PRESIDENT'S FISCAL YEAR 2007 BUDGET FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

FEBRUARY 8, 2006

Serial No. 109–55

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

30–636 WASHINGTON : 2006

For sale by the Superintendent of Documents, U.S. Government Printing Office
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PRESIDENT'S FISCAL YEAR 2007 BUDGET FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

WEDNESDAY, FEBRUARY 8, 2006

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 10:12 a.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee), presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 01, 2006
FC–18

CONTACT: (202) 225–1721

Thomas Announces Hearing on President's Fiscal Year 2007 Budget for the U.S. Department of Health and Human Services

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on the President's Fiscal Year 2007 Budget for the U.S. Department of Health and Human Services. **The hearing will take place on Wednesday, February 8, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:30 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the Honorable Michael Leavitt, Secretary, U.S. Department of Health and Human Services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On January 31, 2006, President George W. Bush discussed several legislative initiatives when he delivered his State of the Union Address. The President will provide further details on these proposals on February 6, 2006, in his fiscal year 2007 budget, as submitted to the Congress. The budget for the U.S. Department of Health and Human Services includes important benefits and services such as those provided under Medicare, welfare (Temporary Assistance for Needy Families), child care, child protection, child support and other social services programs.

In announcing the hearing, Chairman Thomas stated, "The President outlined several health and social service initiatives in his State of the Union Address that are under the jurisdiction of the Committee on Ways and Means. I look forward to hearing more about these proposals from Secretary Leavitt."

FOCUS OF THE HEARING:

The focus of the hearing is to review the President's Fiscal Year 2007 Budget proposal for the U.S. Department of Health and Human Services.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*109th Congress*" from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=17*). Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Wednesday, February 22, 2006. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office

Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

*** * * CHANGE IN TIME * * ***

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
February 06, 2006
No. FC–18 Revised

CONTACT: (202) 225–1721

Change in Time for Hearing on President's Fiscal Year 2007 Budget for the U.S. Department of Health and Human Services

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee hearing on the President's Fiscal Year 2007 Budget for the U.S. Department of Health and Human Services, previously scheduled for 10:30 a.m. on Wednesday, February 8, 2006, in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 10:00 a.m.**

All other details for the hearing remain the same. (See Full Committee Advisory No. FC–18, dated February 1, 2006).

Chairman THOMAS. At the outset, the Chair wants to indicate to Members that there is a minor bit of a static problem in the Committee room, and the Chair would suggest that as Members sit at their seats, they might want to touch the metal knobs on their drawers prior to touching the microphones, because there is a chance that the microphones might short out. I will tell the gentleman from California, you can touch your mic any time you want.

[Laughter.]

Chairman THOMAS. This is the new and exciting technological age.

Good morning. This was scheduled to be the second of a series of hearings on the President's budget. We were scheduled yesterday to hear from Secretary of the Treasury, Secretary Snow. Pretty obviously, the funeral of Coretta Scott King, quite rightly, took precedent over that. We believe the Secretary will be available to us on the February the 15th, and so we are in the process of rescheduling that particular hearing.

This then would have been the second in a series of hearings, but is therefore the first, on the President's 2007 budget proposal, and the Committee welcomes the still relatively new Secretary of the U.S. Department of Health and Human Services (HHS), the Honorable Michael Leavitt. Thank you and we look forward to your testimony.

In the world of health care, the Centers for Medicare and Medicaid Services (CMS) announced significant news last week. Due to strong and competitive forces, the average premiums paid by Medicare beneficiaries for the new prescription drug benefit are down 30 percent. They are estimated to be reduced from $37 a month to $25. This comes on top of the news that 21 million Medicare beneficiaries are now receiving their prescription drugs through Medicare.

The Chair believes that by most reasonable standards, implementation of this program has been successful. The Chair would refer to a quote. This one actually refers to hospitals. "Hospital spokesmen say the reimbursement formula does not give them enough return, and that the future growth, and in some cases even survival of their institutions may be jeopardized." This comes from a New York Times article dated 1967. I think you will find, if you go back and look at the press articles in 1966 and 1967, focusing on the start-up of Medicare itself, there were always some difficulties in getting major programs under way, and the Medicare Modernization Act (P.L. 108–173), which included the new drug program, of course, is the largest expansion of the Medicare Program since its inception.

So, we look forward to hearing from you, Mr. Secretary, about the progress in rolling out this program.

The President's budget includes a number of proposals to help reduce the growth in Medicare. These proposals support our commitment to ensure that providers are paid accurately to secure the best deal for taxpayers and seniors. I am pleased that the Administration relied heavily on the recommendations offered by the Medicare Payment Advisory Commission (MedPAC).

The Chair is also concerned about the accuracy of the current hospital diagnosis-related group (DRG) payment system. Last year,

HHS acted on MedPAC's recommendations to base payments on the health of the patient, but only for some cardiac conditions in which there was an argument that doctors were performing procedures based upon the payment structure, rather than in the best judgment of a medical decision for the patient. As a result, the overall payment system has now been made more accurate in the area of decisions on heart operations, but remains highly inaccurate in other areas. I strongly encourage you, Mr. Secretary, to build on the progress made last year, and continue to apply a more sophisticated payment adjustment structure where appropriate, so that payments can reflect the acuity and severity of the decision made in the patient's health.

We are going to look at a number of cost-saving provisions. There is going to be a lot of discussion. I do want to indicate that later today the President is expected to sign the Deficit Reduction Act (DRA) (P.L. 109–171). It reauthorizes the Nation's welfare programs, makes a number of provisions to help more low-income parents work and support the families. I assume there will be some questions directed to you, Mr. Secretary, on that program as well.

I am very interested in hearing from you, but prior to that, I would recognize the gentleman from New York for any remarks he may wish to make.

Mr. RANGEL. Thank you. I welcome the Secretary and his father here, and want his father to know that all remarks made at you are not personal, and that certainly we think you are a very courageous man to assume this great responsibility for your country.

Most of our questions on this side will be to verify whether or not your office and this Administration truly believe that the government is incompetent in providing social services to American citizens, and whether they believe that the private sector, with its competition, can do a better job. More specifically, we would like to know, where is Social Security? Is it different from the last proposal? Are the private accounts still on the table? Is it going to cost a trillion dollars or more? We would like to know more about that as we move forward with this year's work.

Health Savings Accounts (HSAs), is this another example where we want to get rid of entitlements, get rid of Medicare, and allow individuals to be more in charge of making the decisions and bolstering up the private sector to assume the responsibility that Medicare has. We want to know whether this philosophy has folded over into the way we have provided funds for the private sector and prescription drugs, and whether or not you think that the HSAs would have any better way of distributing health care as we found the pharmaceuticals and the Health Management Organizations (HMOs) in dealing with prescription drugs.

We want to know why you are cutting money out of the budget for the block grants in social services, which once again, as the cuts that we have on the floor, will be hitting those families that have the aged, the disabled, the children, and how do you think that is going to help us?

I hope that in your opening remarks that you could let us know philosophically where the Administration is going because people are suffering, and if we are going to depend on the private sector,

as opposed to the employers, for health care, or the Medicare system, then we will know what our work is cut out for. I would like to yield whatever time is left to the Ranking Member of the Subcommittee on Health, Peter Stark.

Mr. STARK. Thank you, Mr. Rangel, and welcome, Secretary Leavitt. In this budget and in the Administration's strategy, I have yet to find a Republican who would deny that the overall goal of the Republicans is to privatize not only Social Security but Medicare, and do away with Medicaid, and turn the health care system, Medicare in particular, into a voucher system, which would possibly protect low income, but certainly do nothing but make it more difficult, more costly, and less opportune for senior citizens to get the medical care that they deserve, and which they now get quite adequately under the fee-for-service part of Medicare.

I want to look at Part D as the poster child of what happens when people get obsessed with the free market. Particularly, I am impressed that the people who talk most loudly about the free market have really never held a job in private enterprise or know much about the free market, but they can spout about it a good bit.

We talk about the number of people in Part D, and we know—and by the way, I would not vote to repeal it. It was a lousy bill. I voted against it, but it is there, and I believe we should fix it. We have written to you, written to the Chairman, asking for oversight and an opportunity to work together to make it a Medicare benefit and not a gift to the private prescription drug industry. Twenty million people who signed up already had prescription coverage, and it was a lot better than what they got in the new plan. We are hearing reports now of the benefit manager, after people have signed up, in the first month of the operation of the plan, dropping drugs and raising prices on people who can't change. So, they are in, and all of a sudden they either have a higher cost for drugs they need or their drugs have disappeared. I think that we are treating the most vulnerable, sick, poor people in this country in an obscene manner, and those are the dual-eligibles who are being harmed the most.

I hope you can explain to us why privatization for these programs, which have heretofore been entitlements, will be better for the American public.

Chairman THOMAS. Thank the gentleman. Time has expired. For the record, the gentleman from New York mentioned that Secretary Leavitt's father, Dixie Leavitt, is here. The Chair also wants to indicate that his brother, Mark Leavitt, and his cousins Wade and Rod Leavitt are here as well.

Mr. RANGEL. It is not going to be that rough. He has the whole family?

[Laughter.]

Chairman THOMAS. They believe in strength in numbers where they come from.

[Laughter.]

Chairman THOMAS. He has quantity and quality going for him. Let me say that any Member who has a written statement who wishes to place it in the record may do so without objection. Mr. Secretary, your written testimony will be made a part of the record,

and you can address us during your time as you see fit. The time is yours.

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

Secretary LEAVITT. Thank you, Mr. Chairman. I must say that I heard it was bring your father to work day.

[Laughter.]

Secretary LEAVITT. Hence, I brought my father, and I am delighted he is here, as well as my brother——

Chairman THOMAS. Let me tell you, speaking for all of us who are no longer able to do that, I think it is a wonderful thing.

Secretary LEAVITT. Thank you. I am pleased to have him here. The budget that the President has put forward is nearly $700 billion. It is a significant part of the effort of the U.S. government to meet the needs of our taxpayers.

Roughly, broken into two categories you are well familiar with, one is the entitlement programs and the second would be the discretionary budget. The entitlement programs, over which this Committee has broad jurisdiction, I am sure will be the subject of much of our discussion. With respect to the discretionary budget, it makes up about $75.5 billion in the 2006 budget. We are in a period of time where deficit reduction is necessary, and you will see that budget that the President has put forward contains a $1–1/2 billion reduction of the discretionary budget.

I would like to spend just a few minutes, Mr. Chairman, in talking about the way I went about putting the budget together within the Department. I think rather than try to take a handful of specifics, the philosophy, as Mr. Rangel suggested, might be helpful in terms of understanding. As I respond to your questions today, I will try to refer back to the underpinnings of how I went about it.

Let me first acknowledge I was Governor for 11 years of my State, and I put together 11 balanced budgets. I know many of those years were good years where we had growth in revenues; other years were years where we did not. I came to understand fully that reducing deficits is hard work, and it is difficult because almost every program that finds its way into a budget is there for a good reason, and there are people who feel passionately about it. Consequently, difficult decisions have to be made. I want to acknowledge that the decisions I have made will not be the same that some on the Committee would make, and that is why I am here, to let you know basically what decisions were made in the proposal and why they were made that way, and, obviously, you will then have an opportunity to exercise your judgment as well.

The instructions I gave to those who assemble budgets in HHS were fairly straightforward I believe. The first was to tell them there are some new initiatives that need to be undertaken that will have a profound impact on the future of the Department and our citizens. For example, Health Information Technology is an example of such a new initiative. The new HIV/AIDS Initiative that you will see in the budget is an example.

There were some commitments that the President has made that need to be filled. An example of that would be community health

centers, expanding those dramatically, a commitment that we have to keep. The commitment that was made on access to recovery and faith-based initiatives. There are some threats that we have responsibility for—bioterrorism and the concern about pandemics—they are relatively growing or new threats that we have been responding to.

Then there are some high demand and highly effective programs, that despite the fact that we are in the process of deficit reduction, I felt, and the President felt, needed to be funded and either new or in greater terms that we needed to set aside.

So, I asked my colleagues to go through a series of principles, and hold the existing budgets up against them. One, I needed to find new money for those particular items, and I said, let's find if there are any one-time funds that we could apply that are not being repeated. Let's look for programs whose purposes have been addressed already, either in some other place or have concluded. Let's look for funds that are carrying over that haven't been used, and apply those against those priorities, or let's look for programs where we offered a cut last year, and they weren't enacted. If we still feel the same way, let's put them forward. So, that is essentially how we went about developing money for the new initiatives.

I then asked them to begin looking at all of the investments across the entire Department. I believe there are a set of principles that can be put forward, and I asked them to compare each expenditure against those principles, and I would like to just enumerate those quickly for you.

First is the need for our investments to be targeted. I asked them to look for programs where there was good done on a general basis, but where the more specific need was apparent. Therefore, let's begin to target. In some cases you will see examples of where we have funded fewer people, but the ones we have funded have been funded better, so target expenditures.

The second would be looking for prevention programs. If we can prevent illness, we ought to prevent it instead of just paying for the treatment, so you will see an emphasis placed on prevention programs.

You will also see, in a budget that is reflecting deficit reduction, I want to provide services and not always just build infrastructure. Infrastructure is important, but in a time of declining revenues, or at a time when we have fewer revenues, I want to make sure that people are served and not just bolster the infrastructure all the time.

Fourth, I do believe that market-based choices or systems that allow markets to drive various investments to their most logical and their most efficient form are better than circumstances where we have "Government does it all" philosophy.

Fifth, individual choice. I think if there are places where individuals can choose. Again, I think that is better than just the government always making choices.

Sixth, I would point to the need for new research to be done, and if there are areas where research has basically worked its way through, then we need to discontinue our funding in that area and begin to find the new technologies.

I have also asked them to look across the entire Department and to avoid siloed investments. Look for ways in which we can leverage investment across the entire Department. You will also find a very high standard was placed on looking for performance measures. If we can't measure it, I am suspicious of that. I want to be able to see how investments we have made are making a positive impact. If I can't measure it, it is a candidate for reduction.

Mr. Chairman, that is an introduction to the principles, and I am happy to respond to questions from the Committee.

[The prepared statement of Secretary Leavitt follows:]

Statement of The Honorable Michael O. Leavitt, Secretary, U.S. Department of Health and Human Services

Good morning, Mr. Chairman, Representative Rangel, and Members of the Committee. I am honored to be here today to present to you the President's FY 2007 budget for the Department of Health and Human Services (HHS).

Over the past five years, the Department of Health and Human Services has worked to make America healthier and safer. Today, we look forward to building on that record of achievement. For that is what budgets are—investments in the future. The President and I are setting out a hopeful agenda for the upcoming fiscal year, one that strengthens America against potential threats, heeds the call of compassion, follows wise fiscal stewardship and advances our Nation's health.

In his January 31st State of the Union Address, the President stressed that keeping America competitive requires us to be good stewards of tax dollars. I believe that the President's FY 2007 budget takes important strides forward on national priorities while keeping us on track to cut the deficit in half by 2009. It protects the health of Americans against the threats of both bioterrorism and a possible influenza pandemic; provides care for those most in need; protects life, family and human dignity; enhances the long-term health of our citizens; and improves the human condition around the world. I would like to quickly highlight some key points of this budget.

We are proposing new initiatives, such as expanded Health Information Technology and domestic HIV/AIDS testing and treatment that hold the promise for improving health care for all Americans. We are continuing funding for high-performing Presidential initiatives, including Health Centers, Access to Recovery, bioterrorism and pandemic influenza; and we are also maintaining effective programs such as Indian Health Services, Head Start, and NIH medical research.

We are a nation at war. That must not be forgotten. We have seen the harm that can be caused by a single anthrax-laced letter and we must be ready to respond to a similar emergency—or something even worse. To this end, the President's budget calls for a four percent increase in bioterrorism spending in FY 2007. That will bring the total budget up to $4.4 billion, an increase of nearly $178 million over last year's level.

This increase will enable us to accomplish a number of important tasks. We will improve our medical surge capacity; increase the medicines and supplies in the Strategic National Stockpile; support a mass casualty care initiative; and promote the advanced development of biodefense countermeasures through NIH to a stage of development so they can be considered for procurement under Project BioShield.

We must also continue to prepare against a possible pandemic influenza outbreak. This budget includes a $2.3 billion allowance for the second year of the President's Pandemic Influenza plan. These funds will enable us to meet several important goals, including providing pandemic influenza vaccine to every man, woman and child within six months of detection of sustained human-to-human transmission of a bird flu virus; ensuring access to enough antiviral treatment courses sufficient for 25 percent of the U.S. population; and enhancing Federal, state and local as well as international public health infrastructure and preparedness.

The President's FY 2007 budget provides more than $350 million for important ongoing activities such as safeguarding the Nation's food supply (FDA), global disease surveillance (CDC), and accelerating the development of vaccines, drugs and diagnostics (NIH).

The budget includes a new initiative of $188 million to fight HIV/AIDS. These funds support the objective of testing for three million additional Americans for HIV/AIDS and providing treatment for those people who are on state waiting lists

for AIDS medicine. This initiative will enhance ongoing efforts through HHS that total $16.7 billion for HIV/AIDS research, prevention, and treatment this year.

The budget maintains the President's commitment to the doubling of NIH, and includes new funding at NIH for important cross-cutting initiatives that will move us forward in our battle to treat and prevent disease—such as an additional $49 million for the Genes, Environment and Health Initiative and an additional $113 million for the Director's Roadmap. In addition, it contains an additional $10 million at the Food and Drug Administration to lead the way forward in the area of personalized medicine.

One of the most important themes in our budget is that it increases funding for initiatives that are designed to enhance the health of Americans for a long time to come. For instance, the President's budget calls for an increase of nearly $60 million in the Health Information Technology Initiative. Among other things, these funds support the development of electronic health records (to help meet President Bush's goal for most Americans to have interoperable electronic health records by 2014); consumer empowerment; chronic care management; and Biosurveillance.

The Budget also includes several initiatives to protect life, family and human dignity. These include, for example, $100 million in competitive matching grants to States for family formation and healthy marriage activities in TANF. And it promotes independence and choice for individuals through vouchers that increase access to substance abuse treatment.

In the area of entitlements programs, I want to begin by congratulating you and other Members of Congress for having successfully enacted many needed reforms by passing the Deficit Reduction Act (DRA). DRA supports our commitment to sustainable growth rates in our important Medicare and Medicaid programs. It also strengthens the Child Support Enforcement program.

The Deficit Reduction Act also achieves the notable accomplishment of reauthorizing Temporary Assistance for Needy Families (TANF), which has operated under a series of short-term extensions since the program expired in September 2002.

Medicaid has a compassionate goal to which we are committed. Part of our obligation to the beneficiaries of this program is ensuring it remains available well into the future to provide the high-quality care they deserve. Last year when I made my statement before this Committee, I said that the growth in Medicaid spending is unsustainable. With its action on many of our proposals from last year in the Deficit Reduction Act, the Congress has made Medicaid a more sustainable program while improving care for beneficiaries. The President's Budget proposals build on the DRA and include a modest number of legislative proposals which improve care and will save $1.5 billion over five years in Medicaid and S–CHIP and several administrative proposals saving $12.2 billion over five years.

This Administration has also pursued a steady course toward Medicare modernization. In just the past three years, we have brought Medicare into the 21st century by adding a prescription drug benefit and offering beneficiaries more health plan choices.

Medicare's new prescription drug benefit provides seniors and people with disabilities with comprehensive prescription drug coverage, the most significant improvement to senior health care in 40 years. Millions of seniors and people with disabilities are already using this benefit to save money, stay healthy, and gain peace of mind. According to CMS' Office of the Actuary, Medicare's drug coverage will have significantly lower premiums and lower costs to federal taxpayers and states, as a result of stronger than expected competition in the prescription drug market. Moreover, beneficiary premiums are now expected to average $25 a month—down from the $37 projected in last July's budget estimates. The Federal government is now projected to spend about 20 percent less per person in 2006 and, over the next five years, payments are projected to be more than ten percent lower than first estimated. So taxpayers will see significant savings. And state contributions for a portion of Medicare drug costs for beneficiaries who are in both Medicaid and Medicare will be about 25 percent lower over the next decade. All these savings result from lower expected costs per beneficiary; projected enrollment in the drug benefit has not changed significantly.

Our work to modernize Medicare is not done. Rapid growth in Medicare spending over the long-term will place a substantial burden on future budgets and the economy. The President's FY 2007 Budget includes a package of proposals that will save $36 billion over 5 years and continue Medicare's steady course toward financial security, higher quality, and greater efficiency.

Along with the sustainability of Medicaid, our budget takes steps to improve the long-term fiscal health of Medicare. We are proposing a number of adjustments that will produce a substantial savings.

The bulk of these Medicare savings will come from proposals to adjust yearly payment updates for providers in an effort to recognize and encourage greater productivity. These proposals are consistent with the most recent recommendations of the Medicare Payment Advisory Commission. To ensure more appropriate Medicare payments, the Budget proposes changes to wheelchair and oxygen reimbursement, phase-out of bad debt payments, enhancing Medicare Secondary Payer provisions, and expanding competitive bidding to laboratory services. Building on initial steps in the Medicare Modernization Act, the Budget proposes to broaden the application of reduced premium subsidies for higher income beneficiaries. Finally, the President's Budget proposes to strengthen the Medicare Modernization Act provision that requires Trustees to issue a warning if the share of Medicare funded by general revenue exceeds 45 percent. The Budget would add a failsafe mechanism to protect Medicare's finances in the event that action is not taken to address the Trustees' warning. If legislation to address the Trustees' warning is not enacted, the Budget proposes to require automatic across-the-board cuts in Medicare payments. The Administration's proposal would ensure that action is taken to improve Medicare's sustainability.

President Bush proposes total outlays of nearly $700 billion for Health and Human Services. That is an increase of more than $58 billion from 2006, or more than 9.1 percent.

While overall spending will increase, HHS will also make its contribution to keeping America competitive. To meet the President's goal of cutting the deficit in half by 2009, we are decreasing HHS discretionary spending by about $1.5 billion in the next fiscal year.

I recognize that every program is important to someone. But we had to make hard choices about well-intentioned programs. I understand that reasonable people can come to different conclusions about which programs are essential and which ones are not. That has been true with every budget I've ever been involved with. It remains true today. There is a tendency to assume that any reduction reflects a lack of caring. But cutting a program does not imply an absence of compassion. When there are fewer resources available, someone has to decide that it is better to do one thing rather than another, or to put more resources toward one goal instead of another.

Government is very good at working toward some goals, but it is less efficient at pursuing others. Our budget reflects the areas that have the highest pay-off potential.

To meet our goals, we have reduced or eliminated funding for programs whose purposes are duplicative of those addressed in other agencies. One example of this is Rural Health where we have proposed to reduce this program in the Health Resources and Services Administration, given that HHS administers 225 health and social services programs that provide resources to rural areas. In addition, the Medicare Modernization Act contained several provisions to support rural health, including increased spending in rural America by $25 billion over ten years. For example, it increases Medicare Critical Access Hospitals (CAH) payments to 101 percent of costs and broadens eligibility criteria for CAHs. Moreover, recognizing that Congress adopted many of our saving proposals last year, we are continuing to make performance-based reductions.

Our programs can work even more effectively than they do today. We expect to be held accountable for spending the taxpayers' money more efficiently and effectively every year. To assist you, the Administration launched ExpectMore.gov, a website that provides candid information about programs that are successful and programs that fall short, and in both situations, what they are doing to improve their performance next year. I encourage the Members of this Committee and those interested in our programs to visit ExpectMore.gov, see how we are doing, and hold us accountable for improving.

President Bush and I believe that America's best days are still before her. We are confident that we can continue to help Americans become healthier and more hopeful, live longer and better lives. Our FY 2007 budget is forward-looking and reflects that hopeful outlook.

Thank you for the opportunity to testify. I will be happy to answer your questions.

Chairman THOMAS. Thank you very much, Mr. Secretary. I know that today's hearing is designed to focus on the President's Fiscal Year 2007 budget, so we are talking about today and principally tomorrow in the area of HHS. I do want to underscore, so

if someone wonders why we aren't going to spend a lot of time on Social Security, notwithstanding the initial statement, Social Security was made independent from HHS in 1995, and that will be the subject of other hearings that will come before us.

So, mindful of the fact that we are supposed to look at today and tomorrow, I think, nevertheless, a brief comment from you, Mr. Secretary, about yesterday. Last year we went through some very unprecedented natural occurrences. It was kind of headlined by Katrina, but clearly, it was hurricanes in the plural that we had to deal with, and your responsibilities were important in making sure that people were comforted. I will provide you with a brief period of time if you so choose to make some comments about that prior to our examining the 2007 budget, which is the purpose of the hearing. Mr. Secretary?

Secretary LEAVITT. Mr. Chairman, that period of time was a profound moment in human service history. It was a point in time where literally millions of our citizens were displaced and found themselves in need of human services in a way that most of them had never experienced and never thought they would experience.

I spent a good share of the month of September and October traveling to shelters where people were making temporary homes, where we were delivering health and human services to literally hundreds of thousands of people, including medical care, including all of the array of human services that our society has established to create that kind of safety net for people in need.

One of the things I believe Hurricane Katrina taught us is that once the disaster has concluded, that helping people put their lives back together is a very important part of recovery. The Congress saw fit to allocate $550 million to go to the Social Services Block Grant, for example, to the affected States. I am happy to announce today that we have allocated the funds to the States, and that they will be going to the States immediately. We have allocated it based on a percentage of the Federal Emergency Management Agency (FEMA) registrants for each of the three hurricanes, Katrina, Rita and Wilma.

In recognition of the severity of Hurricane Katrina, registrants from that hurricane are double weighted under the formula. Each Katrina registrant is counted twice, whereas each registrant from Rita and Wilma will be counted once. The allocation formula also weighs total FEMA registrants by the percentage of individuals in poverty in each State. That is to say, that the total number of FEMA registrants from Mississippi, for example, is multiplied by the percentage of individuals in poverty in Mississippi.

The Department believes that the allocation formula directs funds to the States in a manner that is effective, and that it realizes the President's commitment to ensure that no State will be unfairly disadvantaged for providing aid and for providing services to affected individuals.

I would like to acknowledge as well that in the course of all of the recovery, little note came about the fact that the States provided benefits to nearly 500,000 people. It was almost unspoken. It just happened. They stepped up. They provided the benefits, and have taken care of people in a time of need, in many cases people who were not from their States. They did it without hesitation.

Chairman THOMAS. Thank you very much. Earlier, the Chair mentioned briefly a quote, and I have a series of quotes which I think are going to be useful as we talk about the phasing in of the single biggest expansion of the program in its history. I have a quote from the Fresno Bee, July 1, 1966, and it is an editorial saying, "Medicare is here and there will be problems, but society has determined it is needed in the name of compassion. It is this spirit which must guide all who have anything to do with putting it in practice."

More to the point, the Waltham, Massachusetts News Tribune, on July 2nd, 1966 said, "The most persistent problems occurred when hospitals ran out of government forms or patients forgot to bring their Medicare identification card. 'If we are by the worst of it, I think this thing is going to work. If Medicare grows over the next 6 to 10 months, we'll be able to grow with it and handle any problems that come up,' a hospital spokesman indicated."

I notice you have charts showing clearly that from the beginning of January until now, in anticipating the continued ability to deal with the unprecedented numbers since the inception of the program. The Chair looks forward to the Secretary making those presentations when such questions are asked.

The Chair sees that his time is up, and the Chair will hold all Members to 5 minutes, including himself, and the Chair recognizes the gentleman from New York for any questions he may have.

Mr. RANGEL. Thank you, Mr. Chairman, and thank you again, Mr. Secretary.

In getting back to the philosophical deal of the Administration, and it is your position, as a trustee on the Social Security Trust Fund, do you believe the time has come where the Social Security system should shift more responsibility of retirement to the recipient, and that the private accounts would be a better way to do this rather than the Social Security as we see it today?

Secretary LEAVITT. Mr. Rangel, as the Chair indicated, while I am a trustee—and I will answer in that capacity—it is not a direct responsibility of the Secretary of Health and Human Services beyond its trusteeship, but I take the responsibility as a trustee very seriously.

Mr. RANGEL. I thought I mentioned—I described you as that.

Secretary LEAVITT. You did it perfectly, sir.

Mr. RANGEL. Thank you.

Secretary LEAVITT. There is little question that Social Security is a problem. There comes a time in the life of every problem when it is big enough you can see it, but still small enough you can solve it. Social Security—and I would add the other two or three other major entitlements—are clearly in that window. It is my view that there are innovations that we can use that will in fact improve the long-term viability and the sustainability of not just Social Security but for Medicare and Medicaid.

Mr. RANGEL. You do believe that there is a role for government to play, and that the entire responsibility for health and pensions should not be left entirely to the private sector?

Secretary LEAVITT. Clearly, government has a role both in establishing, maintaining, regulating and assuring their success.

Mr. RANGEL. Would you make an exception to prescription drugs, as you turn that over to the private sector, that that was either a tremendous mistake or a lot of corrections would have to be made?

Secretary LEAVITT. Actually, I am very supportive of what has been done on prescription drugs. First of all, we have a prescription drug program for the first time for millions, and the prescription drug coverage that millions more had is now more secure. So, the government——

Mr. RANGEL. So, that means that we as Members of Congress can go to our constituents and say that the Federal Government is proud of Medicare Part D, we are proud of what we have done, and if we had to do it again, we would do it the same way?

Secretary LEAVITT. We are 38 days into the biggest change in Medicare's history. We are 38 days into what may be the most significant long-term change in our health care system in some 40 years. Let me just give you an overview of the big picture.

Mr. RANGEL. Mr. Secretary, we are here for the short term; the elections are in November. The answer to your question is, if we had to do it again, the Administration would do it the same way, and that they are very proud of the way we have taken over the prescription drug program. Then we need, for reelection purposes, the rest of the follow up, but basically at the end of the day at the townhall meeting, we are proud of the money that we have given to the private sector and how they have handled it in providing prescription drugs to our older people.

Secretary LEAVITT. This country will feel more than satisfied. I think they will be very pleased as this program has a chance to take legs and to operate——

Mr. RANGEL. Just give us the literature and that is all we got to run with anyway. Having said that, would we be just as proud of the HSAs, because it seems to be—and I hope you would agree—that having the HSAs takes the risk from the employer and shifts it really to the employees to take care of its own health needs, the same way the 401(k)s were supposed to take care of the employees' pension needs. Do you see an analogy between the two?

Secretary LEAVITT. Let me respond by saying I think the country will be quite unpleased if we continue to have health care costs that escalate beyond what they are——

Mr. RANGEL. I agree with you there.

Secretary LEAVITT. —sixteen percent of the gross domestic product. Unless we are able to find some way——

Mr. RANGEL. We are talking about the solution, Mr. Secretary. Everything that the President has decided—how he wants it done—has been a real problem, whether it is getting out of Iraq, cutting back the deficit, trying to provide for the poor and Katrina. So, we know the problem and we aren't working in a bipartisan way, unfortunately, toward the solution. Playing the cards that we do have, I am just asking—we know the problem of the soaring cost of health care, what the cost the employers have. I am asking, will the HSAs shift that risk more to the employee rather than the employer?

Secretary LEAVITT. The HSAs will make cost-conscious consumers of all of us, and it will in fact, I believe, have a positive

impact of connecting people to their health care decisions. When that——

Mr. RANGEL. Will that lessen the cost to the employer?

Secretary LEAVITT. It will lessen the cost of health care to all of us, and assure that we can provide health care to more and more people.

Mr. RANGEL. The answer is yes.

Secretary LEAVITT. The answer is it will lessen the cost of health care to all of us, and that——

Mr. RANGEL. Including the employer.

Secretary LEAVITT. That is correct, including the employer, which is an important part of keeping the American economic equation competitive, so that people can have jobs and that they can pay for health care.

Mr. RANGEL. There are figures in the budget to justify how HSAs will be costing us less in health care, the cost of the HSAs compared to the current cost. Do you have any numbers anywhere to say that it will be less costly?

Secretary LEAVITT. What is clear is that if we are able to take the expenditures that we make currently and use them more efficiently, we can provide health care to far more people. Currently there are far too many, somewhere between 35 and 45 million in America who have no health insurance. That is something we would all like to change, and HSAs is a very good part——

Mr. RANGEL. I agree with what you said, but we don't have figures that justify saying this is going to cut the cost as it relates to the Federal Government.

Secretary LEAVITT. I think it is very clear that it will help constrain the cost of health care, and then we all benefit when the cost of health care, the Federal Government, State governments and individual consumers, employers, our economy generally.

Mr. RANGEL. I may agree with you, but it is not in the budget. That is all, it is not in the budget.

Secretary LEAVITT. It hasn't been implemented yet, Mr. Rangel. I don't know how——

Mr. RANGEL. So, there are no estimates, right?

Secretary LEAVITT. I think economists have been very clear that, in fact, making cost-conscious consumers creates a downward pressure on health care, and if we are all paying less, we are all happier.

Mr. RANGEL. Thank you, Mr. Chairman. I tried.

Mr. SHAW. [Presiding.] The time of the gentleman has expired.

Mr. Secretary, I would like to add my welcome to you to the Committee. We have been holding, in my congressional district, a number of Medicare meetings, townhall types meetings in order to familiarize my constituents with the new drug bill. There has been a lot of enthusiasm, the attendance has been high; but there is also some confusion, and I would like to direct you to one specific issue, which I think is probably—I think my constituents are—really, politics is getting into this more than anything else, and I would like for you to try to clear this up this morning.

One of the specific issues that my seniors continue to raise is a concern about the bait and switch issue of Part D plans dropping coverage of a particular prescription drug mid year. I think Mr.

Stark made comment to that in his opening statement. Would you explain to me what is being done to prevent this? Is there any way that the program can be amended or should it be amended to prevent this mid year switch?

Secretary LEAVITT. This is a subject where people express concern. To my knowledge, no plan has yet amended their formulary to do that. There is a process. They cannot do it independently. They cannot do it on their own. They have to go to CMS, make an application, demonstrate that it is in the best interest of the plan. In many cases they may be shifting in a way that will make their plan either more competitive or will provide greater choices, but they can't do it without going through a significant process to demonstrate why it is being done, and have regulatory approval to do it. Those who suggest that it has happened misstate the facts. It has not. There is a process through which the plans can amend it, but it is not going to be done in a large number of cases, nor will it be done without oversight.

Mr. SHAW. In my congressional district there are over 40 plans for the seniors to choose from. What is currently being done to improve the way the seniors navigate through all this information, and what advice would you give the average senior who is very frustrated with the entire enrollment process?

Secretary LEAVITT. I have been at the site of many enrollments. My father is here. I helped him enroll. I helped my wife's mother enroll. I have some experience with this, and I have some specific suggestions, but primarily it involves just getting drugs together, sitting down with someone who can help them if they need help. If you go on the 1–800–Medicare line, which has a less than one-minute wait now, they will talk people through it. Or if they like to use the Internet or have a family who does, they can do it from start to finish in less than one-half hour.

I was in Oklahoma this week, and I sat down with a woman named Dorothy. She had just walked up to an enrollment fair, had not thought she would line up. Called the drug store, got the list of six medications that she took. She was paying $300 a month. In less than a half an hour at an enrollment fair, she was able to come up with a plan that cost her $36 a month including her copay. She will save $3,000. People are having that experience all over America.

We are signing up 250,000 new enrollments a week. If that wasn't a good plan, if people weren't saying to their neighbors, "I saved money," if they weren't saying to their neighbors, "I got my prescriptions filled just fine," we wouldn't be having 250,000 new enrollments a week. This is a good deal for seniors.

Some require assistance. Health care is not without complication, and for that reason we have established 10,000 partnerships at drug stores. Pharmacists are helping people in heroic ways. This is a huge transition but we are working our way through it. We have over 24 million people who are now participants, and it goes up every day.

Mr. SHAW. In the time I have left, I want to get into another area. As you know, the issue of cancer treatment, early detection and prevention is near and dear to me. I owe my very life to early detection. I am actively supporting the National Cancer Institute's

goal of ending the suffering and death due to cancer by 2015. I am extremely disappointed and discouraged to see that the President's proposed budget cuts 40 million in funding from the National Cancer Institute. I also understand that if we want to reach the 2015 goal, the key does not lie solely in the appropriation process. I will soon be introducing legislation strengthening the amended Medicare Program in the area of cancer treatment and detection. With the baby-boomers approaching Medicare age, we will have a major crisis on our hands in this program. We must lay the groundwork for us to provide these future beneficiaries with adequate cancer care.

What specific improvements to the Medicare Program would you like to see in the area of cancer screening, treatment and prevention, and how can the Committee on Ways and Means help achieve this 2015 goal? We are so close to finding a cure, and this falls in, I think to No. 7 in your opening statement, that it is effective, what we are doing. When you are in a foot race, you see the finish line, you don't jog, you sprint, and I think we can do a better job. If you would address that, I would be most grateful.

Secretary LEAVITT. Mr. Shaw, your question is asked both, as you suggest, with personal experience and conviction, as well as wisdom. It deserves a lengthy response and one I would be happy to give you either privately or submit for the record. I see that time is out, and therefore, don't want to shortcut the answer.

Mr. SHAW. I would very much appreciate hearing that, and I would like for it also to be part of the record.

[The information was not received at time of printing.]

Mr. SHAW. Mr. Stark?

Mr. STARK. Thank you, Mr. Chairman. I want to submit for the record a letter that was sent to Dr. McClennan on February 2nd. It was a study of five ZIP code districts, taking prices from the Medicare.gov website, and it shows that, for instance, in New York, the plans in the first month, 38 of the 47 plans increased the cost of a five-drug package which generally covers drugs used by senior citizens for a variety of common ailments. The average cost increase was $155.80 a year. The increases range between a dollar and $400 annually. This is in the first month of the plan, and it was studied across the country, New York, California, Florida, Illinois and Texas.

Mr. Secretary, if you haven't seen it, I would ask you to look at a copy of it. I would like to make it part of the record, Mr. Chairman, which defines that these companies are kicking up prices, and the seniors will have until May, I understand, to switch, but I think that in the program of Part D, one would presume that when the benefit managers get a contract for a prescription drug they would have assurance that they could hold the price for at least a year, and I hope that your office would look into it.

Then further, we wrote to Dr. McClennan and Mr. Levinson—I hate to be tattling on your subordinates here, Mr. Secretary—there are some plans that are violating the law, and I am sure as a former insurance broker, you are aware of this idea of coercing people or low-balling them into a drug plan, and then an attempt to sell them on the managed care plan, which may also be operated by the benefit manager. That is against the law. It is on page 131

of the Marketing Guidelines. Humana is one of the serious offenders. We have asked that the Inspector General look into that and that it be prohibited, and they should have to immediately cease from those practices. I hope you will look into that. I would like to make this letter to Dr. McClennan and Mr. Levinson part of the record.

A final question then deals with MedPAC, who we have learned, at least, has been bipartisan, quite objective in advising all of us, and I want to know if you can tell me what MedPAC recommended with respect to Medicare Advantage payments. Are you aware of their recommendation there?

Secretary LEAVITT. No. I mean I am not able to give them to you today.

Mr. STARK. Okay. They did recommend that we cut back, and we are overpaying them. It is costing—for everybody who signs up for one of these plans, it costs the government more, increases adverse selection against either Medicare or other plans, and there seems to be no reason why we couldn't save perhaps $50 billion over 10 years by reducing the overpayments that we are now making to these Medicare Advantage plans.

Would you assume for a moment that I am right, that for everybody who signs up into one of these plans, they cost the government more, they create adverse selection against the fee-for-service part. Would you think that perhaps it would be a good idea to review and lower the payments to these Medicare Advantage plans, at least to the price that we pay for fee for service Medicare?

Secretary LEAVITT. Would you like me to respond to all three of your questions or——

Mr. STARK. Should we—if in fact, MedPAC is correct, don't you think that we should lower the price that we pay to these managed care plans?

Secretary LEAVITT. The managed care plans ought to operate under the same price structure that other providers do, and if they are able to find ways of creating efficiency, they ought to realize the benefit of that.

Mr. STARK. Should they be paid more, which to say, paid about 115 percent of what we pay even standard fee-for-service Medicare? Does that sound fair to you?

Secretary LEAVITT. The objective is very clearly to give consumers a choice. If they choose and find the services better, they should have the capacity to do so. You raised the issues on prescription drug plans. We are without question now seeing prices——

Mr. STARK. Should the taxpayers have to pay that, Mr. Secretary, or should the plans—because the plans can provide better care. In my district, Kaiser Permanente is one of the best managed care plans in the country, but my question is, should they be overpaid, or should they be able to operate in the market like everybody else?

Secretary LEAVITT. In the long run the objective is to find uniformity and to find efficiency, and I know that there have been phase-ins that ultimately will end. The Congress did that for a reason. I suspect it was a good reason, and over time those will phase

out, and they should be allowed to find efficiency, and where they do, they should be rewarded.

Mr. STARK. There is no savings from these managed care advantage plans, so it might be something to look at.

Mr. SHAW. The time of the gentleman has expired. Without objection, the two letters referred to will be made a part of the record.

[The information follows:]

February 2, 2006

The Honorable Mark McClellan, Administrator
Centers for Medicare and Medicaid Services
Washington, DC

Dear Dr. McClellan:

In addition to other startup problems with the new Medicare Part D drug benefit, a consumer issue appears to be developing that has serious long-range implications and, unless corrected, could seriously harm consumer confidence in the program. A cursory sample of various drug plans (see below) conducted by Consumers Union has revealed that the cost of some prescriptions has dramatically increased in just 1 month; in the many plans with cost increases, the average increase in annual cost was about 5 percent.

While by no means a true representative sample, these initial numbers may serve as a ominous warning sign that consumers cannot count on price stability in these drug plans, stability which is so vital to seniors on a fixed budget.

Our small sampling of drug prices in five Zip Codes throughout the country from the Medicare.gov Web site (which states that it cannot guarantee the accuracy of company data) included an examination of the popular drug Lipitor, as well as a bundle of five drugs for various common ailments. The prices were sampled at the end of December 2005 before the benefit began, and at the end of January—1 month into the program.

A majority of plans sampled showed an increase in annual costs to consumers. These increases ranged from as little as $1 to, in some cases, over $400 annually. Several companies did reduce annual costs (and one Texas plan had a major downward correction). But overwhelmingly, the annual cost of plans for this sample package of drugs was upward. In the New York survey, for example, 38 of 47 plans increased the cost of the five-drug package, with an average increase of $155.80.

With the 2004–2005 prescription drug discount card program, prices of drugs moved up and down, but a majority trended downward—which was great news for consumers, but begs the question why prices are up so sharply on these five drugs in most Medicare Part D plans in the first month.

Is CMS tracking all drug prices in all plans? And if so, are you finding this general trend upward? Should consumers be warned of this development and review their choice while they still have the opportunity to switch plans before May 15, 2006?

We had assumed that when a Prescription Drug Plan (PDP) negotiated discounts with a drug manufacturer, it would lock in that price for a contract year to provide price stability to the Medicare beneficiaries who elect to join that plan. That assumption appears not to be accurate. Is there information on whether any PDPs have negotiated such price stability? If so, could that information be made public so that the consumer would know which plans offer some stability, and which are likely to be more price volatile?

Our nation's seniors have been going to a great deal of work to pick a plan that is best for them, with the understanding that they will pay a set premium for the year for a reasonably defined benefit package. While this first initial enrollment period permits non-Medicare/Medicaid (dual eligible) consumers to make one switch in plans, after May 15th they are locked into their plan through the end of the year. Consumers Union's initial data shows—at least for the sampled drugs—that a consumer's thoughtful shopping choice can be diminished or perhaps even negated by changes in the plan's charge for one or more drugs. In some cases, the price increases are so large, they smell of a bait-and-switch.

If CMS is detecting the same trend of price increases, we hope you will immediately and publicly urge the drug plans to halt these price increases. We also urge CMS to publicly report on the full range of price movements so that consumers can avoid plans that are showing this type of bad faith at the very beginning of this vital health program. Right now there are more than enough plans for Medicare beneficiaries to choose from—but seniors need to be made aware of those plans with

poor startup service and bait-and-switch pricing behavior to make informed decisions about their health care.

Sincerely,

William Vaughan
Senior Policy Analyst
Consumers Union, publisher of Consumer Reports

Changes in Annual Cost to Medicare Beneficiaries for selected prescription drugs between December 28, 2005 and January 30–31, 2006 as reported on *www.Medicare.gov*

State and zip code	Drug	# of PDPs that increased annual cost	# of PDPs that decreased annual cost	# of PDPs that had no price change in the month
New York	Lipitor,[1] 10 mg	12	0	35
	Package of 5 drugs	38	3	5
California	Lipitor	10	0	38
	Package of 5 drugs	36	7	5
Florida	Lipitor	7	0	36
	Package of 5 drugs	34	5	4
Illinois	Lipitor	9	0	34
	Package of 5 drugs	35	5	2
Texas	Lipitor	10	1	36
	Package of 5 drugs	37	8	2

[1] The Lipitor increases were all minor, generally about $10 increase in annual cost.

In using the Medicare.gov Website, only PDPs were selected (no MA–PDs), no preference was given to pharmacy, and all plans serving that Zip Code were reviewed.

The package of 5 drugs includes one medicine from each of five major classes of drugs: it is not meant to be a package of drugs that anyone individual would take. It consists of Altace 10 mg capsules (an ACE inhibitor for high blood pressure); Celebrex 200 mg capsules (for joint pain, etc.); Lipitor 10 mg tabs (for cholesterol adjustment); Nifedipine 30 mg extended release tabs (for chest pain and high blood pressure); and Zoloft 100 mg tabs (for anti-depression).

The Zip Codes are 00501, Long Island, NY; 32425, Bonifay, FL; 60406, Chicago, IL; 75135, Caddo Mills, Texas; 94246, rural Northern California.

January 26, 2005

The Honorable Mark McClellan, M.D., Ph.D.
Administrator
Centers for Medicare and Medicaid Services
200 Independence Ave, S.W.
Washington, DC 20201

Daniel R. Levinson
Inspector General
Health and Human Services
330 Independence Avenue
Washington, DC 20201

Dear Dr. McClellan and Mr. Levinson:

I am writing to bring your attention to a very disturbing article that appears in BusinessWeek online (see enclosure). According to this article Humana is violating CMS regulations by paying higher commissions to sales representatives enrolling

people in Medicare Advantage (MA) plans rather than stand alone Prescription Drug Plans (PDP). An article in yesterday's *Wall Street Journal* (also enclosed) also references Humana's strategy on enrollment and implies that it may be widespread among organizations that offer both MA and PDP plans.

Coercing beneficiaries to join the Medicare Advantage plan when they attempt to join a stand-alone drug plan is a direct violation of the Medicare Marketing Guidelines issued August 15, 2005: *"The commission rate (i.e., the percentage per enrollment) should not vary based on the value of the business generated for the Plan Sponsor paying the commission (e.g., profitability of the book of business)."* (page 131)

Given the overpayments to MA plans, it is clear from these articles that Humana and perhaps other plans are steering plan enrollees into MA products to further their financial interests. I request the Inspector General open an immediate investigation into the marketing practices of Humana and all contractors who offer both stand-alone PDPs and MA–PDs to identify which plans are using these illegal marketing schemes.

Furthermore, CMS must immediately direct plans to cease and desist this deceptive marketing, and impose appropriate sanctions for breaking the marketing guidelines. Plans that continue to violate the guidelines should have their contracts terminated.

Beneficiaries are already overwhelmed trying to navigate the new law. They should not be subject to bait-and-switch tactics or other misleading marketing ploys once they have made a decision to enroll in a plan. Beneficiaries who express interest in MA offerings should be mailed information so that they have time to make an informed choice by evaluating the new plan and checking whether their providers are in its network. They are unable to make a properly informed choice when presented with the option over the phone.

It is imperative that CMS and the Office of Inspector General hold Part D plans accountable for their misdeeds. If the law does not grant sufficient authority to allow the Administration to protect Medicare beneficiaries from these predatory practices, I ask that you work with me as soon as possible to enhance your enforcement capabilities under the statute.

Sincerely,

Pete Stark
Ranking Member
Ways and Means Subcommittee on Health

Mr. SHAW. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Secretary Leavitt, welcome. On the question of the managed care plans, the President, I believe, is signing today a piece of legislation, the Spending Reconciliation Bill, which Congress just passed. Does it contain a reduction in expenditures for Medicare managed care plans over the next 5 years?

Secretary LEAVITT. I don't know the answer to that, Congressman.

Mr. MCCRERY. It contains $6.5 billion. So, we have taken to heart Mr. Stark's suggestions—at least to that extent, and I agree with him we need to continue to monitor that, and make sure that that sector of the Medicare program is not unduly reimbursed.

I also agree with him that we need to closely monitor the actions of participating private sector plans and Medicare Part D. I am not familiar with the reports that he cited, but I would like to review those. I also know though of a number of other reports that have been issued recently that show that out of the top 25 pharmaceuticals most often purchased by seniors, there are discounts ranging from 35 percent on average at retail pharmacies, to a 46 percent discount with the mail order plans that are available under Medicare. Obviously, those studies, while not in conflict, may not give different impressions. So, it appears to me that at least from

some studies that have been published, the private sector is doing a very good job through competition of lowering the price that the pharmaceutical——

Mr. STARK. Would the gentleman yield for a second? There were several plans, although only about 10 percent that actually lowered cost, but the predominance was not. There were some that lowered.

Mr. MCCRERY. Yes, but I think on average this refers to prices under the plans compared to over-the-counter prices before the plans were instituted, and that is certainly an improvement for seniors. We do need to continue to monitor that.

Mr. Secretary, you recently visited my home State of Louisiana, and I very much appreciate your taking the time to visit the health care providers in the New Orleans area. I don't represent New Orleans, as I am from Shreveport, as far away from New Orleans as one can get and still be in Louisiana, but New Orleans and the surrounding area is extremely important to our State, to the economy of my State, and so I certainly am concerned about that. Louisiana faces significant challenges as we try to rebuild the health care system in that part of our State. I am just interested in hearing from you firsthand what your impressions were, what you took away from that visit, and what plans HHS might have to further assist getting the health care system in that region of my State up and running again?

Secretary LEAVITT. Congressman, my first visit to pursue the goal you have discussed, the rebuilding of the health care system, actually took place in week two, where I met at the New Orleans Airport with hospital administrators to begin essentially a triage of the health care system. I have since met regularly with them, and I was in New Orleans about 3 weeks ago for an entire day, where I met with all of the major hospital administrators, the insurance plans, the Members of Congress from the State, various legislators. We had a very large group and met for an entire day to begin developing a collaborative approach to the rebuilding of the medical infrastructure in the greater New Orleans area.

It is clear to me as well that the State of Louisiana sees this as an opportunity to begin to make dramatic changes for the better in their health care system generally. There is an opportunity in the greater New Orleans area brought about by this devastating catastrophe to build the medical system of the future.

Frankly, I was in New Orleans the week before Katrina. I was told by the head of the Department of Health there that if you were to go to any hospital in the New Orleans area on an emergency, you would have a 24-hour wait. That is unacceptable. The system was not working. The opportunity here is to create a new system that provides outreach, not just in tertiary hospital emergency rooms, but in community health centers, and having a system that literally is driven by electronic medical records and where everyone has access to health care. There is a very exciting opportunity, and, frankly, there is available resources to do that, because once we take the money that is being spent on Medicaid and disproportionate share payments and Medicare and all of the other grants available, and the generosity of the Congress, there is an opportunity that is unsurpassed right now in the Gulf region to build

a health care system of the future, and I think there is a good sense of interest in doing it.

Mr. MCCRERY. Thank you for your interest, and I am hopeful that you will direct the Federal Government's effort to be a partner with Louisiana in building that new, more modern, progressive health care system in that region. We badly need it.

I want to ask you about the Intravenous Immune Globulin (IVIG). I did get your letter today. Appreciate that, and appreciate the efforts to make sure that patients have access to the IVIG products. Thank you. Thank you, Mr. Chairman.

Mr. SHAW. Mr. Levin?

Mr. LEVIN. Thank you very much. Welcome, Mr. Secretary, and your family.

Secretary LEAVITT. Thank you.

Mr. LEVIN. We are going to discuss Social Security some other time. I just want everybody to understand—and you are a trustee—what is in the President's budget. For the first time there are actual figures representing the effect of privatization of these private accounts. There is also spelling out the proposals which are essentially the same as they were when the President presented them last year. The cost is $81 billion plus over the years 2007 to 2011, and $712,144,000,000 in a 10-year period.

I raise this because you mentioned your philosophy, and Mr. Rangel raised it, and it is clear, it seems to me, when you put this all together, that what this Administration is proposing to people, whether it is health care, whether it is Social Security—and I want to come back to other issues—more and more you are going to be on your own.

On the HSAs, for example, I was reading a recent article in the Wall Street Journal, and they quote people who make clear that that is the impact. This is one quote from a health care analyst: "The risk is being transferred without the consumer really realizing that." It is being moved from the employer to the individual.

You also mentioned the subsidization—MedPAC has suggested a major change in the subsidization. We are subsidizing the HMOs in major amounts. Mr. McCrery mentioned a reduction, but most of the subsidization remained, and it was left in, in a conference where no Democrat participated. So, essentially, we have a movement here from a system with an assured health benefit and assured pension benefit, to everybody being on their own. I don't think that should be masked. I think it should be said straight out.

I wasn't sure I was going to talk about the cancer, the National Institute of Health (NIH), but Mr. Shaw mentioned it, and so I do want to come back to it, Mr. Secretary, because I read from this op-ed that was put in on Monday by people at Johns Hopkins, and here is what they say: On an inflation-adjusted basis—and I quote—"the current NIH appropriation is smaller than it was 4 years ago in constant NIH funding dollars. The NIH funding has declined by more than $1 billion since 2003."

Now, I know you are given a number and you have to work with that number, but I don't think we should mask—and you are not doing that—you should say straight out what the impact likely is, for example, on cancer research and other research, because this op-ed spells out the kind of negative impact that could occur on

cancer research at Johns Hopkins. So, you said you would like to provide something more detailed. Give us a straight answer on the impact of straight-lining NIH for a number of years on cancer research and other vital research.

Secretary LEAVITT. Congressman, I don't think we should move forward without acknowledging that we are investing $4.8 billion a year in this type of research. I would also like to make clear that I view the future of medicine to be much different than the past. The future of medicine is about finding ways to highly personalize therapies, to find ways that are preventative and preemptive, and much of the research that is being done to do that is at the National Cancer Institute, but much of the research is not. Much of it is at other institutes that are at the NIH. One of the most exciting is a new venture that we are instigating in a different area of NIH on genes and the environment, recognizing that we can identify the genetic makeup of the top 10 most socially costly diseases, cancer being one of them, and finding ways that we personalize our therapies. Now, that is not represented in the budget at NCI, but it is clearly benefiting from it. We are making a substantial investment.

Would we all like to do more? The answer is yes. Will we do more in the future? The answer is yes. Are we contributing to finding the solution to cancer in other institutes? The answer to that is also yes.

Mr. SHAW. The time of the gentleman has expired. Mr. Nunes?

Mr. NUNES. Thank you, Mr. Chairman. Welcome, Mr. Secretary. I want to start off talking about—I basically have one question for you, but I do want to go back to some of the quotes that the Chairman was outlining in his opening statement, and when you go back to 1966 and 1967, many of the newspapers editorialized—and here is a quote from the New York Times. "This great new experiment must be given ample time to get over its growing pains." That is a common theme that runs throughout most of the editorials when you go back to that time when the first parts of Medicare were first put into law.

As negative as the press has been and that most Democrats have been on this new law, I, for the most part, believe that it is working pretty well, as evidenced by—in my district I don't receive very many calls on Medicare Part D, and when we do recommend people over to automated phone service that CMS has provided, it has been very successful. Recently CMS has found that the net cost to the Federal Government is expected to be $30 billion, down from a previously estimated $38 billion.

So, as we are moving through this process, Mr. Secretary, do you think that this new competition that has been added to Part D is going to continue this projected savings? I know that these are just your estimates, early estimates, but I want to know your thoughts on how competition among prescription drug plans is affecting the Federal budget as it relates to Medicare Part D.

Secretary LEAVITT. Congressman, there is no question that competition is driving the cost of pharmaceutical products to consumers down. When we started this program the estimated cost was $37 a month. It is now $25 a month, almost a third savings. Not only are we seeing a couple hundred thousand people a week

enroll in this benefit, but we are seeing millions of prescriptions filled every day, and we are seeing costs fall, and we are 38 days into it. This was the most significant change in Medicare in 40 years. No realist would expect that we would go through a change that is that profound, that large, without having some unexpected problems. We make no excuses. There were things that had to be fixed, but we found them, we fixed them and we are finishing them. Every day we are seeing the program work more smoothly.

This is a good deal for seniors. The program is smoothing out in a way that I believe is going to benefit consumers on an ongoing basis.

Mr. NUNES. I agree with you, Mr. Secretary, and furthermore, I think it is important to point out that, as you said, we are only 38 days into this program. It was 40 years old, and I hope that you will continue to work with this Committee to make sure that we can smooth out these bumps in the road because the American people expect us to. This Committee has an important job. You have an important job. We don't need to be continuing this constant badgering that the press and others have given you, that is, I think, totally unacceptable in this day and age. The American people expect us to make this program work. They asked for it. We have given it to them, and now we should work through the bumps. I thank you for your time here.

Mr. Chairman, I yield back.

Mr. SHAW. The gentleman yields back the balance of his time. Mr. Cardin?

Mr. CARDIN. Thank you, Mr. Chairman. Behind each of these numbers and statistics is a person in this country who is struggling to meet their health care needs and deal with their own individual issues, and there are families that are concerned about it.

So, Mr. Secretary, I just want to give you an example of one person who lives in my district. Her name is Barbara Waters. She suffers from epilepsy. Prior to January 1st, the medicines that she needs, $100 a month, was paid for under governmental programs, so she paid a small copayment. Because this drug is a benzodiazepine, it has been excluded from the Medicare Part D. She now has to pay $100 a month for this prescription. She asked me a very direct question. She said to me, "The President said that this program's going to help people, that it won't hurt any of us. I can't afford $100 a month." She has to get help from friends right now in order to buy her medicine. If she doesn't buy it, she is subject to seizure.

I guess my question to you is, will you support legislation that Mr. Ramstad and I have introduced, so that these drugs will be covered under Medicare Part D and we can live up to the commitment made to Barbara Waters and many, many other people when we said that this legislation would not harm those who are the most vulnerable, but would add additional benefits within the Medicare system?

Secretary LEAVITT. Congressman, there are plans that can help people in your constituent's situation. The Congress chose to exclude some drugs from coverage. You are right, every single person who has a problem, it is a very serious problem to them, and this

particular person you have talked about, I would like to see if we are in a position to be helpful to her.

Mr. CARDIN. I thank you for that, because it is affecting her life, and I think we need to deal with it. She was protected before this law became effective, and now she is not.

Let me move on to the second point. I must tell you, I am disappointed. I think you are the first Secretary in a budget appearance before our Committee not to mention the health disparity issues among minority populations and outcome, and life expectancy, and survivor rates from cancer, and from access to health care. I am concerned that the budget that you are presenting, which is going to flat fund NIH and cut dramatically from the professional education assistance, which, as I understand it, you are concerned as to how effective it has been in bringing minority professionals into health.

I can tell you in my conversation with health care professionals, cutting the money, $120 million from this program, is certainly not going to be helpful in trying to attract more minority health professionals to gain access for minority populations and the NIH flat funding. So, what strategy do you have in order to bring more access of care to our minority populations?

Secretary LEAVITT. I mentioned, Congressman, that I thought there were a number of programs where targeted strategy would be more efficient and better. This is a very good example. The idea is that currently we are funding a broad array of programs to assist in the recruitment of physicians and nurses and other health care workers. In many segments, we don't have a shortage. We do have a significant shortage in the area that you have spoken of, and the idea is to say let's have fewer programs that are funded, but let's fund them better.

Mr. CARDIN. My concern is if you cut the money, it would be one thing if you were going to put the money into a new program, but as I understand it, you are just cutting the funds.

Secretary LEAVITT. If we just kept funding the program in the same way, and we weren't more selective and more targeted, that would be an appropriate conclusion, but what I am suggesting to you is that there is a way for us to target our funds and have an impact in the areas where there are serious deficits that will be more profound than we have done in the past. It does mean that there are people who have been getting money from the Federal Government who won't, but the areas that you have spoken of, there would be no reasons for us not to fund them more intensely, not less intensely.

Mr. CARDIN. Thank you. Let me just ask a last question, and that is about the therapy caps that went into effect on January 1st. I personally have been working with 200 plus Members of Congress to get rid of the therapy caps because it is not good health care policy. The law allows you to issue regulations so that there could be exceptions to the therapy cap. Do you know the status of those regulations as to when they are going to be issued?

Secretary LEAVITT. I don't know the exact date. I have been involved in some discussions. I know, in fact, that they are under consideration.

Mr. CARDIN. If you could make sure that our Committee is kept aware of that, I would appreciate that.

Secretary LEAVITT. I will get back with that.

Mr. CARDIN. I would hope that you would also consider legislation to get rid of that therapy cap once and for all.

Secretary LEAVITT. If I could get the name of the person that you were talking about, I would like to make certain that we are responsive to her need.

Mr. CARDIN. I will get you Barbara Waters' information. Thank you.

Mr. SHAW. Mr. Ryan?

Mr. RYAN. Thank you, Chairman. Thank you, Secretary Leavitt, for coming today. We have heard some talk about HSAs, which was a very important component of the Medicare law. I wanted to ask you a couple questions along that theme. I think it is important to note what HSAs are and what they have done. They have only been in law for about 3 years, and really in practice for a little over 2 years.

Some have said that HSAs are not working, they are not a good policy. If you take a look at the data, I think it speaks for itself. Number one, HSAs went from one million people using them a year ago to 3 million people using them now. Thirty seven percent of the people who have HSAs are people who did not have health insurance before. So, what HSAs have already done is priced health insurance within reach for 37 percent of those 3 million people who otherwise did not have health insurance.

As far as the notion that there is adverse selection, the opposite has rung true. When you take a look at the data, over 30 percent of the people earn less than $50,000. Fourty five percent of the people who have HSAs are over 45 years of age. So, what we are finding is that HSAs have become a good tool for people with risky health profiles; for people with lower incomes; for people who are older; to get health insurance that they could otherwise not have afforded.

The question is this. HSAs get the consumer back in the game because we believe the current third-party payment system where you really don't care what things cost because somebody else is paying the bills, and you are not allowed to shop around on things like price and quality because you are either told who and where you have to go to by your HMO, or you don't get that information in the first place.

So, now that we have this insurance product in place to incentivize consumers to actually care what things cost, we don't have the information necessary to make those kinds of decisions. That is the question I want to get to you. We have made progress on quality initiatives. The Medicare law put together a good quality initiative for hospitals. The DRA, which is being signed into law today, makes strides to improve dissemination of quality metrics for physicians. Where we don't have much transparency is in price.

This is the question, Mr. Secretary. In the President's State of the Union address, he proposed a comprehensive agenda to make health care more affordable and more transparent. We have very little price information. Often when we get price information from physicians or hospitals, they are charged prices, not the actual paid

prices. There is a huge gulf between what is actually charged and what is paid, and they vary among payers, just within certain regional areas.

In 2003, the Office of Inspector General proposed a rule to redefine charges to be the average negotiated market price. Number one, when does the Department intend to finalize this rule, and number two, what other steps is HHS taking to improve price transparency, actual price transparency, so people who are beginning to shop for health care can actually do so with real information?

Secretary LEAVITT. Congressman, I don't have to go any further than myself to find an example of where an HSA has improved my consciousness of decisions being made about my health and my purchases.

After having an indemnity plan for a long time, I got an HSA, and for the first time I found out what my prescription drug costs were. It surprised me. I found that there was a generic, and for the first time it mattered to me, and I changed to the generic. The same thing happened with my spouse.

I had a medical device I needed to buy. I found that the place I was going to be buying it through my health plan was far too expensive. It is kind of a colorful story—I won't take the time to tell you—but I found I could buy it for less than a third if I made a purchase myself. I suddenly had a reason to care, and I concluded for myself, and it meant something to me.

It is happening. It is happening across the country. The point you have made about 37 percent of those who subscribe to HSAs who have no insurance at all is a very clear indication to me that we are pricing health insurance outside the reach. If we were to do the same thing with car insurance, where it paid for your oil filter and your gasoline, like we do health insurance, it would be a very difficult thing to buy car insurance as well. So, I believe what we are doing is the right thing, and that there will be more and more who see the virtue of it.

Mr. RYAN. What is HHS doing——

Secretary LEAVITT. What are we doing at the Department? I would suggest something you didn't mention that is very important to this. It is health information technology, the capacity to gather information and to provide it to consumers in a way that they can use it.

Secondly, people need to be able to go to a health care provider and know what they are charging for things. Now it will be difficult in the near term to make that transparent on everything, but there are some very common procedures that could be listed by providers.

A second thing is the need to bundle at times on a procedure basis. If I go in for a hip replacement, or a knee or an appendectomy, I get a hospital bill that has 42 different things on it. I don't know what is part of the charge, what isn't. It would be nice if I could say to a hospital or provider, "What is it going to cost for this common procedure," and be able to know, and that the providers would have to live up with that price. We can have an impact on that at HHS by making information known as to what we are paying so that there are cost comparisons and there is the capacity to have cost transparency.

Mr. RYAN. The proposed rules?

Secretary LEAVITT. The proposed rules are in the works, and I am not able to give you a date, but I can tell you that they are in the works.

Mr. RYAN. Okay, thank you.

Secretary LEAVITT. Thank you.

Mr. SHAW. Thank you. Mr. McDermott?

Mr. MCDERMOTT. Thank you, Mr. Chairman. Governor Leavitt, it is good to have you here, and I am sure you remember your days as a Governor.

Secretary LEAVITT. Indeed.

Mr. MCDERMOTT. You are now operating in a place where the principle of this budget is that we pit one group of poor people against another for less money while we give tax holidays to the rich. I assert that on the basis of what I see in this budget. Seattle has the best urban Indian health program in the country. The budget put here today cuts it by 40 percent, and the assertion in the budget is, well, what you will do is you will just go to a community clinic. Now, you are going to go from a culturally sensitive clinic that has been dealing with Indian urban problems, and you are going to throw them out into the rest to compete with the other uninsured in the community. There is no justice in that. The problems that have been dealt with through that kind of program absolutely are going to be shattered.

The same thing with your Social Security block grant. That Social Security block grant in Louisiana covers 36 percent of the children's welfare costs in that State, and you are cutting half a billion dollars—excuse me, $500 billion out of that program.

Now, I guess what you are saying is we are going to recoup the money from the rest of the country to pay for the problems of Katrina and the problems of Louisiana. This example you just gave about your cost-conscious stuff, what you are doing is pitting consumers, that is, patients, against insurance companies.

Now, when you are going out to buy food or contact lenses or whatever, that is like buying tile or buying a refrigerator. The other day—I am glad you have your father here today, and I certainly wish I could have my son here today. He would tell you that the other day when his wife had an emergency C-section for a baby in distress, he did not go to his computer and look for where the cheapest hospital in Los Angeles was. It probably would have been Los Angeles County, about 30 miles away. Instead he went to the hospital 6 miles away where the doctor was that had taken care of his wife.

Now, when you say that you are going to—if people got skin in the game, as they say, this is when they make these judgments. They will kind of sit there and be cost-conscious. My son was not cost-conscious. I did not want him to be cost-conscious. You would not have wanted him to be cost-conscious.

Now, Governor Leavitt wrote us a letter on October 15, 1999, and he said—this is 1999. Now, this is a long time ago. "Further reductions in funding for Social Security Block Grant (SSBG) will result in cuts to vital human services for our most vulnerable citizens." You went on to identify them as low-income children, families, and elderly and the disabled.

Now, you tell me what is the justice in this budget. How do you defend cutting programs that you yourself, when you were on the receiving end, said would hurt you? Do you think the 50 Governors are not going to be hurt by this budget? I would like to hear your response in justifying how you can cut programs where you know from your own experience—you had to deal with it. I had to deal with it in the State legislature, what goes on up here. So, I would like to hear you justify it.

Secretary LEAVITT. Congressman, let me start back with the issue of the Indian health centers and the community health centers. One of the things I learned as Governor is that if you have two facilities and they are across the street from each other, while they may be sponsored by different organizations, that is a function of silos, and that you can likely have one and have it serve people better because you can have better facilities than if you have two and they are sponsored by different organizations and that somehow those barriers—and that is what we are doing in this situation, is we are saying we have already got community health centers, why should we have two facilities in one area as opposed to having one excellent facility.

Mr. MCDERMOTT. So, you are cutting out the Indian health service clinics by design in order to shove those Indians into the community? Is that it?

Secretary LEAVITT. I hadn't thought of it as "shove them," but we certainly invite them to have good quality care at community——

Mr. MCDERMOTT. You give them no alternative.

Secretary LEAVITT. Where we, I might add, serve already about 14 million people in a program that people love, compete and scramble to get one. Now, I would also like to talk a little bit about the use of funds to cover more people. One of the reasons that we are looking to have more efficient systems is because it allows us to cover more people. It is a lot better for everyone to have access to basic quality care than it is for a few to have unlimited care. That is the reason we have to be cost-conscious.

I would like to respond to the block grant issue. There is no question that your view is based on where you sit, and I have now sat in both places, and I can tell you why it is that Governors like those grants. First of all, it is very flexible money. By flexible, it is also very difficult to know where it is having an impact and where it is not having an impact.

Mr. MCDERMOTT. We set it up that way because you asked for a block grant——

Secretary LEAVITT. There is no question——

Mr. MCDERMOTT. —we had specific programs, and we lumped them all together and said here is the money, do it flexibly.

Secretary LEAVITT. If we were not in deficit reduction, I would be suggesting that that would be a fine place to put that money, but I can tell you that my colleagues in the States are in a much, much different position than they were in 1999. There are many States who are doing extraordinarily well with their revenues. The State where I was Governor when that letter was written, at the time, was looking at budgets that had dramatically less money than they had dealt with the year before. They now have a billion

dollars of new money, and I am delighted for them. We are in the position where we are reducing deficits. If we had the money, it would be great.

Mr. MCDERMOTT. What about Louisiana?

Secretary LEAVITT. We don't——

Mr. MCDERMOTT. What about Louisiana? They lost their tax base——

Mr. SHAW. The time——

Mr. MCDERMOTT. —and you are saying to their Governor, hey——

Mr. SHAW. —of the gentleman has expired.

Secretary LEAVITT. We are watching Louisiana, as well we should.

Mr. SHAW. The time of the gentleman has expired. Mr. Weller?

Mr. WELLER. Thank you, Mr. Chairman. Mr. Secretary, welcome to the Committee. Good to have you here, and I appreciate the opportunity to talk with you this morning. The subject of community health centers, I appreciate my colleague from Washington State drawing attention to them, and first I just want to thank you as well as your predecessor, Secretary Thompson, for implementing the President's goal of expanding community health centers. Certainly in the last 5 years, I think the numbers I have seen, there are 777 new health centers that have been established and expanded, and 3.7 million more Americans, particularly low-income Americans who previously had limited access to quality health care, are now being served because of that expansion, and I have enjoyed working with Secretary Thompson and others in this goal.

Let me direct my question, I guess, as we look at the President's budget as it addresses community health centers. The President's budget states that he wants to increase access to health care, particularly for low-income Americans, through adding 300 new and expanded health care sites, and including within those 300 new and expanded health care center sites 80 new sites in counties with a high prevalence of poverty. How will that be achieved in the President's budget? Can you give us more specifics on how they would achieve that goal?

Secretary LEAVITT. The funding is there, and you have the statistics right. We are looking to add 302 new centers, which will continue the movement toward the President's goal of 1,200. He now has a new matter that has been proposed, and that is to add 80 of those in low-income or high-poverty areas. That is just one part of the way the President proposes to expand the kind of access that people have. It is a goal on which the President has some passion, and I think you have expressed it.

As we indicated, these are sites that communities love to have and compete to have, and I have regular calls from Members of Congress saying, "We would like to have one of these in our area. We think we should qualify, but we have not been approved." I wish we had more money to do it because we could expand them in an almost unlimited——

Mr. WELLER. The county community health center located in Joliet, Illinois, in my district, I have been a supporter of that. When I visit it—and I visit at least once a year—I see not only low-income families, but also immigrants, minorities, and a lot of moth-

ers with children that are utilizing the health care that is available through the community health center. Specifically, Mr. Secretary, can you tell us, in the President's budget that he has submitted to the Congress, what he proposes in funding for community health centers and how that compares to past year?

Secretary LEAVITT. There is an increase of $181 million that has been proposed in this budget for that purpose.

Mr. WELLER. How does that compare to previous years?

Secretary LEAVITT. I am not sure. I am not sure of the answer to that in terms of the actual dollars.

Mr. WELLER. Was that a $181 million increase?

Secretary LEAVITT. We have 4,000 centers in all, in total. The President set a goal to improve or add 1,200 new ones.

Mr. WELLER. Right.

Secretary LEAVITT. You have cited the fact that we had already done so with 700-plus, and we now want to have another 302, and 82 of those will be in areas that, of course, will be targeted——

Mr. WELLER. You are saying the President proposes a $181 million increase over previous funding.

Secretary LEAVITT. That is correct.

Mr. WELLER. I would note, having worked on this issue with your predecessor and with the Bush Administration, that every year the President has proposed a record increase in funding for community health centers, and I applaud that as we set priorities. As you know, we are in a deficit reduction mode. We have got to get spending under control. The President has made this a priority.

One note, and I consider this a serious note, an area where I hope, Mr. Secretary, that we can work together, and that is the issue of the per visit payment limit, otherwise known as the Medicare payment cap. Studies have shown that a large majority of community health centers have experienced losses totaling over $51 million as a result of this payment cap, the average loss being about $75,000 on average for each community health center. We often think from Washington terms that is not that much money, but for a local community health center, that can have a big impact on a health center, and obviously reimbursement issues—and as a Governor, you dealt with them as a Governor and know how they affect the quality of care. I would note that the payment cap methodology has not been reviewed or adjusted since its conception in 1992, and the payment cap itself is adjusted for inflation only for physician services.

That is why, Mr. Secretary, I want to ask you to examine the payment cap and look at how that can be part of the President's strategy to improve health care that would be available through community health centers. I have worked with my friend and colleague, Mr. Lewis of Georgia. I know he is interested in this issue, and I was wondering what your thoughts are on the payment cap. Is this something you feel deserves review, and is this something that we can work together to improve upon so we can help achieve the President's goal of improving health care through community health centers?

Secretary LEAVITT. Congressman, I have been in dozens and dozens of community health centers. Every one of them is unique. Every one of them is a community that has in some way come to-

gether to put together a formula that works for them. There are some consistencies not only in the formulas they come up with, but the problems and challenges. The one that you mentioned of the payment cap is one that is universally cited as I go around and speak with them. We would be very pleased to have a conversation about the way that barrier could be overcome.

Mr. SHAW. The time of the gentleman has expired.

Mr. WELLER. Thank you, Mr. Secretary. I look forward to working with you on this.

Mr. SHAW. Mr. Becerra?

Mr. BECERRA. Thank you, Mr. Chairman. Mr. Secretary, thank you very much for being with us, and thanks again for the patience. We know it takes a while to get through all the questions, but we appreciate that you are willing to stay with us.

Secretary LEAVITT. Thank you.

Mr. BECERRA. I have a couple of questions. First I would like to touch on this whole issue of the prescription drug implementation, because in my State of California, as you are aware, not only the Governor and our four legislative leaders in the Senate and Assembly, Republican and Democrat, have written to you and the President saying we need some help, but I think throughout this country Governors and State legislators are saying this is not going well. The implementation has begun disastrously. You have millions of seniors who are wondering what to do. Now, I am looking at a letter—and I would like to submit this for the record, Mr. Chairman—dated January 13 from Governor Schwarzenegger in California and the four legislative leaders, Republican and Democrat, in the California legislature, asking for your help—it is addressed to you directly—in making sure that this transition from the Medicare Programs that existed and whatever drug plans that seniors had in California to this new plan, that during that time seniors, especially what we call dual-eligible seniors, those who are qualified for Medicaid—in California it is called MediCAL—don't lose their coverage. I will just quote a couple of passages from the Governor's letter.

"Our residents are having difficulties accessing their prescription drugs." He goes on to say, "Too many Californians are unable to get the prescription drugs they need to stay alive. Pharmacies are being overloaded with administrative responsibilities while trying to clarify patients' eligibility and enrollment information so they can bill the drug plans for services provided. The drug plans are not answering the phone calls coming in and are not resolving a large number of the problems people are facing. In short," he goes on, "the transition is not functioning as CMS intended." He goes on, "As a result, beneficiaries are being denied access to life-saving medications they need."

He goes on to ask if the Federal Government will work with the States to implement a temporary automated system that can help manage this transition, and he makes a call for the Federal Government to "work with the State of California to ensure that the costs incurred by California taxpayers for this temporary expenditure are reimbursed."

So, my question first, Mr. Secretary, is: Are you prepared to say today that the Federal Government will reimburse my State of

California and its taxpayers and any other State that faces similar problems with their dual-eligible Medicaid-Medicare patients, reimburse those taxpayers for the costs incurred by the States in making sure that these seniors that qualify for prescription drugs don't lose those prescription drug benefits?

Secretary LEAVITT. Congressman, what is the date on that letter?

Mr. BECERRA. January 13th of this year.

Secretary LEAVITT. We are approaching a month since then, and I can tell you that things are dramatically different. I think I may have met with Governor Schwarzenegger in his office a very short time before or after that letter, and——

Mr. BECERRA. Well, I know he just held a press conference earlier this week saying that the problem is still dire, that the State legislature is going to move forward with an emergency plan to make sure that about a million seniors in California continue to have their coverage. So, they are still looking for reimbursement. They still haven't received the answer, and I am hoping that perhaps today here you can clarify whether or not the Federal Government will reimburse States like California, California taxpayers.

Secretary LEAVITT. I have met with Governor Schwarzenegger and had regular communication with his office. I will tell you that things are dramatically better than when that letter was written. I will also tell you that we have indicated a willingness to reimburse the States. We have waivers now—or had signed demonstration waivers with 30 States. California has not chosen to sign one.

Mr. BECERRA. Mr. Secretary, the fact that you are saying you are willing to reimburse is probably the most important thing, and I think that is critical.

Secretary LEAVITT. I am willing to reimburse, but the States have to do their part as well. The 30 States have done that so far, and we are willing to work and are working daily with California.

Mr. BECERRA. I appreciate that.

Secretary LEAVITT. The important thing for me to communicate with you, though, Congressman, is that the conditions that existed when that letter was written do not exist today.

Mr. BECERRA. Then we have to talk to the Governor because, as I said, he held a press conference this week saying that the situation is still the same for seniors in California.

Secretary LEAVITT. I will say that, generally speaking, in a situation like this, the enthusiasm of critics is not always tempered with realism.

Mr. BECERRA. Let me move on to one other point that is of some concern to me. As a trustee for the Social Security program, you have a great deal to say about what happens with Social Security. The President's budget includes very explicitly some $712 billion for privatization, his idea of privatizing Social Security. I have a difficult time understanding how it is that the President is able to find $712 billion in his budget for privatization of Social Security, yet the President's budget also calls for the elimination of a $255 lump-sum death payment that has been part of Social Security for more than 50 years for the survivors of a Social Security recipient who dies. On top of that, the budget calls for a cut-off of monthly survivor benefits to 16- and 17-year-olds who are not in

high school, so if they had to go to work to help the family, they would lose their monthly survivor benefit if their parent who was a Social Security recipient happened to die.

Then you look at the fact that there are numerous programs under your jurisdiction that are being cut. Alzheimer's disease demonstration programs under the Administration of Aging, a $12 million program is being zeroed out. Traumatic brain injury program focused on kids, a $9 million program being zeroed out. Universal newborn hearing program, a $9 million program being zeroed out. Emergency medical services for children, a $19 million program being zeroed out. Training in primary care medicine and dentistry, an $88, $89 million program being zeroed out.

All of these wouldn't total up to even 1 percent of the cost of the President's proposal to privatize Social Security over the long term, and so I am wondering if you could comment as to the priorities that the President and this Administration has with regard to seniors, Social Security, and health care.

Secretary LEAVITT. Regrettably, we won't have time to respond to all of those. In my opening comments, I indicated that we are in a time of deficit reduction, and every program that you have spoken of is a program that obviously resonates with me, as it does you. I laid out a series of principles that we are using to do our best to meet the needs of the American people, all of them.

Mr. BECERRA. I appreciate it, Mr. Secretary. Mr. Chairman, I would like to make sure that included in the record is the letter from Governor Schwarzenegger dated January 13th, and also to make sure that Mr. McDermott's reference to the October 15, 1999, letter of the National Governors' Association, of which then-Governor Leavitt was a part, is also included in the record.

Mr. SHAW. Without objection.

[The information follows:]

Governor Arnold Schwarzenegger
State Capitol
Sacramento, CA 95814
January 13, 2006

The Honorable Michael O. Leavitt
Secretary of Health and Human Services
U. S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Secretary,

We write today to express our deep concern over the initial implementation of the new Medicare Part D prescription drug benefit. We want to work cooperatively with you to ensure that the nearly one million Californians who are dually eligible for Medicare and Medi-Cal have access to the prescription drugs that are essential to maintaining their health. The individuals are among the most vulnerable of Medi-Cal beneficiaries—they are either seniors or disabled persons—many with physical or mental disabilities, all of whom have few resources or income.

Our residents are having difficulties accessing their prescription drugs. As a result, we are triggering state programs to provide temporary, emergency coverage of prescription drug benefits for the nearly one million Californians who are dually eligible for Medi-Cal and Medicare. We recognize the difficult task facing the staff at the Centers for Medicare and Medicaid Services (CMS) during this initial transition. The creation of a new program of this size is a monumental task, but the unprecedented movement of these one million dual eligibles to the new Medicare drug program on one calendar day appears to have overwhelmed the CMS and drug plan systems.

As you know, CMS has been assuring states and beneficiaries that mechanisms were in place to ensure that during the transition no dual eligibles would go without their needed medications. While your staff reports that error rates have declined from 90 percent to 20 percent, this is still unacceptable. Too many Californians are unable to get the prescription drugs they need to stay alive. Pharmacies are being overloaded with administrative responsibilities while trying to clarify patients' eligibility and enrollment information so they can bill the drug plans for services provided. The drug plans are not answering the phone calls coming in and are not resolving a large number of the problems people are facing. We receive daily reports of beneficiaries in great distress because they have been unable to obtain their medications or are mistakenly required to pay significant fees in order to fill a prescription. In short, the transition is not functioning as CMS intended for some of the dual eligible population, and as a result, beneficiaries are being denied access to lifesaving medications they need.

We would like to work with the federal government so that a temporary automated system can immediately be implemented to have Medicare pay for drugs for dual eligibles who are unable to obtain medications due to the transition problems. As you can appreciate, such a process would allow pharmacies to be paid for prescription medications using their normal billing system without the need for either the pharmacy or the beneficiary to make calls to either Medicare or the Medicare drug plan. This will allow Medicare patients to continue to have access to their needed medications while the new program's implementation problems are being addressed. This is critical to ensure that the burden of this implementation does not fall upon those patients who are least able to handle a loss of their medications.

We intend to work closely and cooperatively with you and the Congress to ensure that beneficiaries receive the medications they need and the law intends. In addition, we call on the federal government to work with the State of California to ensure that the costs incurred by California taxpayers for this temporary expenditure are reimbursed. In the meantime, we will continue to assist your efforts to implement the Medicare Modernization Act to protect and care for our most vulnerable residents.

Sincerely,

Arnold Schwarzenegger,
Governor

Don Perata
Senate President Pro Tempore

Dick Ackerman
Senate Republican Leader

Fabian Nuñez
Assembly Speaker

Kevin McCarthy
Assembly Republican Leader

National Governors' Association
Washington, DC 20001
October 15, 1999

The Honorable Ted Stevens
Chairman, Senate Appropriations Committee
S–128, The Capitol
Washington, D.C. 20510

The Honorable Robert C. Byrd
Ranking Member, Senate Appropriations Committee
S–206, The Capitol
Washington, D.C. 20510

The Honorable C.W. Young
Chairman, House Appropriations Committee
H–218, The Capitol
Washington, D.C. 20515

The Honorable David Obey
Ranking Member, House Appropriations Committee
1016 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Stevens, Senator Byrd, Chairman Young, and Representative Obey:

As you begin negotiations on the fiscal 2000 Labor, Health and Human Services, and Education (Labor-HHS) appropriations bill, the nation's Governors strongly urge to maintain your commitment to key state programs. We are adamantly opposed, as stated in the attached resolution the Governors adopted in August, to cutting funding for other vital health and human services programs such as Temporary Assistance for Needy Families (TANF), Title XX/Social Services Block Grant (SSBG) Medicaid, the Children's Health Insurance Program (CHIP), child support, and education and training programs which would adversely affect millions of Americans—with the greatest impact on children and the elderly in the greatest need.

We are especially concerned about the status of SSBG in the current versions of the Labor-HHS bills. Over the past few years, SSBG has taken more than its share of cuts in federal funding. As part of the 1996 welfare reform deal, Congress made a commitment to Governors that SSBG would be level funded at $2.38 billion each year. In fact, Governors reluctantly accepted a 15 percent cut in SSBG funds at that time in exchange for the commitment for stable funding in the future. However, repeated cuts in SSBG have been enacted regardless of that commitment. In fiscal 1998, funding for SSBG was reduced to $2.299 billion. It was again reduced in fiscal 1999 to $1.909 billion. Further reductions in funding for SSBG will result in cuts to vital human services for our most vulnerable citizens.

In addition, Governors strongly support the provision from the 1996 welfare reform law that allows states to transfer up to 10 percent of their TANF block grant into SSBG. Both the House and Senate versions of the fiscal 2000 Labor-HHS bill reduce the amount states can transfer from TANF to SSBG. This restriction of flexibility is in essence an additional cut in funding for SSBG. The nation's Governors strongly urge you to restore the transferability provision to the full 10 percent.

SSBG provides services to needy populations, including low-income children and families, the elderly, and the disabled. While SSBG does have a strong connection with welfare reform efforts in states by providing valuable resources for child care and transportation, it also provides services to many individuals who are not considered welfare recipients. For example, in many states, SSBG funding is used to provide foster care assistance, meals on wheels for the elderly, and independent living services for the disabled—programs which are not allowable uses of welfare funds such as TANF.

The Governors are not seeking increased federal funding; we are simply requesting that you fulfill your commitments and reject cuts in programs such as SSBG that would jeopardize our strong state-federal partnership.

Sincerely,

Governor Michael O. Leavitt
Chairman

Governor Parris N. Glendening
Vice Chairman

Mr. SHAW. Also without objection, I would like to put in the record a letter from the Department of Health and Human Services dated February 6th in which it shows that the reduced drug cost is going to save the State of California $113 million, and I think that bears directly upon the problem that you have related to. So, without objection, both letters will be put into the record.

[The information follows:]

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Administrator
Washington, DC 20201

Feb 6, 2006

S. Kimberly Belshe
Secretary
Health and Human Services Agency
State of California
1600 Ninth Street
Sacramento, California 95814

Dear Secretary Belshe:

Thank you and your staff for the time spent over these past several months in discussions regarding the implementation of the Medicare Modernization Act of 2003 (MMA) and the Part D program. Most recently, your staff participated in the development of the section 402 Demonstration Application Template for Reimbursement of State Costs for Provision of Part D Drugs which was released last week. I am pleased that states are already applying for the Demonstration.

Throughout the discussions and requests for data regarding the state's net savings as a result of MMA, it has been our impression that California has consistently underestimated its savings in both the short-term and long-term. Moreover, California's recent request to be repaid the difference between what Part D and what Medi-Cal pays in the current discussions about the transition period to Part D certainly implies that the state would have spent more on behalf of dual eligibles than what Medicare plans will spend.

As the President's Budget for 2007 is officially released today, I am able to fully respond to your letter of December 14,2005 in which you raised questions about the estimated savings to the state through federal assumption of prescription drugs which is then partially offset through the phased-down state contribution.

Over the course of last year, our staffs had a number of occasions to discuss the state's estimated spending and savings and your requests to use alternative accounting method for rebates. The state estimated the requested adjustment would "drop California's phased-down costs by $37.1 million." You also requested an adjustment to the baseline to "recognize the significant Medicaid prescription drug cost containment we implemented in September 2004." According to your letter, California's growth rate for calculating the state contribution should be 24.66 percent rather than the federal projected growth rate of 35.54 percent.

I am pleased to inform you that the newly updated National Health Expenditures (NHE) growth rate to be used for the calculation of the state contribution in the President's Budget is even lower than California's index. Nationally, the state contributions will be reduced by $37 billion in the period 2006–2015 compared to these costs estimated last summer in the Mid Session Review. In addition, we will apply the new index to recalculate the per capita amount used in the state contribution for CY 2006. California's new per capita amount will be $89.02 for the January-September period compared to the old amount of $98.54, a reduction of 9.7 percent.

According to our estimates, when comparing annual payments based on December actual enrollment reported by California, using the new (NHE) will mean additional savings of $113 million for the state in CY 2006. These savings are significantly larger than you have requested based on your own estimates.

In November, your staff provided data that estimated the State General Fund cost of drug expenditures for 1,021,000 dual eligibles in 2006 at $1,158,368,500. In CY 2006, the state will make only 11 payments for the state contribution. Even at the old per capita amount, California would have saved $52 million in CY 2006 (1,021,000 x $98.54 x 11 months equals $1,106,702,740) which is worth even mote than the change to accrual methodology that you requested. Applying the new per

capita amount to California's data, the state will save $158,584,880 (1,021,000 x $89.02 x 11 months equals $999,783,620).

We had previously estimated California's drug spending for duals in 2006 would have been higher than state estimates resulting in even greater savings to the state, but applying California's own data, there is no reason to doubt the state will spend less with the state contribution than it would have if California had continued full coverage of the duals under Medi-Cal.

While California has reported it has spent $18 million (including administrative costs) as of February 3 for the transition period to Part D, our Demonstration would reimburse the state for what it has spent. It is unclear to us, based on the guidance provided to pharmacists, whether California is being billed for the $1 or $3 Medicare copayment or whether they have been collected at the pharmacy. What is clear is that state would recoup nearly all of the $18 million it has spent should the state choose to participate.

While economists and analysts can reasonably adopt different sets of assumptions and estimates are constantly updated to reflect better and more current data, we are pleased that even using California's own data, the new growth rate will get savings that exceed your expectations.

Sincerely,

Mark McClellan, MD, PhD

Attachment:

Revised Clawback Comparisons

A States	B Annual Payments Old NHE w/December Actual Enrollment	C Annual Payments New NHE w/December Actual Enrollment	D ifference (C–B)
Alaska	$19,040,841	$17,202,153	$(1,838,687)
Alabama	$65,599,530	$59,264,881	$(6,334,648)
Arkansas	$33,815,887	$30,550,440	$(3,265,447)
Arizona	$57,615,285	$52,051,639	$(5,563,646)
California	$1,172,151,995	$1,058,962,604	$(113,189,391)
Colorado	$72,876,673	$65,839,304	$(7,037,369)
Connecticut	$124,059,021	$112,079,205	$(11,979,816)
District of Col.	$10,975,558	$9,915,699	$(1,059,860)
Delaware	$14,025,128	$12,670,785	$(1,354,343)
Florida	$479,984,275	$433,634,375	$(46,349,900)
Georgia	$130,993,456	$118,344,013	$(12,649,443)
Hawaii	$22,175,070	$20,033,724	$(2,141,346)
Iowa	$66,174,915	$59,784,704	$(6,390,211)
Idaho	$18,060,946	$16,316,883	$(1,744,063)
Illinois	$333,221,963	$301,044,232	$(32,177,731)
Indiana	$99,283,770	$89,696,387	$(9,587,382)
Kansas	$48,756,251	$44,048,082	$(4,708,170)
Kentucky	$81,122,635	$73,288,990	$(7,833,644)
Louisiana	$82,793,438	$74,798,452	$(7,994,986)
Massachusetts	$239,970,806	$216,797,916	$(23,172,890)
Maryland	$92,240,710	$83,333,444	$(8,907,266)
Maine	$45,260,376	$40,889,787	$(4,370,589)

Revised Clawback Comparisons—Continued

A States	B Annual Payments Old NHE w/December Actual Enrollment	C Annual Payments New NHE w/December Actual Enrollment	D ifference (C–B)
Michigan	$188,540,434	$170,333,941	$(18,206,493)
Minnesota	$109,733,219	$99,136,780	$(10,596,438)
Missouri	$191,708,376	$173,195,969	$(18,512,407)
Mississippi	$76,553,279	$69,160,877	$(7,392,402)
Montana	$12,238,192	$11,056,405	$(1,181,787)
North Carolina	$247,898,287	$223,959,876	$(23,938,411)
North Dakota	$5,458,968	$4,931,821	$(527,148)
Nebraska	$41,619,392	$37,600,396	$(4,018,996)
New Hampshire	$30,585,921	$27,632,378	$(2,953,543)
New Jersey	$271,291,722	$245,094,314	$(26,197,409)
New Mexico	$8,845,259	$17,025,458	$(1,819,801)
Nevada	$22,496,284	$20,323,920	$(2,172,364)
New York	$779,819,148	$704,515,557	$(75,303,591)
Ohio	$230,584,176	$208,317,710	$(22,266,466)
Oklahoma	$55,382,475	$50,034,441	$(5,348,034)
Oregon	$63,234,635	$57,128,354	$(6,106,281)
Pennsylvania	$399,667,987	$361,073,866	$(38,594,121)
Rhode Island	$41,678,993	$37,654,242	$(4,024,751)
South Carolina	$77,385,665	$69,912,883	$(7,472,782)
South Dakota	$12,956,089	$11,704,978	$(1,251,111)
Tennessee	$283,931,372	$256,513,410	$(27,417,962)
Texas	$303,361,506	$274,067,264	$(29,294,242)
Utah	$21,471,442	$19,398,042	$(2,073,400)
Virginia	$166,965,498	$150,842,399	$(16,123,099)
Vermont	$18,454,617	$16,672,538	$(1,782,078)
Washington	$145,340,530	$131,305,656	$(14,034,874)
Wisconsin	$145,195,338	$131,174,484	$(14,020,854)
West Virginia	$30,780,689	$27,808,337	$(2,972,351)
Wyoming	$8,358,727	$7,551,563	$(807,164)
Total	$7,311,736,748	$6,605,675,559	$(706,061,189)
Percent Reduction			–9.66%

Revised Per Capita Amounts

STATE	Per Capita Amounts		Per Capita Amounts	
	Old NHE w/December Actual Enrollment		New NHE w/December Actual Enrollment	
	JAN–SEPT BASELINE	OCT–DEC BASELINE	JAN–SEPT BASELINE	OCT–DEC BASELINE
AK	145.32	142.67	131.29	128.89
AL	61.31	62.64	55.39	56.59
AR	48.31	49.05	43.64	44.31
AZ	49.43	50.19	44.66	45.35
CA	98.54	98.54	89.02	89.02
CO	126.97	126.97	114.71	114.71
CT	156.20	156.20	141.12	141.12
DC	56.02	56.02	50.61	50.61
DE	124.97	125.20	112.90	113.11
FL	112.05	112.40	101.23	101.55
GA	89.00	85.90	80.40	77.61
HI	74.83	77.12	67.61	69.68
IA	98.07	102.46	88.60	92.57
ID	84.56	83.30	76.40	75.26
IL	127.63	127.63	115.31	115.31
IN	97.45	98.42	88.04	88.92
KS	105.40	105.83	95.22	95.61
KY	77.71	76.90	70.20	69.47
LA	75.52	75.77	68.22	68.45
MA	104.59	104.59	94.49	94.49
MD	133.43	133.43	120.55	120.55
ME	82.56	81.74	74.59	73.85
MI	82.13	82.53	74.20	74.56
MN	128.79	128.79	116.35	116.35
MO	119.96	121.00	108.38	109.32
MS	47.08	47.29	42.53	42.73
MT	75.35	79.00	68.07	71.38
NC	95.61	92.92	86.38	83.94
ND	76.43	78.96	69.05	71.34
NE	107.61	112.28	97.22	101.44
NH	148.33	148.33	134.01	134.01
NJ	159.59	159.59	144.18	144.18
NM	49.94	48.59	45.12	43.90
NV	109.35	111.35	98.79	100.60

Revised Per Capita Amounts—Continued

STATE	Per Capita Amounts		Per Capita Amounts	
	Old NHE w/December Actual Enrollment		New NHE w/December Actual Enrollment	
	JAN–SEPT BASELINE	OCT–DEC BASELINE	JAN–SEPT BASELINE	OCT–DEC BASELINE
NY	117.67	117.67	106.31	106.31
OH	127.34	128.04	115.05	115.68
OK	62.17	61.72	56.17	55.76
OR	100.16	101.46	90.49	91.66
PA	123.75	125.56	111.80	113.44
RI	115.60	120.93	104.44	109.25
SC	55.26	54.86	49.92	49.57
SD	90.90	96.49	82.12	87.17
TN	105.05	106.04	94.90	95.80
TX	78.37	78.13	70.80	70.59
UT	86.95	88.79	78.55	80.21
VA	137.20	137.20	123.95	123.95
VT	101.17	100.09	91.40	90.43
WA	127.21	126.91	114.93	114.65
WI	111.82	112.30	101.03	101.45
WV	63.89	64.30	57.72	58.09
WY	128.57	132.28	116.15	119.50

Summary Of State Use Of IGTs And Recycling

State	(1) States that Do Not Use IGTs	(2) States that Use IGTs Appropriately	(3) States that have Revised Existing IGTs by Removing Recycling	(4) CMS Identifies Potential Recycling-States May Disagree	(5) Unknown-SPAs Pending Review	(6) No SPAs Submitted
Alabama			X(IH/DSH/NF/HHA)**		X(PHYS)	
Alaska	X (OP)			X (IH/NF)		
Arizona*		X(OP)				
Arkansas		X (OP/PHYS)	X (IH/NF)			
California	X (NF)	X(OP)	X (IH/DSH)**			
Colorado	X (IH/NF/PHYS)					
Connecticut	X (IH/NF)					
Delaware						X
DC						X
Florida		X (IH/OP/NF/PHYS)				
Georgia			X (IH/DSH/NF)**			
Hawaii	X (IH/NF)					
Idaho	X (NF)	X(IH)***				
Illinois				X (DSH) – X(NF)		

Summary Of State Use Of IGTs And Recycling—Continued

State	(1) States that Do Not Use IGTs	(2) States that Use IGTs Appropriately	(3) States that have Revised Existing IGTs by Removing Recycling	(4) CMS Identifies Potential Recycling-States May Disagree	(5) Unknown-SPAs Pending Review	(6) No SPAs Submitted
Indiana		X (IH/PHYS/OP/TRANS)				
Iowa			X (IH/DSH/NF)			
Kansas			X (DSH/NF)			
Kentucky	X (OP)	X(OLP)	X (IH/NF) (PHYS)**			
Louisiana	X (DSH)		X (IH/OP/NF)			
Maine	X (NF/OP)	X (IH)				
Maryland	X (IH/NF/PHYS)					
Massachusetts			X (IH/OH/NF)			
Michigan		X(PHYS)	X (IH/NF)			
Minnesota			X (IH—GME)	X (IH/DSH/NF)		
Mississippi		X(NF)		X (DSH)		
Missouri	X (IH)	X (PHYS)X (NF)	X (OP)			
Montana		X (IH/TRANS)	X (NF)			
Nebraska	X (IH)		X(NF)			
Nevada	X(NF)	X (IH/CLINIC)			X (PROF)	
New Hampshire	X (IH)		X (NF)			
New Jersey			X(NF)**			
New Mexico						X
New York		X (CLINIC)	X (IH/DSH/OP/NF)			
N. Carolina	X (PHYS)		X (DSH)			
N. Dakota	X(IH)			X (NF)		
Ohio	X (NF)	X (IH)				
Oklahoma	X (NF)	X (PHYS)	X (IH/OP)			
Oregon		X (IH/SBS)	X (NF)			
Pennsylvania	X (IH)		X(NF)			
Rhode Island	X (IH/NF)					
S. Carolina		X (OP)	X (DSH/NF)		X (OLP)	
S. Dakota	X (IH)		X(NF)			
Tennessee			X (NF)**			
Texas	X (NF)	X (IH/OP)			X (OP/PHYS)	
Utah		X (IH/NF/PHYS)				
Vermont	X (IH/NF)					
Virginia			X (IH/NF/OP)			
Washington		X(IH/NF)				
West Virginia		X (NF/IH/OP)				
Wisconsin		X (IH)	X(NF)			
Wyoming		X (IH/OP)				
Total States	23	23	27	5	5	3

*Has not submitted any IH/NF SPAs
** Final SPAs to be submitted/approved
*** Final documentation of procedures pending
−Cook County DSH

Key: NF—Nursing Facility Services; IH—Inpatient Hospital Services; DSH—Disproportionate Share Hospital; OP—Outpatient Hospital Services; SBS—School Based Services; GME—Graduate Medical Education; Trans—Transportation; Clinic—Clinic Services; Prof—Professional Services; Phys—Physician Services; OLP—Other Licensed Practitioners; and HHA—Home Health Agency

Mr. THOMPSON. Mr. Chairman, could we see that letter?

Mr. SHAW. Yes, I will have it distributed to the Members.

Mr. THOMPSON. Thank you.

Mr. SHAW. Ms. Hart?

Ms. HART. Thank you, Mr. Chairman.

Mr. Secretary, thank you for taking the time to come before us at a very critical time for making sure that Americans are being provided with the services that they expect. Obviously, in a time of transition, there is some pain. We are trying to make sure that we address the problems and certainly fix them.

We have had in my State of Pennsylvania a significant number of glitches; however, I do appreciate your quick response to many of them at this time.

One of the things that has happened, I think, that some of the other Members have addressed a little bit has been the challenge regarding dual-eligibles, those who are covered by Medicare and Medicaid, as they transition from Medicaid to Medicare. Under the system, some of the States, especially Pennsylvania, have spent a significant number of resources sort of filling the gap during the transition, and I know CMS has acknowledged that they will be made whole for these expenditures.

Can you give me an idea of how that is going to be done? Is that going to come out of some of the insurers that you have contracted with? What is the plan for that at this time, if there is one?

Secretary LEAVITT. Let me reconcile the whole experience and then specifically answer your question.

It became evident to us in early January that for the vast majority of people the system was working, but for some it was not. When they went to the drug counter for the first time, the system did not know who they were.

We found that there were two basic problems. First, when people enrolled late, that is to say, if they enrolled in the plan on December the 28th and then they went to the drug counter on the 2nd of January, the enrollment had not yet been accomplished. Consequently, it set off a series of manual transactions that the pharmacist had to do, and it took people more time, and it was frustrating to them. Likewise, if a person were to change plans late in the month, it had the same effect.

There was a second part of that equation, and that is that as the data was transferred from, say, the State of Pennsylvania to CMS or from CMS to an insurance plan, the transition of the data was not always perfect, and the imperfection meant that there may have been Mary Smith in Philadelphia and there may have been 12 Mary Smiths. The pharmacist didn't know who it was and, consequently it caused more trouble. So, there were data-matching problems that there are always in a transition like this.

Consequently, at the beginning of the transition, there were about 10 percent—and many of them were dual-eligibles—that had to take more time at the drug counter. Now, States appropriately stepped up, and we cooperatively worked with them to say let's make certain that no one leaves the prescription drug counter with their prescription being filled. The State of Pennsylvania began to pay the pharmacists in situations where they were not certain.

We have committed to pay the States or to reimburse the States for what the plan would have paid. We will also pay additional ad-

ministrative expenses. Those will not come from the Federal budget—the administrative expenses will, but the cost of the drugs will come from the plans, and we will collect from the plans and give it to the States.

Ms. HART. So, the reimbursement then, to make sure that I am following you, would have been, had all the information been correct and up-to-date and in order, would have come from the plan; therefore, that is where it is going to come from ultimately.

Secretary LEAVITT. That is right. The plans received a premium for it, and they need to pay the claim. We will reconcile and make certain that the States do not have to deal with the plans. We will assure that that happens in a way so that it happens properly.

The States were extraordinarily helpful in all of this, and if anyone decides they want to change 25 million beneficiaries on the same day, again, they should talk to me. One of the suggestions I would make is exactly what we did, and that is to have the States there as a buffer so we can feather out any problems, which is exactly what we are doing. The system is getting better every day. It is not only a good deal for seniors, but we are working through this, and the system gets better every day.

Ms. HART. Before I run out of time, I just want to address one other issue as well, and that is specifically making sure that people with disabilities are getting services appropriately under the system. Is there some special thing that you are doing right now to help make sure that they are in line properly?

Secretary LEAVITT. We have been working with the States to assure that any of those who are in special need categories are given assistance. There have been those who have found it frustrating when they go to the drug counter and find that they have to wait until we can identify them in the system. People are getting their prescriptions filled, the vast majority of them without delay and in a very routine way. Some are having problems. That number diminishes as time goes on, and we are taking particular care of those who are disabled or in the class that you have referred to as dual-eligibles.

Ms. HART. All right. Thank you, Mr. Secretary. I yield back.

Mr. SHAW. Mr. Jefferson may inquire.

Mr. JEFFERSON. Thank you, Mr. Chairman.

Mr. Secretary, I don't know quite where to begin, there is so much to talk about. I appreciate your comments to Mr. McCrery, of my home State, about the opportunity you see there to build a world-class health care facility back home, but I am having a little trouble understanding what the steps are that you have in mind to get there; what the resources are that you have identified to get to that point in time.

I don't know if you have had a chance to read newspaper reports from back home about the doctors who have made the exodus from our city in the wake of the storm, some 4,000 or so before the storm, now some number of perhaps less than 1,000. Many of the ones who are there are specialty doctors who don't have general practices. Many are having a hard time. They have lost their businesses and patients have gone away, of course, so they don't have any—it is very hard to start up again. There are gaps in insurance,

and the Small Business Administration (SBA) is not working for them.

A lot of the programs that our area depended on heavily—you have mentioned already how you were there and how they had a difficult time getting services, even emergency care services. Imagine how bad that would be now compared to what it was then.

So, I would like you to help me identify what you want to apply with respect to the specific services support that will get us back to beyond where we were in the light of the fact that these important reductions in programs are very critical to us. They were critical to us back before the storm, and now even more so, and yet we are looking at cuts here that may hurt us.

One of the programs that is proposed by some of the doctors back home is to give them incentives to relocate, such as those that are given to folks to locate on Indian reservations and in rural areas now, incentives that are cut back in the budget, but which we were hoping we could add on to New Orleans to make it a special kind of place to attract doctors back, to give them support for salaries, to give them support for relief from medical school payments, that sort of thing.

Tell me, if you can, what are the specific resources available to us to get us to this world-class position you were talking about, that are in your budget now? What do you think of these incentives that we need to help draw our doctors back home?

Secretary LEAVITT. The best incentive for a physician to go back home is a health care system that works, and most of those people will tell you and me that the one that was there before didn't, and that if we can build one that does, it will be a big improvement, one they will want to work in.

Mr. JEFFERSON. Tell me how to do that, how you are supporting that.

Secretary LEAVITT. I met with the entire medical community, the leaders of the hospital associations, the medical associations, the insurance companies, with the hospital administrators and so forth, and said to them: You don't want Washington to design this for you. You want to do it yourself. Let's agree upon some principles. Instead of building a lot of tertiary care and expecting people to walk up to your emergency rooms, why don't we have a large number of community clinics where people can get preventative care. Why don't we use the Medicaid and the Medicare funds that we are already spending and the special dollars that have been allocated over the years to Louisiana to pay for its disproportionate share population, and design a system that not only includes prevention and wellness and electronic medical records, but also distributes health care in a way that people can reach out and get it.

If we could agree upon those principles, I would be prepared, I conveyed to them, to spend considerable time and considerable resources from Medicaid and Medicare and the other sources that are available to design a new system that will work and work well and serve everybody.

Mr. JEFFERSON. You would be committed to substantial new resources?

Secretary LEAVITT. There are existing resources——

Mr. JEFFERSON. Well, that is what worries me.

Secretary LEAVITT. There is no health care system in greater New Orleans right now and substantially fewer people. If we can redirect the resources that are there, and there is $2 billion that was included in the DRA, a big portion of which went to pay for Medicare expenses that have already been conducted, but what is left over is available. That is a substantial amount of resources that we have discretion to use.

Mr. JEFFERSON. The other thing I would like to ask you to address for me, although there is no time for it now, your Department invests a lot of money with the Institute of Medicine reports, various ones that talk about overcoming gaps in medical attention, research, and treatment of minority populations versus the larger populations in the country. For instance, the National Health Care Disparity Reports released in 2003, 2004, and 2005 to your agency illuminate a number of organizational, programmatic, and funding priorities that have been recommended to your agency as a result of your having contracted for them. Yet we don't see these being implemented in any meaningful way. Are there plans to take these reports and put them into action on your watch?

Secretary LEAVITT. A good example would be the new HIV/AIDS initiative. We all know in this room that a very high disproportion of minority citizens are in the group who are struggling with that disease, and the initiative will be used to target and to assure that they get the help they need.

Mr. JEFFERSON. I agree with that and I thank you for that, but the recommendations that are most outstanding for them, that are most continuous are the ones that relate to Medicaid and Medicare. I wish you would take a closer look at those and incorporate that into the Department's program for this coming year. Mr. Chairman, I would like to have a chance to submit this to the Secretary, and ask him in the name of the Committee to please make a response to these. There are so many questions here about these issues that I cannot get to them all now.

[The information was not received at time of printing.]

Secretary LEAVITT. Yes, sir.

Mr. SHAW. The time of the gentleman has expired.

Mr. Foley.

Mr. FOLEY. Thank you very much, Mr. Chairman. Welcome, Governor. Let me first just take a minute on HSAs, because I think it is important for consumers to be empowered when it comes to health care. People in my community join Costco. They pay a membership fee to save money on household items. They will drive across a busy intersection to save a penny on a gallon of gas, and they will drive around town looking for an additional quarter percent interest on a Certificate of Deposit (CD). When it is their money, they are concerned about how they spend it. Under the current rules of engagement, insurance providers, others: "Don't worry, it is covered. Your insurance will take care of it." No one asks fundamental questions.

I was in the restaurant business. An all-you-can-eat salad buffet, people load up their plates. If it is 10 cents an ounce, they take only the items they want and what they like. We have to empower consumers. It is not always that easy, but I believe people make best decisions when it is their money.

Community health centers. We had a dedication last week. The speaker complimented the Republican leadership, particularly the President for his focus on community health centers. The person doing the introduction was a Democrat. Sitting in the audience, the phrase was not specifically for me. My colleague Alcee Hastings was there. We have made phenomenal gains, and thanks to the $600,000 grant to that center, they are going to be serving minorities, AIDS patients, and others who currently do not have access. We are taking people out of the expensive emergency room settings and putting them in family user-friendly.

I represent some Indian reservations. Those people are now in community health centers in the community because on the reservation they did not have the professionals to treat the patients. So, when I hear people using pejoratives like they are being "thrown out of" the reservation and into some inadequate health care—let me remind my colleagues, go visit some of those sites on Indian reservations. You will see the apparent need for quality professionals to serve that underserved community. Your community health centers are providing that.

Let me also thank you for the $53 million allocation to displaced residents of the States impacted by the hurricanes—Wilma, Katrina, and others. The $53 million to Florida, we sincerely appreciate it. Let it not be lost on any of my colleagues, particularly those who attended a funeral yesterday—Louisiana is getting $220 million, Mississippi $128 million. So, the money is going to people who desperately need it, regardless of ethnicity, color, or background.

Let me also ask you a very important question, and I thank you because I know Mr. McCrery and Mr. Shaw and I have all sent you a letter on the issue of IVIG, and I have your response, which is heartening, that you acknowledge not only the concerns of the Administration, your office particularly, but are also looking to provide some intermediate assistance. I know there has been a huge cry for help from our community participants in providing this lifesaving treatment for patients with primary immune deficiency diseases, neuropathies, and a number of other disorders.

It has been shocking, the lack of opportunity and access, the costs, and so if you could just take the remaining time and give me a little bit of comfort. I know your letter does provide it. I entered my questions into the record so that we can have a follow-up to those specifics. I also notice in your letter, you strongly suggest that you and other agencies will be working with patients, product manufacturers, distributors, physicians, and hospitals. If you could elaborate.

Secretary LEAVITT. Thank you, Congressman. I would like to give you my direct assurance that we will be working with you and the other Members of Congress and your staff to resolve this situation. The CMS has established a temporary add-on payment for 2006 for physicians and for outpatient departments who administer the IVIG to Medicare patients. The physician can also contact the manufacturer to report problems, but we are on the problem, we understand it, and we want to resolve it.

Mr. FOLEY. Great. That assurance is swell, and now I see my yellow light, but I also wanted to thank you particularly for Florida, as we embark on our Medicaid modernization, to try and find better ways to serve the community, those most needy. You have given us the flexibility. We are watching it carefully. I know there has been a lot of conversation on Part D. Some people have wanted to extend the deadline from the day we started enrollments. We understand there is a problem. We have expressed the concern. We want our constituents to be able to carefully enroll in a program. There is a reason April 15th is the date your taxes are due to the IRS. If you don't have a fixed deadline, no one will sign up. They will continue to push back and wait.

I know you understand the concerns. I know you also understand the confusion. People should be a little patient. We have seen statistics that indicate a lot of people have enrolled in this very valuable program. So, to call it a failure, to call it so utterly confusing that people cannot figure it out, I think, demeans the senior citizens we serve. They made it through depressions. They made it through Korea, World War II, Vietnam, all the other conflicts of this world. Some people act like they cannot figure out a simple form. So, I look forward to working with you on making certain people get the benefits that they are entitled to.

Secretary LEAVITT. Thank you.

Mr. SHAW. The time of the gentleman has expired.

Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman, and thank you, Mr. Secretary. I gather, Mr. Secretary, you agree with Chairman Thomas's opening comments that the implementation of this prescription drug coverage is one of the Administration's real success stories.

Secretary LEAVITT. I think we would all agree that having millions of people have prescription drug coverage who didn't before——

Mr. DOGGETT. As to how many millions fit in that category—you have had all of 2004, all of 2005, we are now into 2006, and the millions that you have covered who were not covered when the President signed the bill into law in December of 2003 is about 3.5 million. Isn't that correct?

Secretary LEAVITT. Sir, we have been enrolling people since October 15th.

Mr. DOGGETT. Yes, sir, and you have had——

Secretary LEAVITT. November 15th.

Mr. DOGGETT. —really 2 years to get ready for it, and you have enrolled—when you say millions, you have enrolled exactly 3.6 million, haven't you, that didn't have coverage before.

Secretary LEAVITT. There are 24 million people who participate, and many of those would not have prescription drug coverage today who may have had it a year ago and may well not have it next year.

Mr. DOGGETT. Everyone—well, I understand the speculation about next year, but of your 24 million that you all boasted about today, only 3.6 million lacked coverage of some kind when this bill was signed into law, right?

Secretary LEAVITT. Medicaid has been in law for 40 years, and there are still 50 percent of the people who are eligible, regrettably, who have not yet signed up.

Mr. DOGGETT. Yes, sir, I am glad you make that point, and I assume you don't disagree with my 3.6 million figure or would have said so. You actually have reduced since last year in your publication in the Federal Register of 39 million people you were—of America's seniors that you were going to target to cover, that you would probably only get to 29 million this year, right?

Secretary LEAVITT. It became evident to me that 28 to 30 million would be a great success. The actuary established a 39-million-person limit——

Mr. DOGGETT. Is this——

Secretary LEAVITT. —but in our judgment and the judgment of those who look at it from Wall Street and the markets, we believe 28 to 30 million is a reasonable number.

Mr. DOGGETT. About 10 million or 11 million less than last year. With reference to this program, you refer in your written testimony to the President's comment about being good stewards of tax dollars. I gather it is also your belief that the implementation of this prescription drug program is one of the best examples of being a good steward of tax dollars, just as it is a good example of success for this Administration.

Secretary LEAVITT. I think there is no question the fact that the market is now driving the cost of prescription drug coverage down is something we all ought to cheer.

Mr. DOGGETT. The cost to the taxpayers of this bill currently is estimated to be over $700 billion for this decade, right?

Secretary LEAVITT. The cost is coming down, and that is good news.

Mr. DOGGETT. The cost to the taxpayers, the estimate still is over $700 billion for this decade, isn't it?

Secretary LEAVITT. The cost estimates are as they are, and I am not——

Mr. DOGGETT. You are not familiar with what it costs?

Secretary LEAVITT. I am familiar with them, but there are lots of ways to express it, and what is clear is that we are seeing a dramatic reduction in the cost of prescription drugs for consumers——

Mr. DOGGETT. Comparing that reduction——

Secretary LEAVITT. —and it is because of the consumer—because of the fact that consumers now have choice——

Mr. DOGGETT. Yes, sir, and comparing that reduction in cost with a program that existed before this bill was signed into law where the Federal Government does some negotiating for our veterans to reduce their costs, you are also familiar, are you not, with the study of the top 20 most prescribed drugs, that if you take the very cheapest prices that these plans are now getting under the Republican prescription drug bill and you compare that to what the Veterans Administration negotiated on behalf of our veterans for their drug prices, that the veterans are still getting theirs at about half the lowest cost under these plans, aren't they?

Secretary LEAVITT. I am not familiar with that study——

Mr. DOGGETT. Not familiar with the tremendous savings——

Secretary LEAVITT. I don't think it is necessarily the——

Mr. DOGGETT. —that we get when you use negotiating power. You don't suggest that if your office on behalf of all Medicare recipients were involved in trying to negotiate the highest prices in the free world on prescription drugs that our uninsured folks have had to pay, that if you were involved in negotiating you couldn't get the prices down to a more reasonable level than what your most successful plans are achieving?

Secretary LEAVITT. If that were the case, Secretaries of Health and Human Services would have used that authority with Medicaid, which is now the most expensive—until the DRA, is the most expensive drug plan——

Mr. DOGGETT. You think——

Secretary LEAVITT. The truth of the matter is the best way to reduce prescription drug costs is to have a market, which we now have for the first time, and we are seeing dramatic reductions in prices for all consumers——

Mr. DOGGETT. So, you continue to oppose giving any negotiating authority as this bill does——

Secretary LEAVITT. It is not the best way to bring prices down. We are seeing the best——

Mr. DOGGETT. One other quick area——

Secretary LEAVITT. —way, which is very clearly bringing the cost of prescription drugs down.

Mr. DOGGETT. One other quick area, since my time is expiring, President Bush made history last year by being the first President in memory, I think, to call a White House Conference on Aging and then not show up for it. The first recommendation of that conference was to increase funding for the Older Americans Act (P.L. 89–73), which in real dollars has fallen every year of this Administration. Under your budget, does that trend continue where you continue to cut the real dollar purchasing power available through the Older Americans Act for seniors across this country?

Secretary LEAVITT. I am not able to respond to that question directly. We will be happy to get the information to you.

Mr. DOGGETT. Thank you. I believe it does, that the trend continues, that the seniors who are relying on the Older Americans Act, the first priority of a White House Conference on Aging, which was mostly Republican-selected Members through the White House and otherwise, that that objective is not being met. Thank you, Mr. Chairman.

Mrs. JOHNSON. [Presiding.] Mr. Herger?

Mr. HERGER. Thank you, Madam Chairman. Mr. Secretary, I want to join in thanking you and commending you for being part of the Administration, for bringing your expertise, and the manner in which you are dealing with these incredibly important issues.

An issue that I have been involved with as Chairman of the Subcommittee on Human Resources that I know you are very much familiar with has to do with welfare reform. My question has to do with an area that I believe we have had some of the greatest success ever with the welfare reform in 1996. We have seen welfare rolls, where we have seen those who were on welfare, families, being able to go out and find work, being able to be trained for work, being able to be prepared, and being able to return to the

workforce. We have seen those that are on poverty, the poverty levels, drop dramatically because of that.

So, my question has to do with that, a follow-up to that on what the Administration is doing now. The DRA, which the President will be signing later today includes provisions to promote even more work and assist even more to be able to work among welfare recipients. This law will expect all States to engage 50 percent, just half of those that are welfare recipients today, in work or training starting next year. Some say that is too tough but I disagree, and I would hope we could encourage even more to be out engaged in either work or being trained on being able to get jobs.

Could you, Mr. Secretary, talk a little about the efforts your Department has started that would better uncover the work that is already going on, already going on but not reported, which would help States meet this goal of 50 percent? Specifically, can you talk about using the National Directory of New Hires and what results you have see thus far from these efforts?

Secretary LEAVITT. Congressman, to give you specifics, I will need to submit them to you and for the record. I will, however, reflect a little on this subject from my days as Governor.

I was quite deeply involved as Governor and also as Chairman of the National Governors' Association in the development of the original welfare reform and the implementation of the Temporary Assistance for Needy Families (TANF) program. I can tell you that the work requirements have been a very important part of the progress we have made, not only the progress institutionally and as a government, but in the individual lives of people. We have given people a sense of motivation that has been critical to their own sense of self.

Now, I want to be clear that there is not a Governor or a Secretary that I know that isn't anxious to assure that the lives of those who are truly in need, that their needs are met, but helping them establish a sense of purpose and having the training that is necessary changes lives in very personal and deep ways, and I have seen it personally, and I am proud to be part of it, and it is time for us as a society to raise our expectations one more notch.

Mr. HERGER. Thank you, and I agree completely. In another area, the DRA proposes $150 million per year in new funding for healthy marriage and responsible fatherhood services. As we know, it is—as a parent—I am a parent. Most listening are, most of us. It is difficult enough to raise children with two parents working let alone, as we see, so many families with just one.

Your budget suggests $250 million per year for these purposes. Since the President is just now signing the DRA which overlaps with the release of the budget this week, I wanted to be clear that you are still proposing an additional $100 million per year in funding for these programs on top of what is provided for in the welfare reform provision of the DRA. Beyond just the level of funding, could you discuss what the Department hopes to accomplish with these funds?

Secretary LEAVITT. Congressman, in the early testimony I made, I indicated that one of the principles that I believe in, a principle of investment, is that you invest in prevention, not just treatment. Most of the funds we spend in our Department are fo-

cused on treatment. We are picking up the pieces after something has gone wrong.

The money that is being proposed to strengthen healthy marriages is about prevention. It is about helping prevent the devastation that often comes when families, the unit of our society that ultimately we have to depend on for the vast majority of care that occurs, to strengthen them and to strengthen the prevention of bad things happening.

Mr. HERGER. Thank you very much, Secretary Leavitt.

Mrs. JOHNSON. Mr. Pomeroy?

Mr. POMEROY. Madam Chair, Mr. Thompson was here before me, and if you are calling in order, I have to acknowledge that.

Mrs. JOHNSON. Mr. Thompson?

Mr. THOMPSON. Thank you, Madam Chair. Thank you, Mr. Pomeroy. Mr. Secretary, thank you for being here. I want to get back to this issue of California. I have another letter that came after my colleague Mr. Becerra's letter, where the Governor mentions that he has talked to you a number of times, as you indicated. As of 5 days ago, California was still paying for about 11,000 prescriptions a day. The Governor has asked—I guess the State has asked—for some certain data from your shop. I guess I want to know when can California expect that they can and the program off to you where you will be fulfilling your responsibility and paying for it. Then, also, what is the status of the data? Are you collecting the data, and can they expect to get answers to their questions anytime soon?

Secretary LEAVITT. The data that they have requested is being provided, and I will tell you that I have asked the Governor to work for a transition as of the 15th of February, one that we are confident can be made.

Mr. THOMPSON. If it is not, is there an extension in the works?

Secretary LEAVITT. We are prepared to make an extension if the States are, in fact, doing what they need to do to take care of this. I have waivers signed now with 30 States. California is not one of them. I did have a conversation with the State of California's representatives a day or two ago, informing them that we were going to be able to return $113 million to them that was savings because of the prescription drug benefit and the——

Mr. THOMPSON. Notwithstanding that, the issue that I was interested in is the fact that California is having to pay for and do the Federal Government's work on 11,000 prescriptions a day. They don't feel confident—as a matter of fact, I will read from the letter. It says, "It is my intent and the intent of the California Legislature to extend the program beyond this date because we are not yet satisfied the problems we have discussed have been fixed to adequately protect California's 1 million dual-eligibles." So, they want some assurance that this is going to happen, and they are looking for the data that I mentioned, including how these systemic problems have been addressed and exactly how many of these have been covered.

Secretary LEAVITT. We have the data, and it has been provided and it is being provided. It is ultimately going to require that the State begin what I refer to as pressurize their system. If they just take all the—if they continue to pay claims the way they are now,

there will be a limit, frankly, the length of time that we are prepared to assure their reimbursement. I have given him every assurance that we are prepared to assure that they——

Mr. THOMPSON. Well, I think our Republican Governor wants to make sure these guys are covered, and they are willing to work with you to make sure that that happens.

Secretary LEAVITT. I am pleased about that, and I flew to Sacramento and I met with him personally. I have talked with him several times. I will——

Mr. THOMPSON. He mentions that in the letter, but as I say, the letter was dated February 6th, and it mentions that although you have had phone conversations and a meeting, the data has not come to them, and they are not confident——

Secretary LEAVITT. There is no reason to think that California is any different than the 30 States which we have been able to strike a waiver with, as they seem to think they are. We are prepared to work with them. We hope very much we can do it. There will be a limit to which I am prepared to make——

Mr. THOMPSON. Thank you, Mr. Secretary. If you could—you say you have the data. If I could get copies of that so I could——

Secretary LEAVITT. We will be happy to supply you with the data.

Mr. THOMPSON. On the State Health Insurance Program (SHIP), I haven't had the same experience as some of the other folks on the Committee, nor the experience that you explained. I hear from a lot of my constituents that they are having trouble navigating through the difficulties of this prescription drug program. What we are finding is that the SHIPs actually help, and I guess you recognize that yourself, and your shop has said that individual counseling has been working wonders. I am interested in knowing how that is dealt with in the budget.

It looks like there is not enough money to provide them with the staff and the ability to provide this counseling, and I guess the money is combined with some other moneys. So, I would like to know how the SHIP funding breaks out. If you do agree that this is the most effective way to help people sign up, why aren't we funding them at a level that is required?

Secretary LEAVITT. The State Health Insurance Implementation Plans have been very helpful, but, gratefully, they are not the only avenue. They have been one. There are 30,000 pharmacies that have been heroic in their——

Mr. THOMPSON. How much funding are they going to get?

Secretary LEAVITT. I don't know the exact budget number, Congressman. I can get that to you, but I can tell you I have met with them all over the country, and they are doing heroic work and they are doing helpful work. This is a conversation——

Mr. THOMPSON. Can we try and get them the level that they need to fund their program?

Secretary LEAVITT. We need to fund them to the extent that they need, but I want to make clear that they are not the only way in which enrollment takes place. We are enrolling 250,000 people a week in this program, and it is happening with increasing efficiency. It is not easy to bring a new benefit, the biggest change in 40 years, and people are working through it. The system is better

every day. As a pharmacist in Alabama told me, there are a few bumps but it is getting better every day, and that is——

Mr. THOMPSON. I don't disagree with you, Mr. Secretary, but if the community-based outreach level of funding, the $43 million—if the SHIPs got all of that, that would equate to only a dollar per constituent that they counsel, and that is just not adequate.

Secretary LEAVITT. As you know, the SHIPs are for the most part volunteers, and those are highly leveraged dollars, and they are a good investment, and they do a wonderful job. It would not be reasonable for us to assume that all of those who are enrolled will be enrolled through the SHIPs. We need to have senior centers, churches, pharmacists, health care workers, and families. I will tell you that the biggest source of enrollment has been the children of mature Americans who have been willing to sit down——

Mr. THOMPSON. I have heard from them, also.

Secretary LEAVITT. Well, it is a very important part of this, and they need to help.

Mr. THOMPSON. I have heard very few positive stories from those children, but, Madam Chair——

Secretary LEAVITT. We appreciate the fact that they worked through it.

Mr. THOMPSON. Thank you, Mr. Secretary. I would like to ask unanimous consent to submit this February 6th letter from Governor Schwarzenegger into the record.

Mrs. JOHNSON. So, ordered, but I thought that letter was submitted earlier.

Mr. THOMPSON. There are two different letters. Mr. Becerra had one that was from, I think, earlier in the month or from last month. Mr. Shaw's letter that he referenced was not from California. It was a letter from the Secretary's shop to California, and it dealt with the clawback, something completely different than what we are talking about.

Mrs. JOHNSON. Thank you, so ordered, and if the Secretary would like to submit the answer he sent back to either of those letters, we would be happy to include them in the record as well.

Secretary LEAVITT. Thank you.

[The information follows:]

State Capitol
Sacramento, CA 95814
February 6, 2006

The Honorable Michael O. Leavitt
Secretary of Health and Human Services
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Secretary,

I write today to follow up on our meeting on January 19, 2006, and our phone conversation on January 24, 2006, regarding the implementation of the new Medicare Part D Prescription Drug Benefit.

As you know, on January 20, 2006, I signed Assembly Bill 132, which established an emergency program intended to serve as the payor of last resort for individuals who are unable to receive their prescription drugs from Part D due to problems in the Medicare system. The legislation appropriated $150 million to provide services under this program, which expires on February 11, 2006. It is my intent and the intent of the California Legislature to extend the program beyond this date because we are not yet satisfied the problems we have discussed have been fixed to adequately protect California's one million dual eligibles.

While I agree with you that Medicare Part D is a federal program and it is the federal government's full responsibility to ensure the program's success, as Governor, I cannot allow California's most vulnerable residents to forfeit their access to the prescription drugs they need to survive. It is California's desire to discontinue our emergency program as soon as the State has confidence that our dual e1igible residents will receive the prescription drugs they need under the federal program.

For us to be confident that our residents are protected, we need one of two things from the federal Centers for Medicare and Medicaid Services (CMS). First, as we have discussed previously, the State of California needs data from CMS that proves the systemic problems in the program have been resolved. As of this point, CMS is not providing data on system performance, data accuracy, or even the number of cases that CMS caseworkers are resolving. The State bas repeatedly requested from CMS data that will allow us to measure the extent of the problem and quantify any improvements. Without this data, it will be nearly impossible for California or your Department to make an informed decision as to when the State should discontinue its emergency program. I ask you to direct CMS to deliver this data to the states as soon as possible.

Second, as I have also mentioned previously, I believe that the federal government has a viable option to make it easier for the states to end their emergency programs. CMS is currently employing the services of WellPoint, a Medicare Part D Prescription Drug Plan, to serve as the fail safe mechanism to assist those individuals who are "falling through the cracks" and have not been assigned a plan. I believe that CMS should expand the role of WellPoint to pay for prescriptions where there is an error in eligibility, including copayment amounts or an incorrect denial of a drug. Further, I believe that CMS can assist WellPoint with the resources to make this solution work. Again, I encourage you to exercise that option as soon as possible because it is a viable option to enable states to end their emergency programs.

As we have discussed, the federal government must fully reimburse California for the costs the State has incurred because of the difficulties with implementing Part D. I appreciate that you and CMS have worked quickly to identify a process that will allow states to recoup some of their costs. However, I understand that your proposal will not cover all of California's expenses because your proposal does not cover the costs of the Part D copayments. This decision guarantees that California will be forced to pay a portion of the costs for this federal program—this is unacceptable. The State stepped in to protect residents of California because of problems with a federal program; California taxpayers should not be forced to shoulder the financial burden of fixing a program that is the federal government's responsibility. The federal government must pay states the Medicare reimbursement amount for services provided and must not reduce that reimbursement by the Medicaid copayment or any other amount. I ask that you direct CMS to cover all of the costs the states incur.

I understand that you plan to make this reimbursement mechanism available for costs incurred through February 15, 2006, and that this deadline can be extended as needed. I look forward to working with you to ensure that states are fully reimbursed for our efforts to protect our most vulnerable beneficiaries and I encourage you to extend this deadline if Medicare and Medicaid eligibles continue to have problems receiving their prescription medications. I intend to continue to work cooperatively with you to ensure that the nearly one million Californians who are dually eligible for Medicare and Medi-Cal have access to the prescription drugs that are essential to maintaining their health.

Sincerely,

Arnold Schwarzenegger
Governor

Mr. THOMPSON. Could we submit other questions to be answered?

Mrs. JOHNSON. Yes, you are always free to submit written questions. Mr. Brady?

Mr. BRADY. Thank you, Madam Chairman. Mr. Secretary, thank for being here today. Partisan comments aside, I think the criticism of the rollout for Medicare in whole are fair criticisms, but I think it needs to be understood that in a major reform, an improvement of a program like this, there are bound to be glitches.

We are dealing with a lot of seniors who can be hard to reach. The ones we are most determined to reach to provide them help sometimes are the toughest to get to. Lots of glitches in the system. We know this will be a difficult year, but in the end—I know in Texas, one-third of our seniors who are the poorest are going to get the most help. My neighbors who are on the plans—it is starting to work and they are seeing a reduction in their drug prices, and while in Texas, too, we are concerned about budget items, I think we are most—I am most concerned about those seniors' budgets. This Medicare plan is going to make a huge difference in a lot of seniors' lives. I love the thought that rather than government handing them a Medicaid-plus program, we have all these drug companies competing against each other to sell them at the lowest price and the most accessible drugs. That is a huge change from the government knows best approach. I think in the long run this will be very, very helpful to our seniors.

Let me talk about Hurricane Rita. In the regions in Texas that I represent, ours are the border counties. They took in first almost half—400,000 of the Katrina evacuees. We are thrilled to have them, and we know if the situation were reversed, Louisiana would be taking us in. So, we are glad to have them.

Hurricane Rita actually is sometimes described as "the forgotten hurricane" because not only did we have the Katrina evacuees, but Hurricane Rita actually landed at a higher wind speed than Katrina. It did more damage to the electrical and water and sewer grid than Katrina, did more damage to the refineries along our coast than Katrina. In many of our counties, 60 percent of the homes are damaged or destroyed. It wiped out our timber industry, and that is a crop that takes 40 years to regrow.

We are really struggling. In fact, because we have so many of our Katrina folks in our hotels and now in our apartments, we cannot get back our own workers to try to recover and rebuild. So, we are in quite a jam.

I was very angry at the U.S. Department of Housing and Urban Development's (HUD) decision to basically turn their back on our Hurricane Rita communities last week in their allocation of the community development block grants. I was pleased to see today the allocation for Texas of $88 million in social services block grants to help in health care and those issues. It is about a third of what we need, but it is a huge step forward. We appreciate that allocation. We know we will be back, both in Congress and with your agency, your Department, to ask for more.

My only comment—it is not even a question. I just would ask for your continuing commitment, as you have already shown, to helping our communities not be forgotten; help us recover and dig out of this hurricane while we also take care of our Katrina neighbors, whom we are glad to have with us. Any comment you want to make, Mr. Secretary?

Secretary LEAVITT. Thank you. I am appreciative of your acknowledgment of the Social Services Block Grant and the allocation that is an attempt to do just that, but I think it is also important for us to continue to remember that the recovery of people and their lives is a huge part of a disaster, and we can learn good lessons from Katrina and Rita and Wilma this year.

Mr. BRADY. We were very disheartened by HUD's decisions. We are heartened by HHS, so thank you for helping us move back into progress.

Secretary LEAVITT. Thank you.

Mr. BRADY. Thank you, Madam Chairman.

Mrs. JOHNSON. Thank you. Mr. Secretary, it is my turn to question now, so I have the privilege of welcoming you to our hearing, and I look forward to working with you in the months ahead on the issues that you have addressed. I do want to share with you, as we open, a comment from a constituent, Gail Glizewski. Gail says, she told me, "I am the happiest senior citizen in town. All you have to do is call for help. I am going to save $2,000 a year. The Medicare drug plan has given me security for the future and peace of mind."

Honestly, I never saw a happier face, and I really commend you and your staff, all the way down to your staff, for the energy and determination you have brought to planning the implementation of this program and dealing with the problems, which have been challenges. I thank you for your leadership. That first weekend I could call down here any time practically day or night and speak to one of the top people at CMS because they were on it, they were working with the plans, and they were working to help individual seniors and individual small pharmacists. I am pleased to say that as I have gone around my district in the last week and talked to the small independent pharmacists, they now see the problems as having been either worked out or are being worked out, and I thank you for that.

I also want to mention that the analogy to the VA is misleading. The VA provides a much narrower formulary and only delivers it to a few hundred hospitals. We provide a very broad formulary, and we are delivering it to every senior and their nearby pharmacies all across the country. I am proud of the breadth of the formulary that you put out there, and I am proud of the job you have done to implement it. The fact that costs are 20 percent less than expected, who would have ever thought? It would never have happened under a command-and-control pricing system. In fact, one of the things we had to do was fix those old pricing systems because we were paying more than anyone else in the market. So, it is a good job.

I was the chief sponsor of the Children's Health Initiative, and we expected 6, 8, 9 million kids would be signed up. The first year, 660,000. The first 2 months you have signed up 21 million. That is simply an incredible record, and I thank you for it because Gail is not the only one. I have had seniors who saved $4,000, $5,000, and I honestly think it is unfair but also unethical that, whether you are news outlet or an individual Member of Congress, that you give more time to the complexities and challenge of the program than you do to the benefits, because of the seniors who have called my office, a significant proportion haven't even tried to register because they are scared. That is terrible. We should be part of educating; we should be part of reminding them of the security and the help. The average savings per prescription is $73 across the country. So, I urge my colleagues, get your answers, but urge people to

sign up, urge them to call. I wanted to be sure to get that on the record.

I want to go on, though, to the Health Technology Initiative that not only is in this budget, but that you personally have really led. I want to ask you how is the National Coordinator of Health Information Technology and the Agency for Health Care Quality and Research going to divvy up this money and what is going to be the relationship between that and the American Health Information Community?

Now, that is a lot of gobbledygook for those listening, but the bottom line is that under your leadership, implanting health technology in the cities through the community health centers and others, encouraging collaborations between community health centers, hospitals, and doctors is actually meaning now we are reaching the uninsured and bringing them into the system with electronic health records. I would not want to say that collaboration through the WAT program and others in any way hampered by budget decisions. So, could you talk about your Health Information Technology Initiative and our efforts to reach the uninsured and the homeless?

Secretary LEAVITT. We have a clear vision of a health care system that is interoperable, where medical records can be the part of the life of every American if they choose. The vision will produce lower costs, fewer medical mistakes, higher quality, and, frankly, less consumer hassle. By the end of this year we will have taken significant steps to accomplish that vision. By the end of this year, we will have basic electronic records standards that will be usable. We will have standards established and implemented on consumer empowerment and on chronic care management and a very important one, biosurveillance, the ability to take information from emergency rooms for public health purposes and for our homeland security purposes.

This is a movement that has to happen because it is at the heart of every aspect of health care. If we are going to see consumer costs constrained, it will be in part because we have used the efficiency of technology. If we are going to see wellness improve, it will be in part because we have access to information. If we are going to see physician payment systems improved, it will be because we have information technology. If we are going to see quality improvement to where people are spending less because they are healthy, it will be because we have improved information technology. It is at the heart of all of those, and we are working hard. By the end of this year, we will use the money in this budget to have actual deliverables.

Mrs. JOHNSON. Thank you very much. I agree. It is one of the key answers to controlling Medicare costs while improving quality. I thank you.

Mr. Larson?

Mr. LARSON. I thank the gentlelady from Connecticut, and I thank you, Mr. Secretary, for your service to the country. I just have first, more of an information question that I hope you can provide the Committee. Last November, the Committee's Democratic staff asked CMS to provide a detailed breakdown of Medicare beneficiaries by congressional district, including the number of duals, number of Medicare Advantage enrollees, age versus disabled, and

other points. This is something, as you know, that the Social Security Administration (SSA) does for Social Security benefits, and it is enormously helpful for everyone, regardless of party affiliation or policy position. In fact, it has been very helpful for me with regard to my district. Yet we have had trouble getting basic data of this sort out of CMS, and I am hoping you might be able to help along that line.

Secretary LEAVITT. I will do my best.

Mr. LARSON. I thank you for that, and that is very important. I think there are an awful lot of good questions, and I do a lot of hearings throughout my district as well as forums, because I do think it is important to provide everyone with all the information that they can have. There are winners and losers in this system. There is no question about that from what I have found. We encourage everybody that we come in contact with to sign up.

There isn't a single hearing that I conduct where people don't wonder aloud why it is that we prohibit you from negotiating directly with the pharmaceutical companies. That is just the hard reality, that in law we prevent you from negotiating directly with pharmaceutical companies. There are many veterans who come to this meeting also and will cite specifically what the VA does on their behalf. So, you might imagine that it confounds the elderly when they look at this essential issue in terms of getting prescription drugs that are affordable and accessible to them. As I say, there are winners and losers in this program. There shouldn't be any losers in a program where we are seeking to provide the best benefits that we can for our seniors.

Would you lobby, would you take on the effort of negotiating directly with the pharmaceutical companies? There are several proposals, I know, including one of my own, before Congress to do just that.

Secretary LEAVITT. Congressman, I have traveled to, I suspect, 42 or 43 States regarding Medicare and stood in front of seniors and talked to them about their individual situations and answered their questions, and I can honestly tell you, if there are winners and losers, I haven't met the losers. I don't know how you lose on a program where you have the government subsidizing either 100 percent or 75 percent of your drug bill. This is a good deal for seniors——

Mr. LARSON. Well, I guess the seniors then in the groups that I have been talking to are struggling through 44 different choices that they have and coming up and saying, well, under this plan or that plan I may be advantaged or not advantaged, and I don't understand why it is that the veteran who lives next door to me pays a $7 deductible and I am going through all these machinations.

Secretary LEAVITT. Well, it may be——

Mr. LARSON. Would you call them winners?

Secretary LEAVITT. I would say it may be that their neighbor is in the veterans' plan, which has, in fact, one of the most restrictive formularies.

Mr. LARSON. Which goes directly to my point.

Secretary LEAVITT. It may have been one of the—it is one of the more restrictive formularies we have.

Mr. LARSON. They will take that restriction, I will tell you that right now.

Secretary LEAVITT. Then one of the good things we could do is have a plan in the choice of plans that would emulate that. If we had——

Mr. LARSON. Your predecessor said that he would, and he recommended negotiating directly with the pharmaceutical companies to lower the price. Tommy Thompson said that that is what he thought was the best way to go. Would you pursue that avenue?

Secretary LEAVITT. I believe that the best way to reduce prices is to have a robust, competitive market, and we have seen that demonstrated in Part D.

Mr. LARSON. If this was competitive, when the government is providing the money to the companies to compete against the government, how is that competitive?

Secretary LEAVITT. We have regulated prices in Medicaid, and——

Mr. LARSON. When every other Nation in an industrial economy negotiates on behalf of their citizens and we don't, we end up subsidizing them with our citizens. How is that competitive?

Secretary LEAVITT. We currently have a high number, some argue too many, but we have a high number of plans who are going to the pharmaceuticals and saying to them, "If I am going to be competitive in this marketplace, I have got to have your lowest cost." They are formulating their plans to be the lowest, and we are seeing the benefit in the form of lower prescription drug costs for the first time in decades. It is a fact. It is happening.

Mr. LARSON. Not according to the report that was most recently issued by Henry Waxman. In fact, you can go to drugstore.com, for that matter, and get lower rates than within the existing program. It is——

Secretary LEAVITT. All I can tell you, Congressman, all that needs to be said, is that when this program was started, the average cost to an American would have been $37 a month. It is now $25. I just sent back hundreds of millions of dollars to States who would otherwise be suffering higher costs because of it. Prescription drug costs are getting lower, and they are getting lower because we have a robust, competitive prescription drug market for the very first time, and that is a good deal for seniors, and it is a good deal for taxpayers.

Mr. LARSON. Respectfully, Mr. Secretary, you are an honorable man and so are all the people that serve on this Committee, but when seniors make decisions, "lower" is a relative term. When you are making the decision between the food you put on your table, how you heat and cool your home, and the prescription drugs that you have to take for your survival, "lower" is a relative term. We need the best possible price, and that happens when you negotiate on behalf of all the seniors impacted, not these narrow groups, not 44 different people negotiating. That doesn't create the kind of competition that we know in terms of supply and demand.

Secretary LEAVITT. Congressman, I would argue that for the first time in the history of this country, there is no reason that a senior should have the worry that their prescription drugs would wipe out their savings. That was not true before January 1st. It is

true now. We are seeing seniors who are not only having their health protected because they have prescription drugs they did not have before. We are seeing them save money, and we are seeing them have the peace of mind that they will not have their prescription drugs wipe their savings out. Is it a perfect plan? No; but for the first time, millions have coverage who did not, and that is good news.

Mr. LARSON. It is an imperfect plan that needs to be perfected by the willingness of the government to step forward on behalf of those seniors and negotiate a price for them where they can survive. Thank you.

Mrs. JOHNSON. Mr. Beauprez?

Mr. BEAUPREZ. Thank you, Madam Chair. Mr. Secretary, thank you for being here. I actually would commend the prescription drug plan. My seniors are very happy that that $36, $37 premium did not come true. What some of us thought would happen when free market principles are applied to health care actually did happen, that when you brought more, not fewer, and certainly not only one option to the marketplace, that it did drive prices down. In my State, we are seeing premiums around $22, $23, and the seniors are very grateful for that. Competition works everywhere else. People like choice everywhere else. I think this was a step in very much the right direction. Our seniors, as well as the taxpayers, are well served by it.

I want to ask a very, almost personal question because it relates specifically to one of my constituents, and I will get to it in a minute. In the DRA, we took some steps to modernize, reform Medicaid specifically, and Medicare. One of those steps related to oxygen and oxygen concentrators that are used by a growing number of seniors. Before my father passed away, he was on oxygen himself, so this does become pretty personal. Can you walk me through what we did in the DRA and specifically what in this budget might address the use of oxygen by so many of our seniors?

Secretary LEAVITT. The practice has been, when people use oxygen, to rent the machine and the service. It has seemed inconsistent to many in the Congress and to many of those of us who administer the program that service goes on and on and on, and at some point in time the machine is never paid for. It just goes on perpetually. So, the proposal is after 13 months of paying 10 percent a month of the cost of the machine, it ought to belong to the consumer. That just seems good sense, and it is good sense for the plan and good sense for the consumer himself or herself.

Mr. BEAUPREZ. At the end of that 13 months, you are not going to cut off payments to where people no longer get their oxygen?

Secretary LEAVITT. We just want them to own the machine.

Mr. BEAUPREZ. Okay. Well, in my district—and I believe probably nationwide—oxygen suppliers specifically sent out letters and informed their users, senior citizens whose lives depended on oxygen, rather obviously, that the Federal Government, this Congress, this Administration, you, I guess, were going to terminate their oxygen. Do you want to tell whoever might be out there listening what the truth is once again?

Secretary LEAVITT. It is true often that the enthusiasm of critics rarely has—they rarely temper their criticism with realism. In

this case, we simply wanted them to have a better deal. We wanted them to own the oxygen equipment. We wanted the government not to have to pay for it over and over and over again, and we wanted the oxygen companies to have a fair price but to not have an unfair price.

Mr. BEAUPREZ. Well, on durable medical goods, such as an oxygen concentrator, it isn't only the government in this case, which I am going to get to in a minute; it is about an 80/20 split with the co-pay that the individual pays. This is a case that was actually brought to me: Russ, on behalf of his wife, Jane, came to me and he said, "This doesn't make any sense. My wife is now on oxygen." He said, "Every single month, I am charged $31.87. My insurance provider pays almost $160." He said, "This is going to go on for as long as my wife lives and is on oxygen." On the back, he copied the concentrator. He said, "I can buy the thing for $635 complete with every bell and whistle." In just a little over 3 months, between his co-pay and the insurance company's payment, you own the thing. Now, what you are telling me is it will actually go on for 13 months and then we give ownership to the individual, to the patient, correct? Continue to provide the oxygen and whatever maintenance is necessary for the equipment.

Secretary LEAVITT. We want people to have the oxygen they need. We just don't want the taxpayers to have to pay an unreasonable amount for it. The system needs to work. It needs to work for taxpayers and for the beneficiary.

Mr. BEAUPREZ. It makes sense to me. I think it is shameless when you have individuals, such as my dad was before he passed away, that were absolutely dependent on every breath they took on that machine, to send them a letter and suggest to them that the Federal Government somehow is going to take away their lifeline, their oxygen. Absolutely unconscionable. I thank you for the explanation, and I yield back, Madam Chair.

Mrs. JOHNSON. Mr. Emanuel?

Mr. EMANUEL. Thank you. I would like to thank the Chairperson for the time, Mr. Secretary, for the hearing, to your father for being here, who I am sure is proud. As Mark Twain used to say, "At 13, I had concluded my father was a fool. By 17, I was shocked what he could learn in only 4 years." One of the—there is a whole debate about whether, in fact, in the budget the propositions are—as it relates to part B are cuts, slowing the rate of growth, and so forth. Let there be no doubt that by your own estimate, that is, the Administration's, $36 billion over 5 years saved. The Administration cites MedPAC as the source for these ideas.

I would like to bring your attention—because as we look for savings across the board, the President says in the State of the Union he would like to find savings. We have to be belt-tightening everywhere. The Medicare Payment Advisory Commission, the source that you all cite for your savings, also says we should eliminate the Preferred Provider Organization (PPO) slush fund, which would save over the same 5 year window $5.4 billion. That was not part of the President's recommendations in the budget, but MedPAC, which is what you cite for these cuts, reductions, slowing the rate of growth—however you want to talk about it—or including in the participation rate for those making over $80,000, MedPAC calls for

the elimination of the overpayment of private plans, saves $30 billion. I am not sure whether that was a 5 or 10 year number, but $30 billion there.

MedPAC called for the elimination of the double payments for medical education. That is a $5.5 billion saving. They also called for the removal of the extra risk fund, which is $19 billion. If MedPAC is going to be the umpire we use, i.e., you use—we talk often about MedPAC here as a source for giving us guidance on how to deal with Medicare issues—there are four recommendations that tally well over $60 billion in savings that we net. Whether it is omission—you didn't get the report, I am more than willing to send you the MedPAC recommendations, Mr. Secretary, if you didn't get them. There is $60 billion in corporate welfare in this deal that is not in the President's budget.

Now, there is some merit to the argument—and we have discussed it at length—of whether people making X dollars should pay a higher cost than those making below X dollars. There is a rationale for that argument. We will have that discussion. I have an indication I know we are going to lose, but what I am wondering is, if MedPAC is such a good source for this guidance on this policy, why were the other recommendations that were real dollars—these aren't rounding errors; we are talking about $30 billion: the PPO slush fund, the overpayment, the double payment for education, as well as the risk adjustment. We are talking about close to $60 billion totally omitted. So, if we are going to look for extra sacrifice across the board, everybody has to have some skin in the game, I am amazed at the omission in the budget of savings.

Now, that doesn't say that those replace the ones you have. There is an argument for that. You can see there is not a question here. It is a statement, because I would argue that this budget keeps in place a lot of corporate welfare of the worst kind. Now, if you want to advocate the free market and using privatization, fine, but I don't think the taxpayer should subsidize the private market. You want to be in the business? Be in the business. You want to compete against Medicare? Compete against Medicare. We are just not asking taxpayers to subsidize your competition. That is what this is.

Now, I would also like to lend my words to my colleague from Connecticut. You have examples of people who are going to be able to get some prescription drugs. I can sit here—Terry Vickers, a constituent of mine who was enrolled January 1st and was cut off January 30th. We still have no solution to that person's problem. They got 1 month of drug benefit in January. I have a couple, Julia San Juan and her husband. She got enrolled—dual-eligible. She got enrolled, he isn't. The pharmacist had to give them five pills to hold them over for his blood pressure. We still have no solution with my caseworkers. It is not just a perfect plan or a good plan, and it is not just a rollout start problems. This is structurally, in my view, flawed.

Now, you can disagree with the direct negotiations. You can disagree with reimportation, because at the end of the day we are subsidizing Europe and the rest of the world, both on the R&D side and the price side, or getting generics to market quicker. In every one of those free market ideas, direct negotiations just like what

Costco does or Sam's Club does, allowing the free market to work in the sense of competition between—I will finish up, Madam Chair—and then also generic markets against name brand. In every one of those areas, it is a free market principle of competition that would bring in better price competition, not just to the seniors but to the taxpayers. In these plans overall, you continue corporate subsidies and corporate welfare and put it on the back of others where they need not have to have these cuts. Thank you.

Mrs. JOHNSON. I am sorry to gavel my colleagues down, but the ones who have been waiting have been waiting for a very long time.

Mr. EMANUEL. I apologize for being long-winded.

Mrs. JOHNSON. I would like to recognize Mr. Ramstad.

Mr. RAMSTAD. Thank you, Madam Chair. Mr. Secretary, good to see you. Thank you for your indulgence here today and your participation. Mr. Secretary, I want to switch gears and discuss another critical issue affecting access to affordable prescription drugs for seniors. As you know, when we passed the Medicare Modernization Act, at least in the House, we also passed an amendment that would have allowed the reimportation of less expensive prescription drugs from Canada and other countries. Unfortunately, the conference did not adopt the provision, but the general practice has been to allow individuals to purchase drugs from Canada for their own personal use. When I have queried officials from Customs or CMS, they have consistently told me that that is the general practice, that is, to allow individuals to purchase drugs from Canada for their own personal use, not to allow pharmacies to make bulk purchases for resale, but to allow individuals to purchase drugs.

So, relying on that policy, both the State of Minnesota and the Minnesota Senior Federation have set up programs to help facilitate the purchase of mail-order prescription drugs from Canada. The programs have worked well. We are a border State with Canada. In fact, many residents have taken buses to Canada, and others have bought prescription drugs over the Internet. It has worked well. It has saved money. After all, we allow the free flow of all other goods and services pursuant to the North American Free Trade Agreement (NAFTA), which many of us here worked hard to pass to create the free trade zone comprising Canada, the United States, and Mexico. So, it seemed consistent with that as well.

Well, just in the past few days, I have been absolutely shocked and, quite frankly, outraged to learn that there has been a surge in confiscations of mail-order prescription drugs by the Customs Service. Seniors from Minnesota who have relied on these drugs, many life or death drugs that they need to continue a quality of life, continue living, their drugs have been confiscated, at least 100 cases that we are aware of. Now, this is obviously very distressing to seniors who are counting on receiving drugs that they quite literally in many cases need to survive.

Mr. Secretary, I want to ask you two questions, please. One, are you aware of why the recent surge in confiscations, just since the 1st of the year? Why has the policy seemingly shifted into one of confiscating mail-order drugs from Canada? Further, given that we import food and all other goods and services from Canada without problems, that there is no evidence of Americans being harmed by

drugs from Canada, can you tell me why HHS continues to block reimportation of prescription drugs as a policy?

Secretary LEAVITT. First of all, our job is not to block it. It is to find out if it is safe, and we are not certain and cannot guarantee that it is. It is the Congress who will make that policy decision. I don't know with respect to the specific circumstances you reference, but I might be able to give you insight as to why that is occurring.

Many people who acquire drugs from Canada do so over the Internet. A site recently noticed on the Internet was called Canadian Generics, and the U.S. Food and Drug Administration (FDA) did some work to find out what was behind it. It had Canadian flags and all kinds of symbols of Canada. When you actually dug into it, you found out that the ISP was in China. You found out the website was in Belize. You found out that the check was negotiated in the West Indies and that the postmark on the drugs was Dallas, Texas.

When you actually look at the drugs that came, you find that every one of them was mis-dosed, in some cases having dramatically more, as much as 100 percent more of the active ingredient than was represented. In some cases, they were brilliantly counterfeited in packaging, but when you actually tested the substance, it was tap water, not the substance that was supposed to be in the syringe.

My point is that if you are buying drugs over the Internet from sources you are not sure of, it is buyer beware. I cannot as Secretary of Health and Human Services attest or warrant to the safety of those drugs. I don't know if that was the case in any of those 100 situations, but I can tell you that it is now a $34 billion industry, and that it is of major concern not just to us but to the World Health Organization.

Mr. RAMSTAD. Well, is it your—and I will yield back, Madam Chair. Is it your suspicion, at least, that there is a nexus there to the 100 cases I referenced of confiscation, that there is a connection between actual reason to believe or proof of unsafe drugs? Or were these random confiscations? That is what I am trying to get at. Has the policy shifted?

Secretary LEAVITT. I don't know the answer to that, except that we know that drug counterfeiting is a substantially greater risk every day. I can tell you that if you——

Mr. RAMSTAD. Well, can you find out the answer to that question?

Secretary LEAVITT. I would be happy to.

Mr. RAMSTAD. The seniors in Minnesota, I think, deserve to know. Is the policy shifting? Should the Minnesota Senior Federation change—they are trying to make it easier to——

Mrs. JOHNSON. Thank you. This is an important point——

Mr. RAMSTAD. —buy prescription drugs for seniors. So, if you would get back to me, Mr. Secretary. Thank you. I look forward to your response.

Mrs. JOHNSON. Yes, if the Secretary would get that information and get back to us, I would appreciate it.

Mr. RAMSTAD. Thank you, Madam Chair.

Mrs. JOHNSON. Mr. English?

Mr. ENGLISH. Thank you, Madam Chair. Mr. Secretary, I appreciate your testimony today. Like some of the others who have posed questions, I have gone through an extensive process in my district in reaching out to seniors who are making decisions about the new Part D benefit. I guess the bulk of my interest today has to do with that. I have been fascinated by the flip-flop we have seen from the other side today. After all, they had proposed language also that barred the Federal Government from direct negotiations on drug pricing. My own view has been that we need to give an opportunity at least for the networks that are being set up here to provide the service to negotiate themselves with the drug companies and see if we could generate discounts.

I noticed with interest that the current estimates on the price of the overall benefit have dropped significantly, and I would like you to comment on whether some of the drug pricing advantages we have seen from the establishment of this benefit and the competition contained with it have actually brought down some of those prices.

Secretary LEAVITT. Congressman, that is at the heart of the reason that the drug prices are going down. We now have an organized competitive market for the first time in prescription drugs, and I believe the benefits have not only been realized because of that, but they will continue to be realized.

Mr. ENGLISH. I am concerned, though, about one of the aspects of the benefit that I have been skeptical of from the outset, and that I have heard a lot about from seniors, and that is the enrollment penalty, the late enrollment penalty for the new Part D benefit. I realize that there are other areas of Medicare, including part B, that have these sorts of late enrollment penalties. I also realize that the penalty is modest up front, but is cumulative. I am wondering, can you articulate in your view the purpose of these late enrollment penalties? Why are they important to the Medicare system? I guess at what point do you think the penalty would become so high as to effectively price seniors out of the coverage market? Does such a point exist?

Secretary LEAVITT. Part D is an insurance program. Like any insurance program, if you wait until just before you are going to use it, it is quite expensive. For example, if you bought life insurance just before you were going to use it, it would be very expensive. If you bought long-term care insurance just before you were going to use it and move into a facility, it would be quite expensive.

The same is true with prescription drugs. If we allowed people to buy the program just before they were going to use it, we know that they would put off purchasing it until just before they had a need, and then they would run up high costs, and that would bring the cost up for everyone. This is a function of creating an actuarially sound pricing mechanism that will recognize the risk that increases when people put off buying it until they know they have a need.

Mr. ENGLISH. At some point, would the Administration consider a proposal that would establish—even as we have a window for people to make changes every year in their benefits, would there be perhaps an openness to the idea of creating some sort of cap on

this penalty if people decide to buy into the benefit within an annual window?

Secretary LEAVITT. That is a policy question that would require the approval of Congress. The basic construct of the program now is the actuarial soundness that I have spoken of. The impact would be that it would increase the cost to all participants; that is to say, if a person chose not to enroll and then later enrolled in that window, the cost of their drug benefit would have been subsidized not just by the government but by all those who were participants before.

Mr. ENGLISH. Understood. That is a policy question, and what I would like to do is engage CMS and your Department and explore the policy implications of perhaps consider a legislative remedy down the road that might speak to some of those concerns. My concern is not with the immediate penalties as much as looking at the out-years, how some of these penalties could buildup to make the benefit, in effect, prohibitive for some who perhaps have enjoyed pretty good coverage and would find themselves in a situation in the out-years of wanting to take on the benefit and would find themselves, through no fault of their own, at a serious disadvantage. I salute you though for your answer, and I am grateful for the opportunity to have this exchange. I yield back the balance of my time.

Mrs. JOHNSON. Thank you. Ms. Tubbs Jones?

Ms. TUBBS JONES. Thank you, Madam Chairwoman. Mr. Secretary, good afternoon. I am Stephanie Tubbs Jones. I come from Cleveland, Ohio. How many letters did you get from our Governor about problems with the Medicare sign-up and how much money needed to be reimbursed to Ohio for problem with the prescription drug program?

Secretary LEAVITT. I actually spent a fair amount of time in Ohio directly with the Governor and with those who are applying for the benefits and visiting with beneficiaries and pharmacists and others. I think I have a reasonably good picture of what has been happening, both in Ohio and other States.

Ms. TUBBS JONES. Does your picture include that tons of seniors—I don't even know how to put numbers on it—were having problems getting through to the call-up lines? I personally opposed the program but attempted to help my constituents in light of the fact that it was a program that involved—sent out brochures. Then people would call my office and say, "Congresswoman, we cannot get through on the line. We cannot"—having a problem. So, what have you done to relieve the problem in Ohio, sir?

Secretary LEAVITT. Perhaps I could show you generally how that is occurring. If I could show these charts, this might be an appropriate——

Ms. TUBBS JONES. You know what? I don't think I have time for charts. Why don't you get those charts to my office and then I will review them. I don't have but 5 minutes.

Secretary LEAVITT. Then just let me give you the quick version, that the time waits were absolutely unacceptable during the first week or week and half, and they have dropped consistently——

Ms. TUBBS JONES. This is just Ohio?

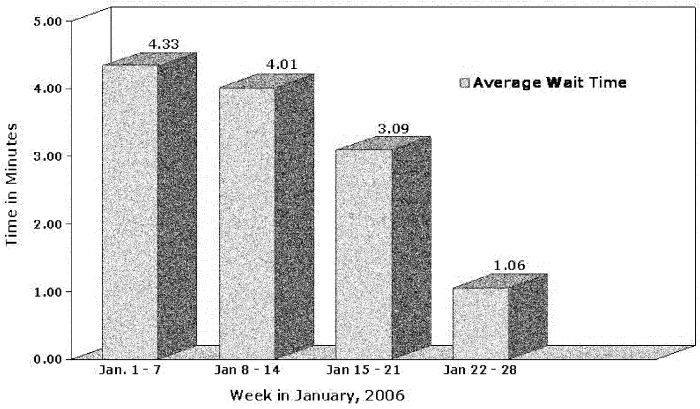
Secretary LEAVITT. No, that is not just Ohio, but that is the national picture. Ohio would have not been any different.

Ms. TUBBS JONES. Well, then, that won't help me, Mr. Secretary. I would love for you to send me these charts so I can review them, but I have a lot of other questions I want to ask you.

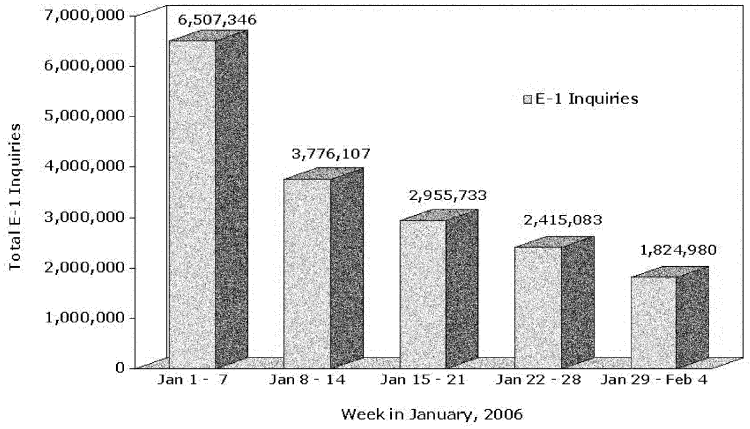
[The information follows:]

1-800-Medicare

Average Call-Wait Time Per Week in January, 2006



E-1 System Pharmacy Inquiries by Week in January, 2006



On behalf of my colleague from Louisiana, he was concerned that, as you talk about trying to do all you can to support Louisiana, the social services block grant for Louisiana was reduced by almost $8 million, from $25.7 million, almost $26 million, to down to $18 million. He is concerned about what—your real concern for helping Louisiana when you would reduce those dollars, their dollars by $8 million, and perhaps you could get back to Mr. Jefferson about what happened there. Let me——

Secretary LEAVITT. Perhaps I could mention to you that that isn't necessarily—they are getting the vast majority of that Social Services Block Grant funding; $220 million of the $550 million is going to Louisiana. So, I am not sure what he is referencing.

Ms. TUBBS JONES. Well, I am not sure either, but maybe you can get back to him. He asked me to ask the question, and I am doing that on his behalf. Another thing that I am concerned about is the reduction of dollars to the Office of Minority Health, and the reason I am concerned about it is when we started doing Social Security, the President committed to African Americans that "I am going to make sure you have Social Security, and I am going to figure out how it is that since you die early, why—that we are going to make sure you get Social Security."

Well, the response by the African American community was, "Mr. President, don't fix Social Security since I die early. Fix why I die early." One of the reasons that African Americans die early is because of the disparity in dollars available to African Americans in health care. One of the most important programs that dealt with that is the Office of Minority Health. Can you give me an explanation of why, when your Administration or the Administration is

concerned about minority health, that you would reduce dollars to that particular program?

Secretary LEAVITT. I can give you an explanation on why it is that we are increasing the dollars going into community health centers, where a large percentage of them are served, is being increased. I can show you how we are using dollars from programs that emphasize the diseases that affect minorities in disproportionate share. I can show you many different situations where we are emphasizing as a matter of both theme and substance our need to supplement the needs of minority people.

Ms. TUBBS JONES. You know what? It is funny because your response is, "The way I am going to fix it is I am going to help community health centers." I am looking at a piece that says the budget eliminates Health Resource and Service Administration's community health State planning grants. I am doing one, and I am reducing the other. The reality is there is a significant need to fund programs that provide support to all communities, but particularly minority communities, because of the health disparity.

Let me take you to another page. According to my notes, the President is cutting funding for national family care giver support, home-delivered meals, congregate meals, protection of vulnerable older Americans, preventive health services, nutrition services, incentive programs, and Alzheimer's disease. Don't you think those programs are more important to the maintenance of seniors in our community?

Secretary LEAVITT. Every program is important to someone in a budget, and we are in a period of time where we are reducing deficits. I have been forced to make decisions that dealt with conflicts between those priorities. These are my judgments. You may have different values and, in fact, that is why we are here, is to talk about which decisions I made and you——

Ms. TUBBS JONES. You recognize—a last question, Madam Chairwoman. You recognize that the programs that I just talked about for seniors are some of the programs that allow seniors to stay in their homes versus going to nursing homes, right?

Secretary LEAVITT. No one in this Administration has anything but enthusiasm about being able to have seniors served in their homes. You will see many programs in this budget that make that possible and enable it.

Ms. TUBBS JONES. Well, we differ on it, and I thank you, Madam Chairwoman, for——

Mrs. JOHNSON. If the gentlelady will suspend, I am going to give the Secretary a chance at the end to make some comments, because so many of the questions have taken all the time and not resulted in dialog.

Ms. TUBBS JONES. Madam Chair, I——

Mrs. JOHNSON. Your questions at this point——

Ms. TUBBS JONES. —am not the only one that took all the——

Mrs. JOHNSON. Your question at this point is repetitive of your earlier questions, and as I say, there are Members that have been waiting a long time to question, so I am going to recognize Mr. Chocola now.

Ms. TUBBS JONES. I appreciate it, Madam Chairwoman, but don't just chastise me. I am not the only one——

Mrs. JOHNSON. Oh, I am not. I have been having to gavel down a lot of my colleagues. I am sorry to do that, but I am doing that out of fairness to the ones who are waiting. In fairness to the Secretary, I am going to give him a few minutes at the end to be able to respond to attacks like corporate protection. Mr. Chocola?

Mr. CHOCOLA. Thank you, Madam Chair, and thank you, Mr. Secretary, for being here. Thank you for your patience. A lot of the questions I was going to ask have already been asked or touched upon, but maybe I will give you a chance to respond to some things that have been discussed. My district is in north-central Indiana. We have had some seniors, Medicare beneficiaries, that have been confused. We have had some problems with dual-eligible issues, but what we have found is kind of a magical thing. When you don't complain about it, when you don't tell the seniors how confusing it is, but sit down with them and help them, we have been able to help thousands of seniors through townhalls, workshops, office visits, telephone calls. We have experienced some great stories. I will just share a couple of them with you.

One constituent spent roughly $654 a month prior to implementation of Part D. Under the new experience, he is paying $217 a month. He pays a $66 premium, so he has one of the higher-priced plans, but he saves $370 a month. He is one of the winners, and he is a pretty happy guy. One other is a constituent that qualified for the extra help for low-income individuals. She takes seven prescriptions, $297 a month. Today she pays $23 a month. So, I don't think that our experience is unique, but would you like to comment further on that?

Secretary LEAVITT. There are 250,000 people a week enrolling in this benefit. They are not enrolling in it because people said they had trouble at the drug counter. People are telling their neighbors, "It worked well for me." The vast majority of people who go to the drug counter will get their prescription in a normal and routine way. There have been a small number of people who have had to spend some extra time, and every one of those, it is a problem for them, and it is a big problem for me, and we are doing everything we can. This is a good deal for seniors. Every one of them saved money.

I had the same experience. I sat down on Christmas Eve with my wife's mother. She had been told by friends of hers at the senior center, "Oh, I heard this was confusing." It took us half an hour. She had a list of her prescription drugs. She was spending well over $8,000 a year. The drug benefit will cost her about—she got a little better plan. She got one that did not have a deductible, but she will save almost $5,000. I worry, like you do, that there have been those who have discouraged seniors. That is unfortunate, because it is a good deal for seniors and we want make certain that they have the prescription drugs that they need.

Mr. CHOCOLA. I appreciate your efforts. Just Friday, I had a call from a constituent that had called our office earlier and said this plan is incomprehensible, there is no way he can navigate through it. We sat down with him, and he called on Friday and said this is the best thing he has ever experienced, and he took back all of his complaints before. So, I think the amazing thing is

when you sit down and help people, we find that there is a lot of help out there.

Secretary LEAVITT. We are getting through this. This is the implementation of the largest change in Medicare's history. Medicare was not implemented originally without unexpected problems. The fact that we are finding them, fixing them and finishing them and that the system gets better every day is the measure of success.

Mr. CHOCOLA. I agree. Just on another issue, I used to be in the manufacturing business, used to make things like chicken feeders, and we could make thousands of chicken feeders without ever making a mistake. We never wrote anything down. Everything was bar-coded. I don't see that level of technology for things that are available to make widgets implemented in the health care system. The President talked about electronic medical records within 10 years. It seems to me that we are at the Betamax/VHS stage where we can't quite determine what the standard ought to be that we ought to operate under. Do you have efforts to try to identify that standard, and how are you going to get to that point?

Secretary LEAVITT. Yes. The Chairperson referenced the American Health Information Community. That is an effort to create standards so that electronic medical records can move forward. In this budget, there is substantial new money directed toward health information technology because it is at the heart of our capacity to make health care more efficient. Your point about the bar-coding in a manufacturing facility is a good one. There are efforts currently being deployed all over the country for bar-coding within the health community. The problem has been that the bar-code standards didn't match up. We are now creating a bar-code standard so that when something is bar-coded in New Mexico, it is the same as when it happens in Minnesota. When that occurs, we will begin to see greater efficiency. I believe that the President's vision, in fact, will be carried out and that it will result in fewer medical mistakes, lower costs, higher quality, and a lot less hassle.

Mr. CHOCOLA. Well, every conversation I have with health care providers, I ask the question: Why can't we apply proven practices and procedures and technology that is used in the manufacturing business every day into the health care system? I am not sure I always get good answers, but I certainly would appreciate all your efforts to make sure that we implement that because I think we will all be winners if that is the case.

Secretary LEAVITT. Thank you.

Mr. CHOCOLA. Thank you, and I yield back, Madam Chair.

Mrs. JOHNSON. Thank you. Mr. Pomeroy?

Mr. POMEROY. I thank the Chair. I have worked very hard to try and get the Medicare Part D program explained to the senior citizens I represent and to assist them to the extent possible in signing up: a mass mailing, a radio Public Service Announcement (PSA), meetings all across the State, and I have hired additional staff to assist with the outreach efforts to try and get the word out to people. I appreciated, Mr. Secretary, your trip to Fargo in basically the same spirit.

My conclusions are slightly different than my friend from Indiana's. I think we have got some real problems here that we are going to have to look at and consider. I believe improvements can

and must be made to this program. Hearing some of the discussion about how swell everything is going, I am thinking of that line from the Groucho Marx movie: Do I believe you or do I believe my own eyes?

On Monday, I had a meeting in Fargo with a number of stakeholders in this system. They certainly included seniors, senior advocates trying to help people sign up, pharmacists, physicians, medical system representatives. There were real concerns expressed at this meeting, Mr. Secretary. I would like to just relay a few of them to you.

One of them involves the issue raised by my colleague, Congressman Ramstad, about the appearance of a stepped up effort to stop people from accessing, of their own free will, drugs in Canada if they want to. I have heard you saying that was not coming from HHS. You have not issued direction or been part of communications about stepped up restrictions?

Secretary LEAVITT. No, I know of no change in policy that would have been reflected in his story. That does not mean that there haven't been changes, but they have not come as a result of the implementation of Part D.

Mr. POMEROY. Okay, but you are stepping up efforts to restrict drugs coming down from Canada?

Secretary LEAVITT. We are stepping up efforts to protect people from counterfeit drugs. That is what I was referencing.

Mr. POMEROY. Right, although the situation—Mr. Ramstad referenced a situation similar to what some in my State have talked about. They have been doing this for a while. This isn't one of these fancy Internet deals, whipping them around the world. These are suppliers they have worked with, maybe for years. Now they are finding problems where they have never found them before, and that would reflect then this new initiative that has been—this stepped-up effort by HHS?

Secretary LEAVITT. It is hard to hear about one anecdote and respond in terms of if it was caused by one thing or another. I don't know the answer to it.

Mr. POMEROY. I do note the part of the your answer that said the policy was pre-existing, we are stepping up efforts to enforce the policy.

Secretary LEAVITT. On counterfeit drugs.

Mr. POMEROY. On imported drugs from Canada?

Secretary LEAVITT. Not specifically. We are working to assure that consumers are protected from counterfeit drugs.

Mr. POMEROY. By stepping up efforts to restrict imported drugs from Canada coming into the United States?

Secretary LEAVITT. Not specifically Canada, but generally. I am not able to make reference—I am happy to respond, but I have no knowledge of any policy change that is directly focused——

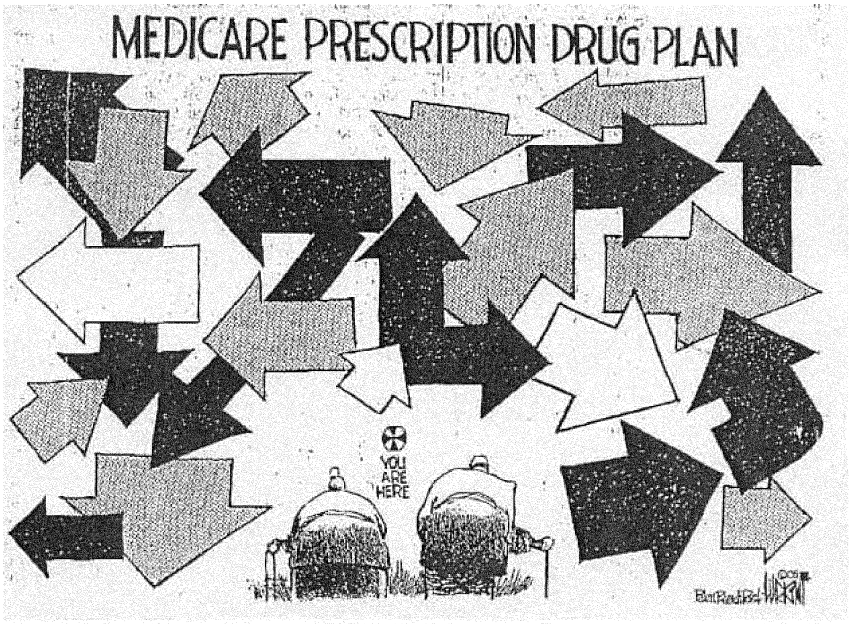
Mr. POMEROY. Not a policy change, but stepped-up enforcement activity.

Secretary LEAVITT. I am not able to respond to that because I have no specific knowledge.

Mr. POMEROY. I would request information to the extent that you can get it. The complexity of this plan is bewildering. It is not a start-up bump. It is going to continue to be bewildering. I am

going to ask that this cartoon that appeared today in the Fargo Forum appear in the record, and it, in a humorous way, depicts the bewildering situation that seniors are facing.

[The information follows:]



Source: *Fargo Forum* - February 8, 2006

Mr. POMEROY. We have had 8,700 people sign up in North Dakota that weren't automatically assigned or have creditable coverage. One of them is my mom, my 85-year-old mother with whom I sat down and worked this through, and I have encouraged in my PSA families to undertake this as a family undertaking, but there is no getting around it. It is absolutely complex, and we need to look at ways to make it more simple. The Republican elected insurance commissioner has called for standardization of formularies, standardization of plan designs. I think that his recommendations need some consideration.

Secretary LEAVITT. Congressman, can I say that we are currently dealing with what I will refer to euphemistically as Part D 1.0. We are going to be starting very soon on what will be prescription drug Part D 2.0, which is the next plan year. Part D 2.0 will be informed dramatically by what we have learned with 1.0. The market has clearly driven the cost down, and the market now clearly needs to simplify it. This program does need simplification, and the market will lead us there, and I believe we will do all we can to guide the market there, because there is no reason that this plan cannot and should not continue to improve every year. It will be a blessing in the lives of millions of people. It is today. It isn't perfect. We were not handed a perfect plan to implement. Our implementation has not been without flaw, but we are finding the problems. We are fixing the problems. Millions of people are getting their prescriptions filled every day.

Mr. POMEROY. I know my time has expired. I appreciate the acknowledgment of the need to work on this program and make it more simple. I did not hear that in your earlier statements. I have been here a while. Look, I will acknowledge this thing is doing some good. My mother is going to save $2,000 this year. I believe that, as frustrating as seniors are finding the sign-up period, it is worth their work to do it, but I want to make it less frustrating for them as we implement improvements.

Secretary LEAVITT. How long did it take you to sign your mother up?

Mr. POMEROY. It took about 45 minutes once we had all her stuff together.

Secretary LEAVITT. That matches my experience. If you can get the drug bottles and the Medicare card, it is half an hour or 45 minutes, depending on if it is the first time you have done it. It takes some time, but it works for people.

Mr. POMEROY. I was the insurance commissioner of North Dakota for 8 years. I know a little bit about coverages, and I can use a computer. She would have had a heck of a time had I not been there. I yield back.

Mrs. JOHNSON. The gentleman from Massachusetts, would you like to inquire?

Mr. NEAL. Thank you, Madam Chairperson. I apologize for being late. Mr. Bolten is at the Committee on the Budget, and that is where I was. They were simultaneously scheduled. I want you to know, Mr. Secretary, your name did come up over there.

[Laughter.]

Secretary LEAVITT. I guess I am relieved.

Mr. NEAL. You did indicate a couple of moments ago—and I am going to go back to Social Security in a second—that the cost of the program is going down.

Secretary LEAVITT. Part D.

Mr. NEAL. Mr. Secretary, is it not fair for those of us who were critical of the initiative as proposed to have heard the former Director of the Center for Medicare & Medicaid Services suggest publicly that it was going to cost $400 billion, and then within a matter of days of the vote, which took place, by the way, at 4 o'clock in the morning—or I think that is when we started. I think we ended around 6:00—that it was suggested it was going to cost $750 billion? Is it a little bit inconsistent then to come back and say the cost of the program is going down after it was suggested at the outset it was going to cost $400 billion? In a sense, it is like the former head of OMB saying that the cost of Iraq was going to be $60 billion a year—or $60 billion in the run-up to the war.

Secretary LEAVITT. I am aware that there were differences of view on what it was going to cost, not between 700 and 400, but there were differences that were smaller than that. The difference between the 700 number is a different plan year and different—it would be comparing apples to oranges, but your point I understand.

Mr. NEAL. Thank you. Mr. Bolten is coming back here I think at 4:30 today, and he will be delighted to see me based on the testimony you have offered after we went back and forth on those num-

bers. I will say he is pretty definite in explaining the position of the Administration as it relates to these numbers.

Secretary LEAVITT. It is clear—I am not referring to differences—I know that it started at one number and numbers were re-estimated. That is a matter of history, not a matter of opinion.

Mr. NEAL. Right, and I appreciate that line. Thank you very much. Mr. Secretary, last year we began the Social Security discussion here, really never began the debate but began the discussion. The issue has kind of made its way back into the President's budget. Is there going to be a recommendation from the Administration that we begin to discuss the solvency of Social Security in a bipartisan manner? Or is it going to be the way that it was done last year, it is our way or no way?

Secretary LEAVITT. The President in his State of the Union address indicated that he believes, as I suspect you do, and I do, that the entitlements need to be dealt with. I believe his commitment is to do it in a bipartisan way.

Mr. NEAL. I raise that question because, if you recall last year, the President suggested as part of the proposal that the only thing that was necessary was that there be private accounts and no discussion of any tax increases. If we are going back to the idea of a commission that is supposed to stand up intellectually under rigor and some scrutiny, I don't know how you could begin the discussion and constrain it by saying these are the two items that are cornerstones of the initiative or there cannot be a discussion. I just offer that to you. You ran a State. You know something about doing these things. If you start from the premise that we are not going to do this or we are not going to do that, it strikes a tough chord for people on the other side who might hold a slightly different view.

Secretary LEAVITT. I understand your point.

Mr. NEAL. Thank you, Madam Chairman.

Mrs. JOHNSON. Thank you very much. As we conclude on this issue of the numbers, I do want the record to reflect that our estimate of our bill was $400 billion. That was 2 years of no program and 2 years of a program. Under that same scenario, the other bill, the major Democrat bill was $1.3 trillion for 2 years of no program and 2 years of a program.

Mr. NEAL. Would the gentlelady yield?

Mrs. JOHNSON. I would be happy to yield.

Mr. NEAL. Thank you. Madam Chairperson, do you think that there would be a reasonable conclusion on this side, given testimony of the professionals who have made a career over at CMS, do you think that when they said they were told not to say anything about the numbers—one of the nice things about appointed officials in this town is that they really do care about their careers after they leave here.

Mrs. JOHNSON. That is——

Mr. NEAL. Is that reasonable?

Mrs. JOHNSON. —an interesting issue, reclaiming my time. You will remember that at that point your bill had not been subjected to a rigorous estimate, so it was hard to say these are the two estimates now and these are the parallel estimates that will take place once there is 4 years of a program. The point I am making is that

there was a big disparity in costs over 4 years. That disparity of costs would have increased commensurately with the change in the estimate of our bill, because when you compare an estimate for 2 years of no program and 2 years of program with an estimate for 4 years of program, you are going to get a higher estimate when the program is in place for 4 years. That is a no-brainer. Everybody knew it. If it had been our bill for 400, that would have been one thing. If it had been your bill for $1.3 trillion, that was another thing, but at the time, we were unable to do apples and oranges. So, it was a lot of speculation, and there were a lot of controversies about the estimates. Bottom line, what is happening with our estimates would have happened if the other bill had been passed, the only difference being the costs would have been extraordinarily more. So, we are dealing with what we have. I appreciate you, Mr. Secretary——

Mr. NEAL. Would the gentlelady yield?

Mrs. JOHNSON. —for being here. I am going to wrap this up. The Secretary has been here a long time, but I would be happy to talk with you afterward. Mr. Secretary, thank you for being here. Thank you for your leadership on the international health issues that we are now as a leader in the world community of Nations and one of the most advanced in health care responsible to provide leadership in those areas, and thank you to you and your staff right down to the secretaries and the others that stayed late, that worked weekends, and that have really held in there over this month of February, and now into March, to make sure that we could straighten out the bugs in the program and that seniors will get the help with prescription drugs that we put in place for them and that they would not be disappointed. Thank you for being with us.

Secretary LEAVITT. Thank you.

[Whereupon, at 1:23 p.m., the hearing was adjourned.]

[Questions submitted by Mr. Shaw and Mr. Thompson to Secretary Leavitt. His responses follow:]

Questions submitted by Representative Shaw

I have been holding monthly Medicare prescription drug benefit information sessions in both of the counties that my congressional district reaches. The attendance at these sessions has been very good. Many seniors have been interested in enrolling in the new benefit. However, like seniors across the county, my constituents have raised concerns and are confused.

Question: South Florida seniors continue to raise concern about the "bait and switch" issue of Part D plans dropping coverage of a particular prescription drug mid-year. Please explain to me what is being done to prevent this. Is there any way that the program can be amended to prevent this mid-year formulary switch?

Answer: CMS recognizes the importance of formulary stability for the Medicare population. However, prescription drug use is constantly evolving, and new drug availability, new medical knowledge, and new opportunities for improving safety and quality at low cost will inevitably occur over the course of a year requiring changes to the formulary. CMS will continue to ensure that each formulary provides a broad range of medically appropriate drugs and does not discriminate or substantially discourage enrollment of certain groups of beneficiaries.

It is important to note, all proposed formulary changes, excluding formulary expansion changes, must be submitted to CMS for review and approval. Additionally, beneficiaries will not lose coverage for their drugs because of a mid-year formulary

change except for clear scientific evidence, cost reasons related to a new generic drug coming on the market, or new FDA or clinical information becomes available.

Question: Seniors in my district have over 40 choices of Part D plans. We all know that competition is great but it is causing much confusion. What is currently being done to improve the way seniors navigate through all the information? What advice would you give the average senior who is very frustrated with the entire enrollment process?

Answer: As indicated in the 2007 call letter, CMS is planning to use its negotiating authority this year to simplify beneficiary choices. Multiple bids for the 2007 contract year from a single plan sponsor represent meaningful variation based on plan characteristics that will provide beneficiaries with substantially different options such as variation in deductibles, the use of flat copays versus coinsurance, and coverage in the gap versus no coverage. This will allow beneficiaries with clear preferences in one or more of these areas to more easily navigate plan options based on the coverage characteristics they value most. Beneficiaries have a variety of resources available to assist in choosing among plans, including comprehensive formulary and network pharmacy information on the Prescription Drug Plan Finder tool at www.Medicare.gov, assistance from trained customer service representatives at 1–800–MEDICARE, and personalized counseling through the State Health Insurance Assistance Programs (SHIPs).

Question: The enrollment deadline of May 15, 2006, for Part D coverage during calendar year 2006 was set to ensure that seniors who wished to enroll did so in a timely manner. However, many have feared that this enrollment deadline will not provide seniors enough time to review plan options and enroll especially in light of the computer difficulties experienced between plans and pharmacists during the first month of the benefit. What specific steps are you taking to ensure that seniors have adequate time to review all plan options and enroll in coverage by May 15, 2006?

Answer: In 2006 Medicare pays a physician $903 for doing an MRI of the brain or an MRI of the abdomen. Medicare will also pay a Hospital Outpatient Department (OPD) $506 for the exact same test. Thus, Medicare is paying almost $400 or 78 percent more for doing these MRI imaging tests purely depending on whether the test is performed in an OPD or a physician's office. Similarly, Medicare will pay 267 percent more for doing an ultrasound guidance for artery repair in a physician's office than an OPD ($228 vs. $62). These comparisons do not include a physician's interpretation of the test for which Medicare will pay a separate fee. There is no consistency in the percentage that the physician fee schedule exceeds the hospital OPD payment amount. The percentage difference varies by procedure.

In the context of: (1) significantly larger payments under the physician fee schedule than the OPD for the same service for certain imaging services, (2) site neutral payments for the same service identified by MedPAC as a long term goal under Medicare fee-for-service payment systems, (3) rapid growth in Medicare spending for imaging services for several years, (4) MedPAC raising methodological issues that suggest relative values under the physician fee schedule for imaging services would be too high, combined with a lack of procedure and equipment specific information on alternative equipment utilization assumptions to use in the practice expense formula to address such issues, section 5102(b) of the Deficit Reduction Act of 2005 establishes a payment limit for the technical component of imaging services. The provision requires that Medicare not pay a physician more than Medicare would pay the OPD for furnishing the same imaging procedure. A physician's interpretation of the test for which Medicare will pay a separate fee is not affected by the provision.

This step to level the playingfield between physicians' offices and hospital OPDs only applies to procedures where Medicare pays more in physicians' offices; the DRA cap provision does not apply to all imaging procedures furnished in physicians' offices. In addition, the percent that Medicare payment rates for physicians exceeds OPDs are not all as large as the examples cited above; in numerous cases, the differential is 10 to 20 percent. Thus, the overall impact is not expected to be as dramatic as the example of some procedures. The DRA provisions will be implemented through notice and comment rulemaking. These proposals are expected to be published this summer and will allow for a 60 day public comment period. A final rule will be published by November 1, 2006 and will be effective for services furnished on or after January 1, 2007.

Question: The issue of cancer treatment, early detection and prevention is near and dear to me. I am actively supporting the National Cancer Institute's goal of ending the suffering and death due to cancer by 2015. I am extremely disappointed and discouraged to see that the President's proposed budget cuts $40 million in funding for the National Cancer Institute.

Question: Our nation is on the brink of numerous breakthroughs on the early detection of, and treatment for cancer. We need to sprint, not jog, to the finish line. Why does the proposed budget cut NCI funding at such a critical point? What commitments have the HHS and the Administration specifically made in support of NCI's 2015 goal?

I also understand that if we want to reach the 2015 goal, the key does not lie solely in the federal appropriations process. I will soon be introducing legislation strengthened and amended the Medicare program in the area of cancer treatment and detection. With the baby boomers approaching Medicare age, we will have a major crisis on our hands in the program. We must lay the ground work now to provide these future beneficiaries with adequate cancer care. What specific improvements to the Medicare program would you like to see in the area of cancer screening, treatment and prevention? How can the Ways and Means Committee help achieve the 2015 goal?

Answer: The prevention, early detection, and treatment of cancer are major priorities within the Department of Health and Human Services. We are pleased to report that Medicare now covers a full range of cancer screenings recommended by the U.S. Preventive Services Task Force. Medicare beneficiaries are covered for screening tests and procedures aimed at early detection of breast, cervical and vaginal, colorectal, and prostate cancers. Coverage of a one-time initial preventive physical exam (aka the "Welcome to Medicare Visit") provides new beneficiaries an opportunity discuss cancer risk factors and screening regimens with their doctor.

Through its evidence-based National Coverage Determination process, Medicare also now covers smoking cessation counseling for beneficiaries diagnosed with a smoking-related illness or condition, or taking medication affected by smoking.

Challenges remain in ensuring these services are well utilized by those who would benefit the most. Toward that end, we have launched a comprehensive outreach program to educate providers and beneficiaries about the availability of these life-saving benefits. In addition, with the new Part D prescription drug coverage, Medicare may now cover a wider range of cancer-related drugs and vaccines, as they become available. Cancer drugs administered by a physician (or oral equivalents of drugs usually administered by physicians) continue to be covered under Medicare part B.

Finally, the Cancer Prevention and Treatment Demonstration for Ethnic and Racial Minorities (established by the Benefits Improvement and Protection Act of 2000) is now underway. This demonstration is aimed at reducing disparities in cancer prevention and treatment for African American, Latino, Asian American/Pacific Islander, and American Indian/Alaskan Native beneficiary populations. These projects will be designed around new and innovative intervention models to facilitate appropriate use of Medicare-covered screening, diagnosis, and treatment services by these populations. We look forward to continuing to work with you in support of these important initiatives.

Question: How do you think Congress can support the 2015 goal and do more to foster collaboration with other agencies and the private sector?

Answer: The President's Fiscal Year 2007 Budget requests $4.75 billion in funding for the National Cancer Institute (NCI) at NIH, which leads the Administration's efforts toward achieving the 2015 goal of eliminating suffering and death due to cancer. Addressing the cancer problem requires that NCI work across institutional and sector boundaries, share knowledge, and bring together the diverse members of the Department of Health and Human Services (DHHS) family of agencies, as well as other federal offices, that can help develop systems-based solutions to the cancer problem. For example, DHHS Secretary Mike Leavitt announced earlier this year the Oncology Biomarker Qualification Initiative (OBQI)—an unprecedented interagency agreement among NCI, FDA, and the Centers for Medicare and Medicaid Services (CMS) to collaborate on improving the development of cancer therapies and the outcomes for cancer patients through biomarker development and evaluation. CMS will continue to join and support these collaborative efforts in pursuit of the 2015 goal, and we appreciate your shared interest.

Question: My doctors have told me that smoking probably did not play any role in my form of lung cancer. I have been told that any number of factors, like our genes, our age, and the environment, can cause cancer. Is the NIH doing enough to support efforts to better understand the causes of cancer? How will the proposed decrease in the NCI's budget affect this?

Answer: The Following was not received at the time of printing.

Questions submitted by Representative Thompson

Question: Reimbursement rates for physicians in counties across America are too low because CMS hasn't updated their geographic cost factors. Doctors in Sonoma County are getting paid 8.2% less than your own staff acknowledges that they should be paid. This is happening to doctors all-over. CMS has supported a budget neutral solution—going so far as to propose a budget neutral fix for Sonoma and Santa Cruz counties in the 2005 August Federal Register. You then withdrew this proposed solution due to what you cited as "nearly complete lack of support" in the November 2005 Physician Fee Schedule Final Rule. We will always see opposition to a "fix" that takes away from group A to give more to group B—regardless of whether or not group B really does deserve more. The CMA has proposed a nationwide fix that would cost only $115 million and has bipartisan support. Is CMS willing to work with Members to find an offset for this cost? What is CMS willing to do to make sure that this problem—which I have been fighting to resolve since I came to Congress in 1998, and others have been fighting even longer—can finally be rectified?

Answer: One proposal by the California Medical Association (CMA) would cost $115 million per year. That's more than a billion dollars over a 10-year budget-scoring window. Another CMA proposal would cost $300 million per year. That's $3.0 billion over 10 years.

Locality changes are budget-neutral with respect to the aggregate amount of Medicare money in a State. That is, reconfigurations of localities within a State do not result in any more Medicare money for the State in the aggregate, but only redistributions of money within a State. Since there will be both winners and losers in any locality reconfiguration, we rely on State medical associations to be the impetus behind these changes. We have assumed that opposition, or lack of support, from a State's medical association generally indicates a lack of broad support for the proposed change through the State's medical professional community. We have been working and will continue to work with the CMA, Members of Congress and other interested parties on the physician payment locality structure in California.

Question: State Health Insurance Assistance Programs—or SHIPs—get funded through the Medicare and You Education Program. According to the FY07 HHS Budget in Brief, they—and other outreach programs—are funded through Community Based Outreach. This year, Community Based Outreach is funded at $43.6 Million. What portion of that funding is allocated specifically for the SHIPs? What factors does CMS consider when determining the level of funding SHIPs need to meet beneficiary demand?

Answer: The Community-based Outreach appropriations are allocated across all the programs under that umbrella based on CMS objectives and corresponding program needs at the time the funding is to be distributed. Annual SHIP grants are awarded in late March, and fiscal year (FY) grants are announced at that time. For FY 2006, CMS awarded about $30 million in funding to SHIPs to help beneficiaries with enrolling in Medicare's new prescription drug program and understanding many other aspects of Medicare benefits. The FY 2007 grants will be announced in late March 2007, with the exact SHIP allocation known shortly before that time.

The level of funding allocated to the SHIPs is generally based on the relative number of beneficiaries in each state and the expected level of effort that is required to deliver counseling services. Consideration also is given for special needs groups that may require greater resources to serve, such as rural beneficiaries or other targeted populations.

Question: The Deficit Reduction Act included language to reduce payments for certain imaging services provided in the physician office setting or at stand-alone imaging centers. The payment amounts will be reduced to the amount paid in the hospital outpatient setting. I am told that some codes may be reduced by more than 30% and others by as much as 75%, such as for vascular imaging using ultrasound. I understand the desire to address differences in payments between settings, but I'm curious about how it was decided to use the hospital outpatient value. Was it because it would save money, or were their other factors involved? Has there been any analysis of whether or not the outpatient payment amount is adequate or appropriate?

Answer: In 2006 Medicare pays a physician $903 for doing an MRI of the brain or an MRI of the abdomen. Medicare will also pay a Hospital Outpatient Department (OPD) $506 for the exact same test. Thus, Medicare is paying almost $400 or 78 percent more for doing these MRI imaging tests purely depending on whether

the test is performed in an OPD or a physician's office. Similarly, Medicare will pay 267 percent more for doing an ultrasound guidance for artery repair in a physician's office than an OPD ($228 vs. $62). These comparisons do not include a physician's interpretation of the test for which Medicare will pay a separate fee. There is no consistency in the percentage that the physician fee schedule exceeds the hospital OPD payment amount. The percentage difference varies by procedure.

In the context of: (1) significantly larger payments under the physician fee schedule than the OPD for the same service for certain imaging services, (2) site neutral payments for the same service identified by MedPAC as a long term goal under Medicare fee-for-service payment systems, (3) rapid growth in Medicare spending for imaging services for several years, (4) MedPAC raising methodological issues that suggest relative values under the physician fee schedule for imaging services would be too high, combined with a lack of procedure and equipment specific information on alternative equipment utilization assumptions to use in the practice expense formula to address such issues, section 5102(b) of the Deficit Reduction Act of 2005 establishes a payment limit for the technical component of imaging services. The provision requires that Medicare not pay a physician more than Medicare would pay the OPD for furnishing the same imaging procedure. A physician's interpretation of the test for which Medicare will pay a separate fee is not affected by the provision.

This step to level the playingfield between physicians' offices and hospital OPDs only applies to procedures where Medicare pays more in physicians' offices; the DRA cap provision does not apply to all imaging procedures furnished in physicians' offices. In addition, the percent that Medicare payment rates for physicians exceeds OPDs are not all as large as the examples cited above; in numerous cases, the differential is 10 to 20 percent. Thus, the overall impact is not expected to be as dramatic as the example of some procedures. The DRA provisions will be implemented through notice and comment rulemaking. These proposals are expected to be published this summer and will allow for a 60 day public comment period. A final rule will be published by November 1, 2006 and will be effective for services furnished on or after January 1, 2007.

[Submissions for the record follow:]

AFGE Social Security Administration
Baltimore, Maryland 21244
February 7, 2006

Committee on Ways & Means
U.S. House of Representatives
1102 Longworth House Office Building
Washington D.C. 20515

Dear Secretary Leavitt,

Below are four questions that necessitate a response. Please find them below.

1. The National 800 Number Network has been a growing concern for Medicare Part D beneficiaries because of the busy rates running above 35%. Can you confirm the busy rate of callers to the 800 Number and explain how this issue is being addressed?
2. How are your Processing Centers addressing the large backlog as a result of the 200,000 in office visitors a day?
3. As the baby boomers retire, how will the SSA have the funds to replace SSA employees when their budget was cut by $300 million this year (FY07 proposed cuts appear to be significant as well); compounded by the increased responsibilities the government imposed on the SSA with the new Medicare Part D program?
4. SSA Commissioner Barnhart recently enacted a two-year hiring freeze across-the-board which went into effect January 6, 2006. In addition, the Commissioner suspended all overtime pay and restricted unpaid leave. How will you address employee dissatisfaction and maintain morale when SSA employees are fighting such an uphill battle?

Sincerely,

Witold Skwierczynski
President

Aurora, Illinois 60505
February 3, 2006

To the Honorable Congressman Bill Thomas and the Committee on Ways and Means:

Please find attached a letter that I had written to Speaker of the House Dennis Hastert regarding my concerns with the Social Security/Supplemental Security and Medicaid process.

I am very concerned regarding the President's Fiscal Year 2007 Budget and its cuts to Medicaid, childcare and TANF. As you will see from my letter, I am an advocate for my clients many who are disabled and seeking SSI and Medicaid. Therefore, I witness firsthand the process involved in applying for these programs both for my clients as well as our local IDHS office.

The current system is already fraught with red tape and back logs in the processing of Medicaid claims especially in our area of Aurora/Kane County. I know however, these same issues are statewide. The current process of IDHS removing the P3 status, as well as the budget cuts to the Kane County IDHS office specifically (notwithstanding a need for further funding for the CAU Unit), our SSA Oak Brook office which serves our residents being too back logged, and finally a shortage of Administrative Law Judges to hear the cases, leads to the actual applicants unduly suffering and not having their cases heard in a fair and timely manner.

Further cuts to the Medicaid Program as well as the other cuts outlined in this budget will be detrimental to many of the over 50 million people who rely on Medicaid, as well as those applying. These cuts will also further burden local IDHS Office's which have already suffered from massive cuts and layoffs and are unable already to process the great volume of claims due to being short-staffed in a timely manner.

I ask that you consider this letter and attachment to be officially submitted for record. Thank you for your time and attention to this matter.

Sincerely,

Kim Aponte

October 13, 2005

Speaker of the House Dennis Hastert
14th Congressional District
235 Cannon Office Building
Washington, DC 20515

Dear Speaker of the House Dennis Hastert:

I am writing this letter to you as a representative of Aurora Township and as a social service professional. As case manager of Aurora Township in our General Assistance and Emergency Assistance programs, I witness firsthand those physically and mentally disabled individual's that come to our office to apply for assistance because they are unable to be self-sufficient due to no income and having to wait oftentimes years for their Social Security Disability Income (SSDI)/Supplemental Security Income (SSI) and subsequent Medicaid cards to be approved.

The application processes for all of these programs are technical, confusing and altogether too lengthy resulting in many individual's not qualifying for the benefits that they should be entitled to. The SSD/SSI process of usually over two years to make a determination on whether an individual is actually disabled or not is inhumane in that it forces those who cannot work and have no income to not have the medical or mental health services they so rightly are entitled to, not have access to prescription coverage (many times to lifesaving medications), as well as having no form of income with which one can survive. This lengthy process has also caused many individuals to become evicted or foreclosed on their apartments or homes and forces the burden then on friends and family members (many who are low-income themselves) to support these individuals until their determinations come through.

Linked to the long application process of SSD or SSI, is the Illinois Department of Human Services (PA) application process for a medical card (Medicaid). This process takes anywhere from 60–77 days and is also very confusing, lengthy and complex. In most cases these applications are automatically denied unless the Social Security Administration (SSA) has deemed an individual disabled.

I am writing to ask your assistance and intervention in advocating for and proposing legislation that would improve Social Security's Disability process.

I currently have many clients that have been waiting over two years for their medical cards and SSD or SSI to be approved. Many of these clients have serious

medical conditions such as Congestive Heart Failure, and are on lengthy lists of medications averaging from $300.00–$500.00 a month. Many are close to being evicted and many more have already lost their homes or apartments due to an inability to work and not receiving ongoing supplemental income. I also have clients that are needing surgeries for a variety of medical conditions and are unable to have this necessary medical treatment because of not having income, insurance or now even the ability to be seen at Cook County Hospital because they do not live in Chicago. I also have clients that were on SSI previously, were taken off due to incarceration and now the reinstatement process also takes up to two years or more, even if their medical situation is the same or has worsened.

Many are represented by lawyers, however, this has not shortened the process, as applicants are now waiting a hearing date before a judge, and they're told there could be up to a year delay as there are a shortage of judges to hear these cases. I feel this two-year plus application process is unfair and unjust. I cannot imagine being too sick and disabled to work and knowing I had to wait up to two years to get assistance that is rightly due to these individuals. I cannot imagine what it would be like myself knowing my medications I needed to survive cost from $300–$500.00 a month and I nor my family had the ability to pay for them. I, myself, could not afford to pay for prescriptions totaling these amounts on my full-time income.

I have spoken to many doctors and lawyers who agree that the process is unfair and inhumane. They too are frustrated wondering how it is that several doctors can deem an individual incapacitated by a medical condition and yet the IDHS and SSA board's medical staff routinely deny and refute these diagnoses.

As a Township, which is mandated to provide General Assistance to its residents in need, we, unlike many others were assisting these individuals with medical and prescription assistance until PA or SSA reached a decision. However now, due to having had several very expensive surgeries for these clients within this year alone (one was $74,303.00 at Public Aid rates), we no longer are able to assist these individuals until they have been denied for Medicaid and have appealed (as they are deemed presumptively eligible for Medicaid). This leaves a 60–77 day window that these desperately ill people will not have any resources to carry them through for medical assistance or prescriptions.

I will be the one once again facing these individual's and letting them know that they will have to do without their lifesaving medication and/or any needed medical treatment for 60–77 days until Public Aid renders a decision which 90% of the time will be denied unless SSA approves them. Perhaps because I am the one who sees them on a daily basis, I feel compelled to stand up for these individual's rights that are being violated by a system that few challenge. I am asking for you to stand up for these individuals as well.

I would appreciate any assistance you may be able to lend to this matter. And if you have any questions, please feel free to contact me at work.

Sincerely,

Kim Aponte

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