured would apply to these patients, it would not be available in FY 2008. How does the Department suggest that KUH, Kansas and other states bridge this gap?

Answer: The Federal government remains committed to funding its share of the cost of providing Medicaid services to eligible individuals. For governmental providers, under the rule Medicaid would continue to pay for its share of costs of covered services for Medicaid-eligible individuals in accordance with applicable statutory and regulatory requirements. To assist safety net hospital providers that serve a disproportionate share of low income individuals with the costs of uncompensated care, the Medicaid statute provides for DSH funding. To the extent that States wish to reduce the extent of uninsurance and uncompensated care, States may wish to explore expanding Medicaid coverage and fully utilizing available DSH funding within the limits of the current statute.

Senator Pat Roberts**Finance Hearing: Secretary Leavitt on the President's FY08 Health Care Budget
February 7, 2007**

Secretary Leavitt, thank you for coming to testify before the Finance Committee. First and foremost, I appreciate the administration putting forth a budget which seeks to control spending and strengthen the long-term security of Medicare and Medicaid. I agree that we need to return to a policy of fiscal responsibility and we must get a handle on the growth in Medicare and Medicaid spending so these programs are viable and sustainable for future generations.

However, I'm afraid of going down a path where in order to save a few bucks here or a few dollars there, we end up hurting the people these programs were created to serve. I certainly do NOT want to be in the business of tying the hands of our health care providers, especially those in our rural areas, and ultimately harming our seniors and low-income populations by restricting their access to care. This is why Congress will have to proceed with caution in any efforts to control spending for Medicare or Medicaid.

I am here today as both a Finance Committee member and a HELP Committee member and I want to share my thoughts on some issues which cross over both committees. Kansas is a rural state. 88 of our 105 counties are considered rural or frontier. Over 75 percent of our community hospitals are located in rural areas and 84 percent have fewer than 100 beds. We have 82 Health Professional Shortage Areas throughout the state.

I want to raise a few concerns with rural health funding in the administration's budget. The budget proposal suggests a \$143 million cut in rural health programs. Two programs—the Rural Outreach Grants and Rural Hospital Flexibility Grants—are proposed for elimination, yet have been vital to the success of our rural health delivery system in Kansas.

Money from these programs has allowed Kansas to create innovative networking and outreach activities, provide necessary recruitment for clinicians, and establish a Statewide Critical Access Hospital Performance Improvement Program, which is now being replicated in several other states because of its success in Kansas.

In addition, the budget proposes to reduce funding for the National Health Service Corps and nearly eliminate Title VII Health Professions programs. In Kansas, we rely on both of these programs to get doctors and other health professionals to serve in our rural areas. Without these programs, many rural communities would find it nearly impossible to attract and retain good doctors.

I also have serious concerns with the lack of proposed funding for the State High Risk Pools program. Last year, I worked with my colleagues on the HELP Committee to renew this important program, and President Bush signed this measure into law last February.

With a small federal investment, high risk pools provide health insurance coverage for individuals who would otherwise be uninsured because of pre-existing medical conditions or inability to afford care.

I simply don't understand how this budget can justify not extending funding for a program that has been successful at insuring individuals who would otherwise be unable to access care at a time when we are looking for innovative ways to expand health care coverage.

SENATOR KEN SALAZAR
STATEMENT
Finance Committee Hearing
The President's Fiscal Year 2008 Budget
February 7, 2007

I want to thank Chairman Baucus and Ranking Member Grassley for holding this important hearing. I also want to thank Secretary Leavitt for his testimony and leadership of the Department of Health and Human Services.

There is no doubt that the President's budget represents difficult choices among competing interests and worthy programs. I am pleased to see that nurse visitation programs, which promote healthy children and stable families, and health information technology, a key element of health care reform, are included in the President's budget. I am disappointed, however, that the President's budget fails to make the health of American children, rural residents and Medicaid and Medicare beneficiaries top priorities.

The State Children's Health Insurance Program is a shining success, with over 6.1 million children receiving quality health care through the program. The President's budget, however, includes only \$5 billion in new funding for the Children's Health Insurance Program, far short of the estimated \$15 billion needed to maintain coverage of the 6.1 million children and their families that rely on the program for critical health care. Not only does the President's budget place children at risk of losing health care coverage, it does nothing to promote coverage of the additional 6 million children who are eligible for coverage under the program, yet not enrolled. Clearly, if we value children's health, we must build upon the success of and fully fund SCHIP so that it covers all eligible low-income children.

The President's Budget also fails rural America by cutting and eliminating programs that support the fragile health care delivery systems that exist in rural towns and communities across this nation. For example, the President's budget eliminates Area Health Education Centers (AHECS), which help to recruit and retain health care professionals in rural communities.

There are five AHECS in Colorado that train and place physicians, pharmacists, nurses and other health care professionals in rural communities. AHECS make a difference in the lives of rural residents by helping to ensure access to medical services. Rural residents deserve our best efforts to promote access to health care services by funding programs that increase medical professionals in rural areas and encourage innovative health programs.

The President's budget cuts to Medicaid and Medicare also reflect the wrong priorities. The President's budget proposals will result in increases in Medicare premiums for senior citizens who can least afford to pay increased fees. Moreover, at a time when the ranks of the uninsured continue to rise, the President's budget makes sweeping cuts that will shift responsibility to the states to fund health care for Medicaid beneficiaries.

Further, the President's provider reimbursement cuts to pharmacies, physicians, home health providers, skilled nursing homes, clinical laboratories and ambulance and hospice providers, among others will have a devastating impact on the access to health care for millions of Americans. Clearly, if we value health care for Medicare and Medicaid beneficiaries, we must reject short-sighted cuts that deny adequate health care to millions of Americans.

Funding worthy programs that provide health care to needy children, rural residents, low-income Medicaid beneficiaries, senior citizens and the disabled should be top priorities. I look forward to working with the Finance Committee to ensure that these priorities are reflected in the budget.

Statement of Senator Gordon H. Smith
Finance Committee Hearing – Secretary Michael J. Leavitt
February 7, 2007

Setting the budget for the nation's health is a daunting task. The policies are disparate, ranging from large entitlement programs, such as Medicare and Medicaid, to the nation's research component at the National Institutes of Health, to the support programs that help everyday Americans make ends meet, like the Family Caregivers Program or the child care subsidies. All are important, and all deserve our focus as we evaluate and discuss the President's proposal for the fiscal year 2008 budget.

Unfortunately, I found myself disagreeing with the President's proposals more often than I would have liked. That is why Congress will take up its responsibility to craft the nation's budget in the coming months. We have a long road, and a lot of work ahead of us. Many proposals need additional funding and additional funds will be hard to come by. Yet, in the end, I am confident we will get our work done.

One of the top priorities for this Committee, and in fact the Congress, should be reauthorization of the State Children's Health Insurance Program, known as S-CHIP. For the past ten years, this program has provided health insurance coverage to million of low-income, uninsured children. In fact, in 2005 it is estimated that almost six million children received coverage at some point during the year.

Unfortunately, our work is not yet done because over three million children remain eligible, but are not enrolled in the program. Given this statistic, it is disappointing to see that the President's budget only provides an additional \$4.8 billion for SCHIP. This amount is inadequate to meet the need that exists in our country. The best estimates at this point show that an additional \$15 billion is needed to cover all those children who are eligible, but uninsured.

In November, nine colleagues joined me in writing to the President to request that he provide adequate funding in his budget to cover all those who currently are enrolled under S-CHIP, all children and pregnant women whose family income is less than 200 percent of the federal poverty level (FPL), and provide for a yearly inflation adjustment so the program continues to keep pace with inflation. While the funding provided in the President's budget is helpful, it won't meet the mark to accomplish those goals. That is why I intend to work with my colleagues to identify appropriate funding sources to meet these objectives.

I also remain deeply concerned by the ongoing attempt by the Administration to attack Medicaid, both through legislative and administrative proposals. It seems that year after year we get the same rhetoric and the same proposals trying to undermine the program and the states' ability to administer it. While I doubt many of the legislative proposals will advance this year, I remain concerned by the Administration's attempt to change Medicaid using its administrative authority.

Many of the proposals contained in this year's budget are recycled from past years, and most of them have been roundly rejected by the Congress. Therefore, I would hope the Administration would abandon its plans to restrict the use of intergovernmental transfers, health care in schools and other administrative proposals that could severely harm access to health insurance coverage for millions of the poorest and most needy Americans.

I am also deeply concerned about the impact of many of the proposals put forth related to Medicare. As Secretary Leavitt pointed out today, more than 44.6 million Americans receive benefits from this important program. We must carefully consider the proposals put forth by the President, many of which were included in budgets of previous years, as we move forward. We should think twice before cutting care to those in need solely on the basis of reducing costs. Rather, we must carefully weigh the needs of our older citizens and do what is right for the program.

On the issue of mental health services, I appreciate the President's strong support of the Garrett Lee Smith Memorial Act, which was signed into law in the fall of 2004. However, for the past two years, the President's budget has requested level funding of \$26.7 million for these important youth suicide prevention activities. This is far below the \$40 million authorized in the Act and I would appreciate your support as we work through the appropriations process.

I am also grateful for the President's attention to the global fight against HIV/AIDS. The President's proposal increases the U.S.' contribution to the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis to 201 million. However, proposed funding for domestic AIDS programs, particularly the AIDS Drug Assistance Program or ADAP, was far short of what is needed to meet existing demand for services. I believe a more permanent solution to the ADAP's historical funding problems is in order, and that is why I plan to reintroduce the Early Treatment for HIV Act (ETHA) in the coming weeks. ETHA will allow states to provide Medicaid coverage for low-income individuals diagnosed with HIV at an enhanced match rate. Individuals living with HIV will receive the care they need, so they can remain healthier, longer. Hopefully, this will prevent their progression to full-blown AIDS, a condition which requires much more expensive pharmaceutical treatments that have often serious secondary effects. As I continue working to pass ETHA in Congress, I am hopeful the Centers for Medicare and Medicaid Services will provide states assistance to create Medicaid demonstration projects so that we can learn more about the long-term effects a coverage expansion targeting this population could have.

I am pleased the Administration has renewed its commitment to supporting the healthcare safety net by providing a \$200 million increase for the Community Health Centers (CHCs) program. CHCs perform an invaluable service in many rural and impoverished communities, providing basic health care to those most in need. Health centers in my state have benefited greatly from the new funding the President has worked to secure over the past several years. But some, like the CHC in Lane County, Oregon, have struggled to secure sufficient funding to construct new facilities. The Lane County Community Health Center has done a remarkable job of providing healthcare to vulnerable individuals, but I am concerned that its future success may be threatened if it does not have a facility large enough to serve all those who need care. I am hopeful the Administration will work with me to identify funding to help health centers like the one in Lane County construct facilities that can fully accommodate the demand in their respective communities.

As we move forward in Congress to assess the President's fiscal year 2008 budget, I hope the Congress will carefully consider the importance of ensuring adequate funds are provided to these important programs.

Statement of Senator Craig Thomas
Finance Committee Hearing: "The President's FY 2008 Budget Proposal"

February 7, 2007

Mr. Chairman, we are at a crossroads in this country. We face very serious fiscal difficulties -- particularly in the area of entitlement spending. With fewer workers contributing for each retiree, the burden to finance these programs will only grow heavier. By 2016, estimates show the cost of Social Security, Medicare, and Medicaid alone will comprise 56 percent of total federal spending. By 2030, these three programs will exceed what it costs to fund the federal government today.

These are grim statistics. For our part, we must begin working together to find reasonable solutions that restrain federal spending so that programs like Medicare, Medicaid, and SCHIP can stay viable. Most Americans live on a budget. We all have to make difficult decisions when making big purchases or long-term financial commitments. There is no reason Congress cannot do the same. We have more than \$66 trillion in unfunded government obligations over the next 75 years. Something must be done to restrain spending, and soon.

Of course, it is easy to talk about reducing spending, but quite another to act. Last year, Congress passed the Deficit Reduction Act (DRA). This bill took initial steps to slow the growth of entitlement programs, but it is clear that it only scratched the surface. Together, we have an unprecedented opportunity to put aside partisan politics and work together and in cooperation with the Administration to make sure the United States economy can handle these fiscal challenges. I believe the President, in his Fiscal Year 2008 budget, has given us a place to start a conversation about entitlement spending. It is my hope that we will have an open and honest debate. Frankly, I know we will not agree on every issue. But, when I travel home to Wyoming, my constituents consistently tell me how the federal government needs to do more to control its spending. I couldn't agree more. We all deserve a government that we can afford, and it is our responsibility to deliver results.

Now, the President's budget also outlines certain health care spending priorities. There is one area of great concern to me that I want to highlight. Through my post as Republican Co-Chairman of the Senate Rural Health Caucus, I have worked hard along side my colleagues to ensure rural providers are paid fairly, and rural residents have access to the same health care services available to folks in urban areas.

That is why I was very disappointed to once again see the Administration's budget eliminate several key rural health programs by approximately \$143 million. If programs are not meeting their intended purpose or are not performing well, I would say it is fair to look at eliminating the program. That is not the case with the Rural Health Outreach and Network Development Grants, Rural Hospital Flexibility Grants, and Small Hospital Improvement Program which have proven to be effective and efficient tools to shore up our rural health care delivery system. While I certainly understand we are operating in a tight fiscal framework, I also believe these programs should not be undervalued. Frankly, if the Administration believes these programs are failing rural America, then I expect Secretary Leavitt will be able to explain to me what plans he is making now to make sure rural folks: farmers, ranchers, blue collar workers, small business

employers and employees, and rural hospitals and providers do not fall behind their urban counterparts. I hope the Secretary will talk a little bit about the initiatives he is working on to improve the accessibility and affordability of health care services in rural and frontier areas.

Thank you, Secretary Leavitt, for your service and your testimony. I look forward to working with the Administration and my Senate colleagues to take the necessary, and often difficult, steps to ensure our country is put on a solid path toward reducing the deficit and also strengthening our rural health care delivery system.

Thank you, Mr. Chairman.

