S. HRG. 108–118

EXAMINING THE ADMINISTRATION'S FISCAL YEAR 2004 HEALTH CARE PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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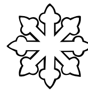

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EXAMINING THE ADMINISTRATION'S FISCAL YEAR 2004 HEALTH CARE PRIORITIES

THURSDAY, FEBRUARY 27, 2003

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

The hearing was convened, pursuant to notice, at 10:06 a.m., in room 215, Dirksen Senate Office Building, Hon. Charles E. Grassley (chairman of the committee) presiding.

Also present: Senators Lott, Snowe, Santorum, Frist, Smith, Bunning, Baucus, Breaux, Conrad, Jeffords, Bingaman, and Lincoln.

OPENING STATEMENT OF HON. CHARLES E. GRASSLEY, A U.S. SENATOR FROM IOWA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Good morning, everybody. Welcome, Secretary Thompson and all my colleagues who are here.

I may have to step out to make a quorum down the hall at Judiciary, but otherwise that would be the only reason for my absence, and that would be for a short period of time.

Today, we are pleased to be here on a very important issue. Obviously, it is demonstrated by the big, big turnout we have from the public.

So we welcome Secretary Thompson to discuss the administration's policies and priorities on Medicare and Medicaid. I am glad that the Secretary has agreed to come to us about the administration's plans to strengthen and improve Medicare and to make the Medicaid program much more flexible.

So far this year, we have had an opportunity to hear many presentations, and maybe sometimes leaks, about what the administration has planned in regard to prescription drugs. It has brought some mixed messages.

We heard one time about a plan, and then we heard more recently about principles. Some ideas found their way into the press before members of the committee were briefed.

The Medicaid proposal, while more detailed, is still very new and needs to be examined. I was given some briefing on that by the Secretary by telephone, and I appreciate that very much.

So I think this is a very appropriate meeting we are having at this time to give us all an opportunity to have it all laid out on the table, just exactly the way the President and the Secretary see it. We need that.

We need it and particularly right now, because we do not have a lot of time to waste. At least as I see it, we do not have a lot

of time to waste because what we do not get done early this year may get mixed up with the presidential campaign, and a lot of times controversial and sweeping issues do not get done.

So that is kind of why Senator Baucus and I have been speeding things along within this committee. We need to obviously get to work on Medicare so that this committee can produce a bipartisan consensus prescription drug and Medicare improvement bill this spring.

I want to compliment the President of the United States and all of his advisors, and I am including in that Secretary Thompson, because the administration has come a long, long ways by putting $400 billion on the table for Medicare, of which the biggest portion would obviously be the prescription drug program.

We did not have those sorts of sweeping changes quantified by the administration in the previous two years. I think, with Congress talking about $400 billion over the last year or two, with figures below maybe $200 billion, all the way up to $800 billion, that $400 billion would be in the ballpark for a lot of members of the Congress. So the President is helping that process along very much.

Now, that by itself, of course, is a tremendous improvement over last year. You, Secretary Thompson, and President Bush, deserve credit for your commitment to this very important issue.

While I want to hear more from you and the President about how specifically you would spend the $400 billion, I am not going to let that $400 billion sit around all year while we wait for the White House to sign off on details. Plan or no plan, this committee must move ahead.

After today's hearing, I will continue to share ideas on prescription drugs and Medicare improvement with members from both sides of this committee, from our seniors, and from our providers who serve them. I want to listen to any and all ideas from my colleagues who share the goal of bringing Medicare into the 21st century.

Over the next 4 months, there will be many meetings, hearings, and my hope is that there will be an honest-to-goodness mark-up that will result in a bipartisan consensus bill that can get 60 votes. As we all know, for anything to get done in the Senate it will need to be bipartisan, and that just about always dictates 60 votes.

Getting there will mean that we have to make hard choices. We have to compromise. None of us will get everything that we want. For my part, I would like to see a prescription drug program that is universal, voluntary, and affordable.

I would like to see improvements to the program that focus on preventive care and disease management, in addition to prescription drug coverage. I would like to see, overall, a program that is more rational, more affordable, and more like today's insurance coverage, particularly the kind of insurance that Federal employees across the country in all states, both urban as well as rural, enjoy today.

Finally, and most importantly, I will insist that any new benefit that we add to Medicare programs be accompanied by meaningful improvements to the current geographic inequities that hurt low-cost States like Iowa.

Iowa doctors and hospitals provide some of the highest quality, most efficient care in the country. But the age-old formulas that determine Medicare reimbursement do not account for that.

So I will include provisions in whatever bill we mark up that corrects these outdated formula flaws and that enables the Medicare program to begin recognizing high-quality, cost-efficient care.

The Majority Leader has assured me, and he is here so I want to thank him for his leadership on this, working hard to bring high visibility to this bill. Senator First has assured me that he will bring the work of this committee to the Senate floor around July 4. We have got an awful lot of work to be done here to get there, so we must get started.

Turning now to Medicaid reform, Mr. Secretary, as you know, States are struggling with some of the worst budget shortfalls in recent history, yet they have consistently seen their medical costs rising.

The National Governors Association reports that States are facing the worst fiscal scenario since World War II, albeit 40 percent of that is in one State of California.

The Medicaid costs are rising and the program has expanded in complicated ways. States are trying, in a number of ways, to address the needs of the uninsured through the Medicaid program.

States have been asking Congress for two types of relief, fiscal relief and flexibility to design a benefit package for certain enrollees.

I think it is appropriate for the Congress to consider a means by which we can get some fiscal relief to States, and I am open to that discussion.

Additionally, States have sought flexibility on how they design their programs through waivers. Mr. Secretary, in the 2004 budget submitted to Congress, this administration is outlining principles that address both fiscal and regulatory relief for States.

I appreciate your willingness, Mr. Secretary, to open up a debate on the issue of Medicaid reform. I appreciate your willingness to work with members of Congress and our Nation's Governors.

I would urge all of us to keep an open mind when we work through the number of these recommendations, as well as other things that members might want to put on the table about Medicaid.

I understand that the administration has left a number of important details unresolved so that you, Mr. Secretary, could get input from the States and from the Congress. I think this is a sound approach. I look forward to working with you to address these issues in timely, thoughtful, and responsible manner. Now I would like to turn to Senator Baucus.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA

Senator BAUCUS. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

Secretary THOMPSON. Thank you, Senator Baucus.

Senator BAUCUS. We are all pleased to have you here. We are always pleased. You are a great public servant and also a man who

has very practical and pragmatic approaches to solutions. I definitely, for one, appreciate all that.

This is the first Finance Committee hearing of the year to address health care and welfare issues. We have got a lot to talk about this morning.

First, you have been very busy. You have put a lot of ideas on the table that have generated a lot of discussion, and quite frankly raised a lot of eyebrows. But I expect nothing less from you, somebody who has an affinity for action and bold ideas, and I appreciate that.

Secretary THOMPSON. Thank you.

Senator BAUCUS. I would like to take this opportunity, though, to lay out my concerns about the administration's budget proposals, at least as they have been reported by the press, and talk about how we can move forward to find some common ground.

First, Medicare. Like many of my colleagues, I believe very strongly that a prescription drug benefit should be available to all Medicare beneficiaries, that is, including those who choose to remain in the current fee-for-service program.

The administration's proposal, at least as I understand it, would not work for, I, my State of Montana, or other rural areas. But I believe that providing more choices to seniors in Medicare can be positive.

In fact, I wish that seniors in my State had the option of enrolling in Medicare+Choice that provided prescription drugs at no cost, or at least at low cost, but that is not the case in my State of Montana.

I also agree that integrating a drug benefit with other medical services makes sense. But while the general notions of choice and integration might sound good, it is not necessarily the case that these policies result in any savings to Medicare.

Private plans have not fared well in Medicare thus far. Medicare+Choice plans have left the program in droves, despite our efforts to ease regulatory burdens and increase payments.

An estimated 64 percent of beneficiaries are enrolled in plans that are paid at rates equal to or above current local fee-for-service rates. Some plans receive as much as 140 percent of fee-for-service payments, yet plans are still leaving the program. I believe that should not be a model for Medicare reform.

I would also stop short of advocating an FEHBP program for Medicare. For one thing, when people say that Medicare should be more like the Federal Employees Health Benefits Program, it is not always clear what they mean.

If that is shorthand for premium support or an attempt to phase out or otherwise disadvantage the current fee-for-service program, then I cannot support it.

On the other hand, if it means that more choices will be available and the same drug benefit will also be available to seniors under the current program, then there is room to talk.

As I have said publicly, I will support a private insurance-based drug benefit so long as it includes beneficiary protections, provides a government fall-back, and implements risk using a phased-in approach.

In short, I cannot support any proposal that would create an unlevel playing field between private plans and the current fee-for-service program. The traditional program must remain a viable option for all Medicare beneficiaries.

A final point on Medicare. When we talk about Medicare solvency, we must have an honest dialogue. I am concerned about the political rhetoric I have been hearing from the administration that Medicare will experience a $13 trillion shortfall over the next 75 years.

That assessment is inaccurate. It leaves out a significant source of Medicare funding, that is, general revenue contributions in Part B, but it counts all the spending in A. Part B is funded, as you know, by general revenues and beneficiary premiums.

This rhetoric should not be used to scare the public into swallowing undesirable reforms, particularly when none of the reforms on the table save any money.

Now let me turn to Medicaid, another area where the administration has proposed a far-reaching plan that has generated controversy and much discussion. What States really need right now is fiscal relief, whether for health care, social services or domestic security. Without this assistance, States will be forced to cut Medicaid even further, cut other spending, or increase taxes.

In the interest of our National economy and the people in our States, I think we need to help the States. Beyond that, I am open to talking about changes in Medicaid. Where do States need more flexibility? What other areas need improvement, clarification, or better accountability?

I think the administration's block grant proposal moves in the wrong direction. The proposal provides some additional dollars up front, but takes it back through a dramatic drop in Federal funding.

Moreover, States opting into the program are locked in for 10 years, 10 years in a program that would not account for any unexpected spending increases for health costs, enrollment spikes, or prolonged economic downturns.

The cap to Federal funding would also limit States' options to expand coverage in the future when the financial picture improves. For beneficiaries, the proposal puts optional populations and benefits at risk.

The term "optional" might sound like these people are less needy, but seniors with incomes as low as $6,600 are considered optional. So is a 7-year-old in family with an annual income of $16,000.

Prescription drugs are an optional benefit, which is ironic, considering how hard we are working to include prescription drugs in Medicare.

Let me reiterate that I am open to working on improvements to Medicaid, but we should not throw the proverbial baby out with the bath water. The program is too important to too many people.

A couple of points on welfare reform. We must get it done this year. Our Nation's welfare program cannot continue to be extended in three-month increments. It is just too difficult for States to administer their TANF programs or prepare for any changes passed by Congress, particularly those States whose legislature meets only once every 2 years.

I strongly support welfare reform. Looking back, that was one of the best things we did in the last decade. Thousands and thousands of people have exchanged a monthly welfare check for a real paycheck.

I appreciate that the President has asked us to do better to try to reach families still on welfare. But I am concerned that the administration's proposal is too proscriptive. It would force at least my home State of Montana to scrap its successful Welfare-to-Work strategy. According to the most recent data, Montana ranked first in the country in getting welfare recipients into jobs. We would like to continue that.

I also favor strengthening work requirements, but in a way that makes good sense and in a way that gives States extra funding for any increased child care and transportation needs so that we can avoid another unfunded mandate. The last thing we want to do is impose that on States right now.

Finally, I have questions about the administration's foster care block grant proposal. When more than 30 States have not passed the current safety standards, I am not sure it makes much sense to loosen oversight. We also must continue to promote and support adoption, as we did in the Adoption and Safe Families Act of 1997.

Mr. Secretary, thank you so very much for coming this morning. I sincerely appreciate your service to our country. We have the opportunity to make a difference, you, the committee, and the Congress, in so many different ways that affect people's lives.

I look forward to working with you, with the Chairman of this committee, and with other members of the committee as we strive to meet the needs of our country. Thank you very much.

The CHAIRMAN. Thank you, Senator Baucus. I am glad that Senator Baucus brought up welfare, because I did not mention that. I think that we have worked out with Senator Baucus to have a hearing on March 12, and I believe you will be here at that time, Secretary Thompson, on welfare.

The Majority Leader has not asked for time. We normally do that. I wanted to tell the other members that. We try to accommodate the Majority and Minority Leaders.

But Secretary Thompson, please go ahead.

STATEMENT OF HON. TOMMY THOMPSON, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary THOMPSON. Thank you very much, Mr. Chairman. Good morning to you, Senator Baucus, Senator Breaux, Senator Conrad, Senator Bunning, Majority Leader Frist, and Senator Smith.

It is wonderful to be in front of this committee, Senators, and have the opportunity to testify on certain subjects that are very important to the President, to me personally, and to the whole country. I thank you so very much for holding this hearing.

In my first 2 years at the Department, we made tremendous progress in our efforts to improve the health, the safety, and the well-being of the American people. We continued to make extraordinary progress in improving health care to lower income Americans.

Through waiver and State plan amendments which have been granted to the States, we have expanded access to health coverage for more than 2.2 million individuals. We have expanded the range of benefits offered to 6.7 million other Americans.

To expand on our achievements, the President proposes outlays for HHS of $539 billion. Five hundred and thirty-nine billion dollars, Mr. Chairman, represents an increase of $37 billion, or 7 percent, over last year's request and an increase of more than $109 billion, or 25 percent, since 2001.

The discretionary part of the budget increase is $1.6 billion, or 2.6 percent, to $65 billion of budget authority. This would be a program level increase of 1.5 percent over the enacted fiscal year 2003 appropriation.

Five hundred and thirty-nine billion dollars is a big number, and I have a solemn responsibility as Secretary to make sure that every one of those dollars is put to good, effective use. I owe it to the people who pay the taxes and I owe it to the people who consume the services.

One way to ensure that these dollars are effective is to work with this committee and your leadership, Mr. Chairman, and that of Senator Baucus, and other committees to improve and strengthen our two largest health programs, Medicare and Medicaid.

These are the two topics that I certainly want to outline for you this morning. As you well know, Mr. Chairman, our Nation's Medicare program needs to be strengthened and improved to fill the gaps in current coverage.

The President has proposed numerous principles for Medicare enhancements to ensure that we are providing our seniors with the best possible care. We have dedicated $400 billion over the next decade to achieve this very ambitious goal, and we look very much forward to working closely with you and all members of this committee, and all members of Congress, to develop and pass a responsible and effective Medicare bill this year.

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

Passing Medicare legislation would be a huge task, and improving Medicaid is also just as urgent. In fact, Medicaid is growing even more rapidly than Medicare. The Federal portion is $162 billion, and the program is growing about 9 percent a year, compared to Medicare at about 6 percent.

But State Medicaid programs are under tremendous financial pressure and beneficiaries risk losing coverage. Two-thirds, 38 States, as a matter of fact, have already made reductions this past year or have reduction spending.

The President has proposed a plan to preserve coverage, make Medicaid more efficient, and provide better health care delivery.

We must begin by addressing the immediate fiscal needs of the States. President Bush's plan would meet the 9 percent base growth in the program, and then forward-fund by $3.25 billion for 2004, and $12.7 billion over 7 years.

The forward funding would help people during the current economic conditions, and the flexibility would put States in a better position to handle future economic downturns without having to cut people from Medicaid. They will have the flexibility to make adjustments to weather the storm.

I had a chance to discuss this proposal with many Governors on Monday, and their reaction was quite positive. Let me be very clear about two things. First, States participation in the new program would be optional, completely voluntary to the States.

Second, mandatory populations will continue to receive all of their mandatory benefits. The Medicaid entitlement for mandatory populations would be unchanged. States will have more flexibility in covering optional population, which accounts for a large part of Medicaid spending.

They will gain the ability to target special needs populations, such as those suffering from mental illness and disability, Senator, as well as HIV and AIDS, and those who prefer home- and community-based care.

If we do not improve Medicaid, one million Americans could lose coverage this year, and millions more next year. I look forward to working with Congress to make sure that they have the opportunity to keep it.

I now would like to take this opportunity to announce a new initiative at the Department to improve care for seniors with chronic diseases. Right now, 78 percent of Medicare beneficiaries have at least one chronic disease, and these patients account for 99 percent of Medicaid spending each year.

Total health care expenditures in our country reached an astounding $1.4 trillion. Of that colossal sum, chronic diseases accounted for more than 75 percent of those expenditures.

Many people with chronic diseases see a confusing variety of specialists, internists, and other providers and many have trouble following all of their advice. This confusion often causes their conditions to get worse and more expensive to treat. Unnecessary hospitalizations are not just expensive, they are unfair to the patient.

Another problem, is that when physicians keep their patients healthy, the patients need less care so the physicians get paid less under fee-for-service plans. It is not fair to physicians to give them a financial incentive that conflicts with their professional obligation.

We have a plan to eliminate this conflict by aligning these interests—and we will demonstrate this plan—in the context of Medicare. Our system should be set up so the best care for the patient is also good for the doctor, and more importantly, for the taxpayer.

I am proud to announce this morning a capitated disease management demonstration projects, Mr. Chairman and members, that will do just that. This demonstration will help certain Medicare beneficiaries who suffer from chronic diseases by coordinating their care and monitoring their progress and behavior through a single organization. This idea is called disease management.

Medicare will pay disease management organizations a fixed amount based on the needs of each patient instead of paying for services rendered. This will give providers a financial interest in the health of their patients, not the quantity of their services.

This demonstration will run for 3 years. If it succeeds, everyone wins. Patients will benefit from better coordinated care, providers will benefit because they will be able to focus on keeping patients healthy, and taxpayers may eventually benefit, too, if we can demonstrate a pattern of keeping costs under control.

While I am here, I would also like to mention one other item in our budget. President Bush recently announced a new initiative, Project Bio-Shield, that would help prepare the country for a bioterrorist attack.

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

The President has made improving our Nation's health, as you know, Mr. Chairman, and health care one of his biggest and highest priorities for the coming year. By working together, we can make it one of our proudest achievements.

I look forward to all of the work, and I know our discussion this morning will certainly get things started. I thank you so very much, once again, Mr. Chairman, for giving me this privilege to appear in front of you and have the opportunity to answer your questions.

Thank you for inviting me.

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

The CHAIRMAN. Thank you very much. We will have five-minute rounds. The order will be: Grassley, Baucus, Frist, Conrad, Breaux, Smith, Lincoln, Bunning. Mr. Lott is here and Ms. Snowe is here. I will get a new list by the time we get around to you guys.

Senator BAUCUS. I am glad you are getting around to them.

The CHAIRMAN. Bunning, Lott, and Snowe.

The first question, Mr. Secretary, is in regard to the 28 percent, or about that percentage, of seniors that already have drug coverage from a former employer, to get an idea how the administration would see that, how you could preserve the good prescription drug coverage that many seniors have through those former employers, while we add a prescription drug program to Medicare.

Particularly if employers are already providing this coverage, how can we assure that we are not replacing private dollars with public dollars? Let me explain what I would consider a political problem as we deal with this 28 percent moving towards one of two things.

We would hopefully not have that dumped on the government program and save public dollars, but, more importantly, I would see that group of people with good health care, and maybe even better health, worried that it would be lost.

If they thought it was going to be lost, you might have about the same group of people that were irate about catastrophic coverage 15 years ago when we adopted it, the group of people that were paying higher premiums and maybe not getting benefits, for people that were going to get benefits. That revolution really caused Congress to repeal that.

That same group of people, maybe middle class, older people, would be the ones that maybe could say, if I am going to lose what I have now, why should I have lesser coverage if we are going to have a government program?

Secretary THOMPSON. Well, Mr. Chairman, you know that there none of us wants the private sector to be pushed out or supplanted by Federal decisions on Federal programs. I can assure you that that will not be the case with the President's and the administration's proposal.

The final details, as you know, Mr. Chairman, have not been completely worked out, so that particular detail will have to be left until the final details are able to be announced by the President and be able to given to you and all members of this committee.

The CHAIRMAN. But the administration is at least considering that as a major issue to be dealt with?

Secretary THOMPSON. Absolutely, Senator.

The CHAIRMAN. And I think you are saying that it is not the administration's intention that those programs would be discouraged because of the government program.

Secretary THOMPSON. Absolutely not. They would be encouraged rather than discouraged.

The CHAIRMAN. Now I would like to go to a Medicaid issue. About 90 percent of Medicaid beneficiaries in nursing homes are optional beneficiaries. These optional beneficiaries include those who are not categorically eligible for Medicaid, but who are impoverished by the cost of nursing home care.

As you know, about a third of nursing home residents are not Medicaid beneficiaries at all, but are private pay. Under the Medicaid reform proposal, would the Nursing Home Reform Act no longer apply to these residents? In other words, would their care be exempted from the Federal quality standards, annual inspections, and enforcements that are spelled out in existing law?

Secretary THOMPSON. All of those protections will be continued and will remain in the statute, and will not be in any way changed whatsoever, Mr. Chairman. The mandatory populations, the mandatory options, the mandatory guarantees that you have just outlined, continue in the law and are not affected one bit.

The CHAIRMAN. There are a number of challenges associated with providing health care in rural areas. As I understand it, your plan would allow States to provide a different level of coverage in urban and rural areas within a State.

How would you address the concern that, unless States are directed to pay attention to rural areas, that those interests may not get the attention that they need? How would you ensure that Medicaid recipients in both areas would receive fair and equitable treatment?

Secretary THOMPSON. Senator, under the current law, Medicaid requires everything to be uniform any time you adopt an optional choice, an optional benefit, or an optional population.

So under the current financial stress of Governors, legislators, and States, the Governors only have one or two choices: maintain the program as is, or drop it. We are going to give them a third option.

We are going to give them, if they volunteer to go into the program, be able to maintain the program or be able to modify it and be able to allow for different benefits if need be.

For instance, sometimes there may be an HMO in a particular area. You may want to be able to provide for HMO coverage in a particular area of a State. You cannot do that under the current law. Under the next flexibility, you would be able to do that.

You know I come from a rural area, like you do. I would not allow for anything that would be able to discriminate against rural areas in a proposal that I am advancing, Senator. I can assure you that that would be the case.

It would give the States and the legislature one more tool in their arsenal to be able to provide the coverages, because what is happening right now is States are dropping these optional populations because they cannot afford it. We want to be able to maintain it, and that is what this proposal gives them the flexibility to do.

The CHAIRMAN. All right. Thank you.

I am going to put a statement in the record for Senator Thomas, who could not be here.

[The prepared statement of Senator Thomas appears in the appendix.]

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Mr. Secretary, I would like to ask you what the administration means when it uses the term "Medicare reform." That means lots of different things to lots of different people.

As I mentioned in my statement, the administration—I do not think you, but the administration—sometimes uses the term "$13 trillion shortfall in Medicare." As I pointed out, that does not include the revenue that goes into it.

Secretary THOMPSON. It does not include the Part B.

Senator BAUCUS. It does not include the Part B revenue, which would make that $13 trillion a lot lower if you were to include that figure. So, it is a little misleading in the materials, at least, that you provided to this committee, to say that it is a staggering amount, and all this.

It is misleading. I just hope, frankly, we compare apples with apples and not get wrapped around the axle on rhetoric which is not really honest or fair.

What do you mean by "Medicare reform?" I ask that, because sometimes the administration and some others refer to FEHBP, but the fact is, FEHBP has increased in cost a lot more in the last couple of years, per year, than has traditional fee-for-service.

So what do you mean by "Medicare reform?" There are no proposals on the table that save any money, and the alternatives actually are more costly than traditional fee-for-service.

Secretary THOMPSON. Senator Baucus, you know that by putting on prescription drug coverage, it is going to be more costly just by the definition.

Senator BAUCUS. All things being equal.

Secretary THOMPSON. There is no question about that. It is going to be more expensive by adding the benefit.

What the administration wants to do, is it wants to strengthen Medicare. It wants more choices. It wants seniors to have the same

kind of choices that you do and I do as Federal employees, and other members of Congress and the administration.

We want to be able to strengthen it. We want to be able to add prescription drug coverage. We want to be able to put a stop-gap loss in for casualty. We would like to be able to have one that is going to be more competitive.

That is the reform we are looking at. The final details, Senator, have not been worked out. As soon as they are, I would be more than happy to sit down and talk to you.

Senator BAUCUS. All right. I appreciate that.

Do you know whether the difference, that is, the 25 percent increase in CALPERS, and the 11 percent increase last year in FEHBP, is due to the inclusion of drugs? Do you have figures? Do you know?

Secretary THOMPSON. I would presume that it has to be. Any time that we have analyzed insurance coverage increases, invariably the biggest driving force has been the drug coverage.

Senator BAUCUS. All right. The point I want to make, though, is I have seen no so-called Medicare reform alternatives that actually save money. Frankly, they all tend to cost more than currently, at least, compared with fee-for-service.

Secretary THOMPSON. I have to agree with you that if you add prescription drugs it is going to be more expensive. I do not think anybody is denying that.

Senator BAUCUS. But I have seen no data that separates out prescription drug from the alternatives either. None. My guess is, if drugs only accounted for the difference, we would be seeing some data that could so explain that. But, at the very least, that is something we should explore to see how much of that is drugs and how much of it is not.

Secretary THOMPSON. We are analyzing a lot of the insurance costs in the Department and we will be able to make a lot of information available as we proceed, Senator. But we are also trying to make sure that Medicare is put on a strengthened footing, as you want.

Senator BAUCUS. I appreciate that.

On the Medicaid proposal, is it true that under the administration's proposal for an optional Medicaid service for beneficiaries, a State could choose to provide a service in one part of the State, but not in another? That is, say, in cities, but not in rural areas? That is, do away with the current State-wide requirement?

Secretary THOMPSON. Yes. If a State wanted to do that, yes, in order to provide the coverage. I cannot imagine anybody doing that, Senator. But right now, the only choice they have is to drop it for the total State, because that is what is happening.

We are not changing the fact that the States, right now, have complete control over the optional service and optional programs,. and 38 States dropped optional services last year. This year, 42 States are. The only choice they have is to drop it completely. We are going to give them the opportunity to maybe be able to change it.

If I could give you an example. The State of Utah had a program in the Medicaid system which was more expensive and had more

benefits than what the Governor and the State legislature and the State employees had.

They want to be able to reduce the benefits down to what the State employees' package is, which would be cheaper, and they would be able to expand it and include more people. That is the kind of innovation that we are expecting as far as this new proposal is concerned, Senator.

Senator BAUCUS. I guess it is really a very basic fundamental and philosophical question here that has to be addressed, and I do not think really is being addressed. That is, when Federal taxpayers provide roughly, on average, 57 percent of the Medicaid funds that go to States, should the Federal Government have any standards, say, on optional benefits or not?

If the administration, as I understand it, is essentially saying—and please correct me if I am wrong—with respect to optional benefits which are matched at the same rate as mandatory benefits, that the States have virtually free choice as to what to do with those optional benefits. That is, it does not have to be State-wide. They can provide drugs some places and not other places in the State.

I just wonder if the Federal taxpayers—we provide 57 percent—ought to have some say as to how the States provide those optional benefits.

Secretary THOMPSON. But, Senator, to correct you, and I hate to do this, the States have that authority right now.

Senator BAUCUS. No, they do not.

Secretary THOMPSON. Yes, they do.

Senator BAUCUS. I am sorry, Mr. Secretary. They have the authority to do it on a State-wide basis.

Secretary THOMPSON. Right.

Senator BAUCUS. They do not have the authority to pick and choose among which seniors in the State get the optional benefit and which seniors in the State do not get the optional benefit.

Secretary THOMPSON. The only choice the States have is to drop it completely. There is no requirement that the States have to have an optional service or an optional population.

Right now, because of the financial problems they are in, the only choice they have is to drop it completely. We are going to give them the flexibility to be able to have co-pays, maybe, some additional co-pays, and maybe be able to put some people in HMOs, maybe be able to allow for different populations.

Senator BAUCUS. Right. I understand that. My time is up. But it gets down to, really, fairness and discrimination. The proposal opens up great potential abuse for unfairness and great potential for discrimination among seniors in our country.

I think we have got to find a better way to address some of the problems the States are having than to open up Pandora's box, open up the door that leads to tremendous discrimination among seniors in many States around the country.

Secretary THOMPSON. Senator, if I could quickly respond.

Senator BAUCUS. Please go ahead.

Secretary THOMPSON. There is not discrimination. Right now, the States have the opportunity, legal opportunity, to drop optional populations. That is what they are doing.

We are going to give them the flexibility to allow those people to continue, maybe by increasing the co-pays, but allowing the service to continue. To me, that is a much better option, to allow people to have the service, than to be able to force the States to drop them completely. That is what the current law does.

The new law, which is voluntary, a State does not have to do it, gives them the flexibility to be able to maintain those services and keep the Federal dollars, and pay less for it.

Senator BAUCUS. Well, you can have last word, even though it is not an accurate last word.

Secretary THOMPSON. It is absolutely accurate.

Senator BAUCUS. It is discrimination. You are allowing discrimination.

Secretary THOMPSON. You are not allowing discrimination.

The CHAIRMAN. Well, hopefully we will have a bill up on Medicaid, so we will have an opportunity to settle this issue.

The CHAIRMAN. I would like to ask Senator Frist, Senator Conrad, and Senator Breaux if they would give permission to Senator Smith, who has to get a plane at 11:00, to go ahead of them. If any of you object, obviously we will not jump over you. Any objection?

[No response]

The CHAIRMAN. Senator Smith, go ahead.

Senator SMITH. All right.

The CHAIRMAN. Then if Senator Lincoln comes, I am going to interrupt so we can vote our miscellaneous tariff bill out that we did not get out last week. And thanks to Senator Baucus for the suggestion.

Senator Smith.

Senator SMITH. Thank you, Mr. Chairman. I guess the last will be first in this case. I thank my colleagues for their indulgence.

The CHAIRMAN. It does not happen very often.

Senator SMITH. No, it does not. I will take it when I can get it.

Secretary Thompson, thank you for being here. Thank you for the tremendous progress you are making on health care issues. I know my State of Oregon, for a long time, has tried to be very innovative in health care, trying to get to full coverage for Oregonians.

But there are still 14 percent of Oregonians who are uninsured, and that number is climbing, given the recession. Yet, the flexibility that you are offering, I think, is very welcome and would have helped Oregon a lot in earlier years had it been available. So, I salute you for that.

But I do want to point out the tremendous support that there has been in the Senate for a bill that Senator Rockefeller, Senator Collins, Senator Ben Nelson and I have put forward in earlier Congresses, and have reintroduced this year, that would increase State fiscal relief above what the administration is proposing.

You have just met with all of our Governors, and you having been one yourself, know how much extremis their budgets are in. My State has already cut several billion dollars from their budget and they have got some more to go.

The CHAIRMAN. Mr. Smith?

Senator SMITH. Yes, sir?

The CHAIRMAN. May I interrupt you, without taking time away from your 5 minutes?

Senator SMITH. Of course.

[Whereupon, at 10:52 a.m. the meeting was recessed to enter into executive session.]

AFTER RECESS [11:55 A.M.]

The CHAIRMAN. Senator Smith, to continue on his 5 minutes.

Senator SMITH. Thank you, Mr. Chairman.

Secretary Thompson, my point is, simply, really a financial one. It does seem to me, one of the legitimate areas where we can help the States, need to help the States, have an obligation to help the States, is when it comes to FMAP.

I think, as we look at the things we are going to try to do in this committee for the President's agenda, I am really asking, is there flexibility on the number. The number that the administration is proposing would give Oregon an additional $38 million that they would receive over the next 18 months to help on this.

But my bill would give the State of Oregon $219 million. It is a huge difference. Even my bill would only diminish their budget shortfall by a fifth. So, I am asking if there is flexibility, not just in your program, but in the dollar amount that we can supply to the States.

Secretary THOMPSON. Of course there is flexibility, Senator Smith. But it just does not make a lot of sense to put more money into a system that is not working as well as it can work, and should work. That is why your proposal just increases the FMAP and does not make the necessary changes.

I think we have to look at the overall Medicaid system, which is very bureaucratic. It needs to be changed and there needs to be more flexibility, and that is what we are offering.

Let me just explain a couple of things. Oregon, right now, cannot use its SCHIP money because it passed a program prior to SCHIP, and that money gets sent back to the Federal Treasury and redistributed. Under this proposal, the new proposal, the SCHIP money would stay in Oregon, which would be a tremendous benefit.

Second, all the waivers that Oregon got also allows for changes in the program to give different individuals different coverages, the same kind of waivers that we granted to the State of Montana on many occasions to allow the State of Montana to do the same thing under the waiver system.

This is what the law does. It encapsulates and encompasses, what we have done in the waiver process, the best procedures. We are going to take the best models and have a clearinghouse and allow the States to be able to find what is working in Mississippi and be able to send that over to Tennessee or to Oregon.

The third thing, Senator Smith, is it is not a block grant. Under the Medicaid law, we have to project out for 10 years what it is going to cost. It is a trend line. We project out for the next 10 years that it is going to be a 9 percent increase.

We are advancing $12.7 billion in the first seven years. In the first year, it is going to be $3.75 billion. That means, if you would equate that to the FMAP, that is a 2 percent increase in the FMAP for every State in America.

The third thing, is every year in September or October States have got to send in to the Federal Government the computations, cost accounting, what it is going to cost, and then the projections for the next year have got to be based upon three things: what the population increase is, what the utilization is going to be, and what the inflationary index of medical costs are going to be in that State. When you put those three variables together, that is the increase on the base that Oregon has got to pay.

Under our proposal, we are going to forgive/forego Oregon, and all the States, the requirement to pay for the population increases and the utilization. That is about a two-thirds of a decrease of $12 billion, because the total cost of the Medicaid coverage for States is $122 billion, and a 10 percent increase is $12 billion.

So you can figure an $8 billion decrease in the amount of money that the States are going to pay, which increases the FMAP. So what you are doing, is you are indirectly increasing the FMAP, first by the advance forward funding, secondly by having the States pay less to get the dollars, and third, giving them the flexibility to get the best programs possible throughout the system.

That is why I cannot understand why people do not just say, this is a great deal for States. Most Governors that sit down and analyze it and know the program will say, this is really good.

Senator SMITH. Mr. Secretary, my new Governor, Governor Kulongoski, with whom I met, went into your meeting—I am reflecting what I think I heard him say—being very suspicious of what you are proposing. He came out, he told me, much encouraged. I think the flexibility in all of the proposals you are making to reform a broken system are very, very welcome and overdue.

My only point, and I make this on behalf of myself and our Governor, is that in addition to those things I think we may need to do a little bit more in terms of dollars.

Secretary THOMPSON. I am listening. I am very flexible, very willing to work with you, Senator.

Senator SMITH. Thank you, Mr. Chairman and my colleagues.

The CHAIRMAN. You have got one minute to get to your airplane. Senator Frist.

Senator FRIST. Thank you, Mr. Chairman.

I want to shift the focus a bit to the disease management statement that you made today, Mr. Secretary. You mention in your statement, in your written testimony, a capitated disease management demonstration project.

It brings to mind, as we look at Medicare modernization and how we bring a program which has been of huge benefit to seniors and individuals with disabilities, but has not kept up with either health care delivery systems or types of delivery that we know do work better, but also have a better chance working in the future as we come to understand better the nature of disease and how it has evolved in our senior citizens.

The cost issues and the money, and how we sustain this valuable program over time, I think, means that we need to start dissecting out where the costs are spent. As you know, about 6 percent of beneficiaries, or 1 out of 20—if we had a full house here, only one of us would account for over 50 percent of all the dollars spent in Medicare, which is truly amazing. That means one of us, or I, could

be responsible for more than 50 percent of all dollars spent in Medicare today.

I see your effort, and I want you to expand on how you see it apply, to be the first real strike. If you could better coordinate my care, then over time we have a chance, in this aging of the population and huge demographic shift, of improving care and at the same time adding benefits like prescription drugs.

Again, more for my colleagues, because I started focusing on this before, it is 6 percent that account for 50 percent of all expenditures, and 14 percent account for over 75 percent of all expenditures.

Then you figure out how you are going to identify who is costing so much.

What is interesting, and what we have to address if we say an integrated model is important—which I believe and I think you believe in strongly—that means prescription drugs, acute care, chronic care, and preventive medicine all have got to be considered together when you are talking about the care of a patient.

You do look at the best model today, which is the Federal Employees Health Benefit Plan.

The difference is, we have got different populations, under 65 and older than 65. But it also gives us great opportunities because, looking at Medicare data, the beneficiary or the person who has more chronic conditions is the one with the highest health costs.

The person who has five or more chronic conditions costs over $13,000 a year per beneficiary. The senior that might have two chronic conditions only costs $2,000 a year, and one chronic condition, only $800 a year.

Thus, I see your program being the real first, recognition of these disparities in terms of managing the care of the individual who is most responsible for the cost. That same individual is the one that has three, four, or five chronic conditions.

Let me just ask, do we have the technology today to identify in Medicare who that individual is, in order to target them? And how do you see this capitation actually working when, as I said, the disparities on number of chronic conditions explain ultimately how much that individual is costing?

Secretary THOMPSON. Thank you. Senator, you and I have discussed this problem so many times, and I thank you so very much for your passion on it. We spend approximately 93 to 95 percent of all Medicare dollars on getting people well after they get sick, and less than 10 percent of the dollars on Medicare keeping people well. That is the theory and philosophy behind what we are going to do.

We have got the computer data, and CMS, the computer bases on which to be able to identify these people and find out if they are taking their medicines, find out if, in fact, they are seeing their doctor. See if they are making their appointments.

See if, in fact, they need to go in and get an annual check-up and be able to monitor them on a weekly and monthly basis. We can also find out if they need help. The technology is available. These are the kinds of specifications that we are going to write into rules.

We are going to manage these people so they take their medicine so they do not have to go into an emergency room. We are going

to be able to monitor their blood glucose, and so on, that you know about as far as diabetes is concerned.

When you take a look, in fact, across America, $155 billion a year is spent on tobacco-related illnesses and 400,000 people die; 300,000 people die for obesity, and it costs us $117 billion; $100 billion a year on diabetes, 17 million Americans have diabetes, 16 million more are pre-diabetic.

All we have to do is look at those three areas. That is $382 billion, compared to $260 billion that we are spending on Medicare. If we can drive down the costs on diabetes, obesity, and tobacco-related illnesses, we will save many dollars, make individuals healthier, make the system better, and improve the quality of health of all Americans. That is what we are trying to do in these demonstration plots in 10 States across America.

Senator FRIST. Mr. Chairman, I know my time is out, but this is the answer, at the end of the day.

Secretary THOMPSON. It is.

Senator FRIST. It is better coordination of care of those seniors who may be on 25 prescription drugs, given to them by six or seven different doctors. I just will close and say the problem with Medicare today is that you have to propose a demonstration project. We do not really have the flexibility built into the system today to simply add this coverage.

As we look to modernization of the program, I hope that we have enough flexibility to engage in these sorts of programs which we will be able to adapt with the times ahead of us.

The CHAIRMAN. Senator Conrad, then after that will be Senator Breaux.

Senator CONRAD. Thank you, Mr. Chairman.

Again, welcome, Mr. Secretary. I had a chance to visit with you yesterday before the Budget Committee. I, again, just want to repeat the regard that I have for you and the way you have conducted yourself in this office in very challenging times.

Also, to thank you for having people on your team like Mr. Scully, who is highly regarded on both sides here for his expertise.

I want to go to the question I talked with you about yesterday which is on this chart, which is our long-term circumstance, the pressure we have of the retirement of the baby boomers, the pressure that puts on Medicare, Medicaid, and Social Security, and the additional pressure generated by the President's proposed additional tax cuts.

What this chart shows, is that right now we are in the sweet spot. Right now, we are in a circumstance in which the trust funds of Social Security and Medicare are throwing off surpluses. But when that changes, when the baby boomers start to retire and those trust funds go cash negative, is the very time the cost of the President's tax cut proposals explode.

The result is extraordinarily deep deficits in the years ahead. We are at record deficits now. None of this adds up now. Yet, under the President's spending and tax proposals, it will get much worse. And these are not my numbers. These are from the administration's own budget documents.

And as I have studied this, I can only come to one conclusion. That is that the administration intends to have deep cuts in Medi-

care and Social Security benefits, and Medicaid benefits, and others because this level of deficits is not sustainable.

Can you tell us, is that the administration plan for the long term, to have significant reductions in the benefits of Medicare, Social Security, and Medicaid, and other mandatory programs? What is the plan?

Secretary THOMPSON. First off, Social Security is not in front of us and a plan has not been developed by the administration. The Medicare plan is being developed by the administration, and wants very much, in order to make sure that seniors have prescription drug coverage, and make sure that they want choice so that the senior has the opportunity to be able to decide for himself or herself what is the best health insurance program for themselves. It does not anticipate, does not expect, and would not support a reduction in benefits.

As far as Medicaid is concerned, I have discussed this many times with you. We want to put the system and make it optional, at the same time maintaining the mandatory populations, for allowing Governors and legislators to be able to structure the program, for disease management, what we think is really necessary, preventative disease, which I am passionate about.

If we are going to really save costs in the medical system, this is where you have to save the dollars. Find ways for annual screenings. Find ways in which you will be able to make sure that people are eating properly. Reduce tobacco intake. Be able to find ways to encourage people to exercise more.

That is what this administration wants to do. We want to make Americans healthier and we want to make sure that we provide the system that is going to encourage them to do so.

Senator CONRAD. Let me just say to you, Mr. Secretary, I agree with the sentiments and I agree with many of the priorities that you have discussed. I especially agree with the notion of targeting those areas where we have especially heavy costs because of certain specific diseases where we could make dramatic strides.

But I have to tell you, as I look at these numbers, they do not add up. It is much worse than that. We are headed for deficits as far as the eye can see, and such a deep ocean of red ink that the only possible outcome that I can see, if we follow the administration's plan of coupling massive tax cuts on top of the tax cuts already enacted, given the increasing costs associated with the retirement of the baby boom generation, that these things collide.

When the trust funds go negative and we are already in deep deficit, the cost of the tax cuts explode, and I do not know what outcome that can lead to other than massive unsustainable debt, which the head of the Congressional Budget Office warned us of last year, or deep, deep cuts in benefits. I do not think there is any other possible outcome.

Secretary THOMPSON. The only other outcome is one which the President believes very much in, and that is to grow the economy and use the tax cuts to stimulate the economy so we create more jobs, more opportunities, more taxes because of the increased economic activity. That is what the administration believes very strongly in.

Senator CONRAD. I would just say this to you, and I say it with all sincerity. The President's own budget numbers do not show that you get more revenue from his tax cuts proposals. They show you get less revenue. They show that the deficits explode. Those are his own budget documents.

Secretary THOMPSON. None of the charts, none of the programs, take into consideration increased economic activity which the tax cuts will certainly cause. They certainly will bring improved economic conditions. That does not show up on any charts in the President's budget because it is not scored by CBO.

Senator CONRAD. I can only say to you, many economists tell us that, instead of increased economic activity, the President's proposal will reduce economic activity because the tax cuts are not offset by spending reductions. It would be true if that were the case.

But, instead, we have borrowed money. That puts a weight on the economy, reduces the pool of societal savings, reduces the money available for investment, and thereby reduces economic growth.

The CHAIRMAN. Senator Breaux.

Senator BREAUX. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. We will not discuss Medicaid, since you and I have had an opportunity to do that already in a previous forum. I would like to focus in on Medicare.

With regard to Medicare, as Yogi Berra says, "Here we go with deja vu all over again." The process is the same every year. We have the Secretary come up and talk about the need to reform Medicare. Then we have GAO who is going to come in and tell us we need to reform Medicare.

Then we are going to probably have the CBO come in and tell us we should reform Medicare, followed by the trustees who are going to recommend some reform to Medicare. By that time, we will probably be into next year, which is an election year, and we are not going to reform Medicare.

That same possibility exists this year. Therefore, it is incredibly important that the administration, this committee, and this Congress, if the stars are finally lining up in the right direction, to possibly really actually do something that reforms Medicare.

The age-old arguments are the same. Many Democrats want the government to do it all, the private sector to do nothing. Many Republicans want the private sector to do everything and the government to not be involved at all.

The answer obviously lies somewhere in between those two extreme viewpoints, where we ought to be combining the best of what government can do with the best of what the private sector can do, and create a 21st century health care delivery system. Medicare is antiquated. It is a 1965 model. It does not cover, on average, 47 percent of the average costs of the average senior.

It is not a good program in terms of what other plans for other citizens contribute in terms of their care. We cannot continue to micromanage it in Washington with 133,000 pages of regulations.

Therefore, we are looking forward to, hopefully, a recommendation from the administration. We do not have that yet. I do not think we need a bill from you guys. I think we need an outline of what you can support with some numbers attached to it.

There are enough ideas out there about how to craft a new system, but we need to move. Otherwise, we are going to be right back where we have been for the last many years, running out of time at a critical point.

The question I would like to ask you, is that some have suggested in previous efforts that we sort of take the model that we have as members of Congress, and the Senate, and you as a Federal employee, and nine million other Federal employees, which does combine the best of what government can do in helping to pay for it, and helping to supervise it, but not micromanage it, and institute a private, competitive delivery system that competes for the right to serve the Medicare population like it does for us.

Some say, well, that may work among younger people, but not under older people. It is not going to work in rural areas. My question is coming about whether it can work, but I want to lay out the plan, first.

Under our plan that we get every year along with nine million other workers, the nationwide fee-for-service plans that are open to everybody includes 10 plans, all fee-for-service plans, some with a PPO option. But if you want to be in fee-for-service, have at it.

There are 10 plans that cover all 50 States, the most urban State and the most rural State. The most rural Federal employee in the most rural county in America has a choice between 10 separate fee-for-service plans that they can pick from.

If you are a Department of Interior worker in a park somewhere and you never see daylight, you still have a choice of 10 different plans that you can pick from.

So my only question to you is, is there any reason why the administration would think that we cannot pattern a modernized Medicare program for our seniors which includes prescription drugs based on the type of plan that we have as Federal employees? Is there any reason we cannot do that?

Secretary THOMPSON. There is no reason whatsoever we cannot do that. If you support that, Senator Breaux, and if we can get a bipartisan coalition, I am confident that we could pass that and get it behind us this year.

I know that is the President's position. He feels very passionate about it. It is my position, and the Department's position. We want to work with you. But, just what you said is exactly what needs to be done, and I hope that we can have the political wherewithal, power, and support to get it done.

Senator BREAUX. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

The CHAIRMAN. After Senator Breaux comes Senator Lincoln.

Senator LINCOLN. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

Secretary THOMPSON. Thank you, Senator Lincoln.

Senator LINCOLN. We are glad that you are here, and certainly looking forward to working with you to come about with some solutions.

I do have some grave concerns about the President's proposal to privatize Medicare, and hope that we can work together to modernize the plan. I agree with Senator Breaux. However, if Medicare was born in 1965 and it is so antiquated, I must be a fossil.

Secretary THOMPSON. That certainly is not the administration's position, I want you to know that, Senator Lincoln. [Laughter.]

Senator LINCOLN. But I think it is so important for all of us to remember, Mr. Secretary, why Congress created Medicare in the first place, because private insurance plans were failing to provide the comprehensive and affordable health care coverage for seniors.

Then again in 1972, Congress extended that Medicare coverage to the two other populations that could not afford to really get good insurance coverage, people with disabilities and people with kidney failure.

So I am hoping that we can remember all of that in the context of what we are trying to do. I, too, want to modernize Medicare, and I think that we can. Working together, we can improve some of the traditional Medicare programs for seniors and individuals with disabilities, while still lowering the cost.

I would like to just comment. Dr. Frist made a comment earlier, and I have got a bill for him that is great. He mentioned improving the coordination of care, particularly for the elderly.

I had introduced last year, and have reintroduced, the Geriatric Care Act, which seeks to improve that kind of coordination. Because if we want to get the biggest bang for our buck, particularly with those elderly citizens, we have to recognize that their health care is very different.

It does need to be a continuum of care. It has got to be multiple individuals that we work with, whether it is the pharmacist, the prescriptions they take, whether it is the psychological aspect of aging, and other things. I think that it is very important that we take that into consideration.

So I hope that some of the reforms we look at in helping Medicare beneficiaries will do so in helping them to gain greater access to geriatricians so we can not only improve their care, but do it in a way that I think is economical.

Secretary THOMPSON. It is.

Senator LINCOLN. It is. No, I agree wholeheartedly.

Secretary THOMPSON. Senator Lincoln, if I could just quickly interrupt, that is what we are trying to do with our demonstration programs. We want to be able to demonstrate to you, and to the seniors in your State and across America, that disease management and preventative health is going to pay dividends to them for improving their health and save dollars for the taxpayers.

Senator LINCOLN. Well, I hope you will take a look at that Geriatric Care Act, because the fact is, with 125 medical schools in this country, only 3 of them offer a residency program in geriatrics. Even now, we are seeing a diminishing amount of geriatricians, as well as those that teach geriatric care.

Secretary THOMPSON. That is very true.

Senator LINCOLN. So, it is important.

Just a couple of follow-up questions. Senator Breaux brought up the Federal health care plan that we have available to us. But since Medicare premiums and spending have been growing at a much slower rate than the Federal program, how do we expect to save any money by moving towards that type of a program?

Secretary THOMPSON. We think that the with choice, competition, and the ability to allow seniors to make those choices, that we will

be able to make it a much more rational system, and we are hoping that it will save money.

Senator LINCOLN. Well, I just know, because I hear from my staff as well as when I see what comes out of my check, the increases that we are seeing in the Federal program. I think that is important to take into consideration if that is what we are going to model.

Secretary THOMPSON. We are taking all of that into consideration, I can assure you, Senator Lincoln.

Senator LINCOLN. Well, we are hoping that we can see those kind of savings. But, again, if it is growing at a faster rate than what Medicare spending is, I think we need to certainly be cautious about that.

The other thing, Mr. Secretary, under the administration's Medicare plan, seniors and individuals with disabilities. Will they be able to get prescription drug coverage if they choose to stay in the traditional Medicare program?

Secretary THOMPSON. All of those details are going to be outlined for you in a very short period of time.

Senator LINCOLN. So we do not know yet.

Secretary THOMPSON. Well, I can assure you that all of those things are being considered and the details will be coming to you very soon.

Senator LINCOLN. Just on the mandatory aspect of what you have been explaining most recently, that will still be covered under an FMAP situation in terms of a matching. I am assuming that there is going to be an MOE for the optional part.

Secretary THOMPSON. Are you talking about Medicaid now?

Senator LINCOLN. Yes. Under the Medicaid options. Yes, sir. We will still have the FMAP, the Federal matching rate, for the mandatory part.

Secretary THOMPSON. Yes. Yes.

Senator LINCOLN. But in terms of the optional, the MOE, is there some kind of cost sharing there?

Secretary THOMPSON. Sure. It is the same partnership, except that the States will not have to pay as much in on an annual basis as they currently do.

Senator LINCOLN. Which means they will not get as much out, probably, for the option.

Secretary THOMPSON. They are going to get more. It is going to be a much better deal for the States. Let me quickly explain. Right now, States have to compute out each year in September and October how much more they are going to have to pay next year in order to get the Federal match.

It is based upon three variables: population increases in your State, utilization in your State, and then the indexing of inflation costs of medical care in your State. That is, right now, costing about an additional $12 billion a year for the States.

We, under the new proposal, if a State would voluntarily come into it, would only have to compute out the indexing inflation of medical costs. They would not have to include in their base dollars the population increases or the utilization, which would be a net savings, a huge savings, to each and every State.

So they would only have one variable that they would have to compute and add on to it, which in essence increases the FMAP participation of the Federal Government and reduces the contribution of the State. But they still get the Federal dollars to come in to maintain the coverage.

Senator LINCOLN. This is the flexibility you are talking about on the optional side.

Secretary THOMPSON. This is the optional.

The CHAIRMAN. Thank you, Senator Lincoln.

Senator Bunning.

Senator BUNNING. Yes, Mr. Chairman. I would like to enter my opening statement into the record.

The CHAIRMAN. Yes. It will be included in the record.

[The prepared statement of Senator Bunning appears in the appendix.]

Senator BUNNING. Thank you. Welcome, Secretary Thompson. How are you?

Secretary THOMPSON. Senator, how are you?

Senator BUNNING. In many areas of the country, the Medicare+Choice program has not lived up to the promise of providing seniors with an alternative to traditional Medicare. In Kentucky, only two companies offer Medicare+Choice services to seniors. Two.

The administration has proposed several changes to the Medicare+Choice program. If these changes are enacted, what will this mean to my seniors back in Kentucky?

Secretary THOMPSON. We are hoping, with the changes that are being discussed, to stabilize and increase the Medicare+Choice proposal, but it is not the central basis of the new Medicare law that we are proposing and hoping to get passed.

We believe very strongly that the Medicare+Choice is a program that the seniors that are in like very much and would like to continue, and we would like to be able to continue that program and be able to make improvements in it so that companies would have the financial stability to be able to expand in your State, in my State, in Senator Frist's State, and every State in America.

Senator BUNNING. Well, Kentucky, in 1991, I believe, passed some laws that chased the insurance companies out of the State rather than invited them in. We used to have 48 people that offered insurance, and now we have two that will cover Medicare+Choice.

Many States, including mine, are making some very, very difficult choices about the service and groups who are eligible for Medicaid in an effort to balance their budgets.

How will the administration's voluntary proposal to combine SCHIP and Medicaid dollars affect both the mandatory and the non-mandatory people receiving Medicaid?

Secretary THOMPSON. The proposal, first, is voluntary, as you indicated, so Kentucky could make a decision if they want to go into it or not.

Second, it does not do anything with the mandatory populations, the mandatory coverages, or the mandatory guarantees, as Senator Grassley asked me earlier. It does not touch the statutory guarantees or the mandatory populations.

What it does do, is it allows the State of Kentucky to be able to take the rest of the Medicaid dollars and be able to develop a better program. They will have to pay less.

The State will have to pay less to get the Federal dollars, and they will get forward-funded $12.7 billion over 7 years, and will be able to continue to increase their dollars in 8, 9, and 10, but at a lower rate than if they stayed in the current program.

We are only asking if they will do this to divide up their Medicaid caseload into two areas: acute care and long-term and prevention care. The acute care is not growing very rapidly at all. The long-term population and where we want to be able to make the biggest impact, is on prevention and disease management for long-term adults.

So we are trying to give templates, the best ideas out there, the best practices to Kentucky and to all the States, how to be able to handle their senior citizens, trying to make sure that they have the opportunity to stay in their home instead of the bias, as Senator Breaux has indicated, to put them into an institution.

That is where the optional program is going to be benefit Kentucky tremendously. They will pay less, get more dollars up front, more flexibility, and more new ideas to manage their caseload, and hopefully get into preventative care. That is the beauty of Medicaid.

If people would just forget about the harsh rhetoric about past experiences and take a look, this would help each and every State be able to develop a flexible, innovative program, adapted to their particular States. That is why it is going to benefit so many States and so many people that need this kind of medical coverage.

Senator BUNNING. Well, there is only one big problem with this. We have so many mandated programs that we have to cover with Medicaid.

Secretary THOMPSON. Yes.

Senator BUNNING. They have chosen to go into about 40 totals, or more than 40 other programs, and therefore they cannot even match the dollars the Federal Government is sending in because of the overrun costs by including the optional benefits that they have chosen to do.

What we are looking at is about a $300 million shortfall because they cannot do it. My suggestion would be to look at the mandatory programs and look at the optional programs, and make sure you do not over-extend your Medicaid coverage.

If you are going to have a one-time kick-up of the Medicaid dollars or a one-time cost increase that they can narrow their optional coverages, I think that would be a very good solution. I do not know if that is even in your thoughts or not.

Secretary THOMPSON. Right now, there are 42 States plus that are looking at cutting benefits. They only have one or two choices under the existing law. One, they can either drop it or continue it.

We are offering them the third choice, giving them the flexibility maybe to increase the co-pays, maybe be able to set up HMOs or PPOs, maybe be able to centralize their drug purchases, maybe be able to allow for mental health coverage in a particular area that really needs it, maybe be able to give protection for a long-term

group in order to purchase long-term health insurance to keep them out of an institution.

All of these things are flexible under the addition, which they do not have the tools to do right now. All they can do is either maintain it or drop it. This is going to give them the options and the flexibility to develop a new system.

Senator BUNNING. Thank you.

The CHAIRMAN. Senator Lott.

Senator LOTT. Thank you, Mr. Chairman.

Thank you, Mr. Secretary. I have always admired your leadership when you were Governor of Wisconsin, and I think you are the right man during a difficult time for HHS. So, we are glad to have you here and have this opportunity to talk with you and hear your answers and work with you in the future.

The more I look at our health care situation in America and the various proposals we are considering, and Medicare, and Medicaid, and how we deal with prescription drugs, the more I realized how complicated, convoluted, antiquated, outdated, expensive it is. We have a huge problem here. As we meet to try to decide how to solve them, I quite often leave very depressed about how we are going to do it.

I commend you for what you are doing in the Medicaid area. Flexibility should be helpful. In my State, for instance, though Medicaid does provide a prescription drug benefit, and low-income elderly poor are the ones I think we really should be focused on trying to help, do have, when they reach a certain income level and a certain age, access there.

One thing that worries me, is that about 12 percent of the prescription drugs, I understand, come through those State Medicaid programs. If we go to a Medicare prescription drug benefit, what will happen with those Medicaid prescription drug beneficiaries?

I presume they are going to move right over to the new program. You are saying give them a choice, but I am worried that that is going to be another burden on the new program as we bring it in.

How do you react to that?

Secretary THOMPSON. It will be a burden, because what you are talking about are the dual eligibles, people that are eligible for Medicare and Medicaid.

Senator LOTT. Right.

Secretary THOMPSON. Right now, they are getting the benefits of the drug coverage under the Medicaid law. If Medicare picks it up, they will be eligible for the Medicare prescription drug coverage, which would lessen the involvement of the States, but increase the potential cost to the Federal Government by quite a bit.

And you are absolutely correct, it is 12 percent. There is about 6 percent on the drugs and the dual eligibles that would be able to be transferred into the Medicare program.

Senator LOTT. Let me ask a question that I guess some would consider heresy. But there is a program now for prescription drugs. I mean, there are several, actually. There are those that have their own insurance in the private sector. We have got this Medicaid program. We really want to help the genuinely low-income elderly, those eligible for Medicare and Medicaid. There is a program in States.

Why wouldn't we maybe want to consider, as we have in the past, putting more money into that program to give States flexibility as to how they design it and keep this from exploding into a huge problem for Medicare?

Secretary THOMPSON. Well, there is that option, Senator.

Senator LOTT. But we are beyond that, is what you are saying.

Secretary THOMPSON. Well, it certainly is an option that should be considered. The administration is not looking at that option at this point in time, but it is one that I think the Congress should certainly look at.

Senator LOTT. Let me ask you another question on Medicaid, then I want to get over to Medicare right quick. I guess it is obvious the States are having all kinds of difficulty with their Medicaid programs, because of the economy, perhaps.

Maybe that is putting some more burden on it because they do not have the flexibility that you are trying to give them, but also because they have added a lot more benefits. Now all of a sudden they have got a problem.

Secretary THOMPSON. Big time.

Senator LOTT. They created the problem, to a large extent. Are there other explanations of why, all of a sudden, this is such a huge problem for the States? You were there.

Secretary THOMPSON. There is no question that there is a downturn in the economy. There are more people that are unemployed and more people going into the system. But there is no question that States have added options.

Senator LOTT. And then they are coming to us, wanting us to give them $38, $50, $60 billion—we who are, by the way, running huge deficits—to help them solve their problem, which, by the way, they really created to a good extent by themselves.

Secretary THOMPSON. Well, that is what we are trying to do with the Medicaid proposal, Senator, is to give them some options up front, forward-fund the money, still maintain the budget neutrality, forward-fund the money so they can get over this immediate hurdle, be able to develop new programs on prevention and disease management, be able to split their populations into acute care, long-term care, and prevention, and be able to come up with new ideas on how to deal with the Medicaid population more efficiently.

Senator LOTT. I think we should do that. I am not sure I agree with all of Senator Breaux's solutions, but there is no question that we have got to modernize and approve Medicare.

Secretary THOMPSON. That is correct.

Senator LOTT. Because, beginning, as this chart shows, about 2011 or 2012, the explosion of projected Medicare spending as a percent of GDP just goes straight up, and that is without a prescription drug benefit.

Secretary THOMPSON. That is without prescription drugs.

Senator LOTT. And then the other part of my concern is, the Medicare Part A trust fund, on the other hand, at about the same time, tops out and begins to go way down. So, in the out years, we have got this huge gap, even without prescription drugs. That is a fact of mathematics that we have got to contend with, right?

Secretary THOMPSON. It seems to me we have to address it now, Senator.

Senator LOTT. No question. One last question, then I will yield.

On this Medicaid drug rebate methodology that establishes rebates to State Medicaid agencies, based in large part on a drug manufacturer's reported best price. There have been some concerns about how that is really working, or maybe even drives up the costs.

You had some mention of that in your testimony, but I did not hear you mention it this morning. Can you add a little more on that?

Secretary THOMPSON. What we are trying to do, is we are trying to get to the manufacturing price instead of the average wholesale price and we are trying to make sure that there is a connection in the States that are doing this to the Medicaid program.

There are some other benefits, other ways in which we can control costs, and the administration is looking at a lot of things. The Department is certainly looking at it.

Senator LOTT. Thank you, Mr. Secretary.

Senator BAUCUS. Thank you, Senator.

Senator Snowe.

Senator SNOWE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. We certainly appreciate your leadership, on behalf of the President, to advance on these critical issues. There is no question that prescription drug coverage has to be one of our top domestic priorities.

I was pleased the President indicated in his State of the Union address that he wants to address it this year. I think we are all determined to get it done this year and we cannot allow another year to lapse without taking positive action on this key piece of legislation.

I would just like to address, at least in terms of what has been discussed about dimensions of the President's proposal. Obviously I have expressed to you, and I appreciate the number of discussions that we have had regarding this issue, that I do think it is essential to offer the prescription drug benefit under all forms of Medicare programs and benefits, whether it is the traditional fee-for-service, the new enhanced fee-for-service, or PPOs, or Medicare+Choice.

I have real concerns if we just rely on a private model such as PPOs, which obviously is a less restricted form of managed care, and whether or not you are going to have that private model delivery system in rural areas in my State and across the country.

We saw what happened with Medicare+Choice. Companies stepped in and provided the services initially, then backed out. We have had huge, gaping holes across this country. My State does not even have Medicare+Choice. Yes, PPOs are offered under the Federal Employees Health Benefits program, and we have some of those in Maine, but it is very restrictive.

If you were to think about offering the breadth of this plan Statewide, I think it would be very difficult if you limit the prescription drug coverage to just a new, enhanced program under Medicare and not under the traditional Medicare program.

So could you address that issue? Because, clearly, I would have concerns if the President's legislation would move in that direction.

Secretary THOMPSON. Well, the President, as you know, has spoken many times about allowing people to maintain their current fee-for-service Medicare system. He still believes passionately about that.

The details, as you know, Senator Snowe, are still being worked on in regards to an enhanced system and using more choices. The final decisions have not been made and I am not at liberty at this time to go into them, I am sorry to say.

Senator SNOWE. No, I understand that. Except I just want to make sure that we are moving in the right direction in the final analysis, because obviously that will represent some difficulties, at least as far as I am concerned, on that issue.

Some of the private companies have indicated that it could be difficult. They could use the private fee-for-service model, for example, without having to rely on preferred provider networks or those types of restrictions. I am just concerned, in using the model of Medicare+Choice, it simply would not work in a State like Maine, and I am sure in many of the rural areas across this country.

I think that people in the Medicare program deserve to know that, regardless of what program they opt into, that they will have the benefit of the prescription drug program. Because if it does not work, and all of a sudden these companies pull out and seniors are in the wrong program, they are not going to get any prescription drugs. I mean, that is the bottom line if you take that approach.

Secretary THOMPSON. I can assure you that the President knows of your concern, and other members' concerns. We are still working on the proposal. We want to work with you, as I have indicated to you personally as well as over the telephone, and we want to come up with the best system that can pass this year. We are going to work extremely hard to get that done, and all I can assure you is of our tremendous support for getting it done.

Senator SNOWE. Also, on timeframe. What is your feeling about the timeframe for advancing this legislation? Because I think that is also critical.

Secretary THOMPSON. It is my personal opinion, Senator, that the sooner we can get at this, the better off we are going to be. I am very hopeful that the timeframes that Senator Frist and Senator Grassley have worked out are the proper ones, and I only hope that we can maintain those timeframes and get the job done.

Senator SNOWE. On dual eligibles, again, and low-income seniors.

Secretary THOMPSON. Yes.

Senator SNOWE. Is that still an issue that is under consideration as to whether or not they will have access to the prescription drug program under Medicare, or would the States continue to provide that? It was not clear from what you said earlier.

Secretary THOMPSON. Well, the States provide it now, but it certainly is in the mix for them to be eligible for the Medicare system. I do not see how you would be able to deny them.

Senator SNOWE. So that they probably would have access under the President's program.

Secretary THOMPSON. That is correct.

Senator SNOWE. All right. Thank you.

The CHAIRMAN. Now it is Senator Bingaman's turn, then Senator Jeffords.

Senator BINGAMAN. Thank you very much, Mr. Chairman.

Mr. Secretary, thank you for being here.

Secretary THOMPSON. It is a pleasure, Senator.

Senator BINGAMAN. I wanted to ask some questions on your Medicaid proposal which I have had some concerns with. As I see the proposal, there are sort of two parts to it.

One, are the various reforms that you have described very well here that do permit States to look at best practices, to emphasize preventive services, to use new ideas, to do a whole variety of things. In general, I think that is a good direction to move in.

Secretary THOMPSON. Thank you.

Senator BINGAMAN. The second part, is the part that gives me pause and concern, and that is the restructuring of the financing.

As I understand what you are proposing, you are persuasive as to how the Federal Government benefits from this, you are persuasive as to how State governments benefit from this, but it seems to me that the people who do not benefit are the low-income children and the seniors who depend upon this program for their health care.

It strikes me that essentially the proposal is, let us reduce the amount of money that is provided for health care services to these groups.

What you are doing, is you are saying, look, we will allow States to reduce what they are putting in, we will reduce what we are putting in, we will impose a cap, and we will give you, the States, the opportunity to spend less on Medicaid if you sign on for this, and we will also give you flexibility in how you do it.

Let me just cite you a letter that you co-signed, along with 40 other Governors, back in 1997 to President Clinton. It said, "We adamantly oppose a cap on Federal Medicaid spending in any form. Unilateral caps in Federal Medicaid spending will result in cost shifts to States.

Under a cap, once the Federal spending obligation is fulfilled, States would become solely responsible for meeting uncontrolled program cost increases stemming from things such as new drug treatments, lawsuits, and disasters.

States would have to choose between cutting back on payment rates to providers, eliminating optional benefits, or coming up with additional State funds to absorb 100 percent of the cost of services."

The bottom line of that letter, is that Governors oppose the very concept that you are now endorsing, as I understand it. Am I missing something?

Secretary THOMPSON. Yes, you certainly are, Senator. I was one of the leaders on that. President Clinton, along with some Democrat Congressmen and Senators—but nobody of your caliber would have ever supported it—was going to put a per capita limit on every individual in the program, take $8 billion out of the system. We are doing neither one of those things. Third, the Governors are going to help write this proposal.

First off, we do not have a cap. We are going to allow the mandatory population, the mandatory coverage to continue. There is no cap. This is different than what President Clinton was talking about. A big difference.

Number two, we are not taking $8 billion out of the system.

Senator BINGAMAN. But there is a cap on the optional groups and the optional services, as I understand it.

Secretary THOMPSON. The same way there is right now under the SCHIP program, Senator.

Senator BINGAMAN. I know. But there is currently no cap on optional groups and optional services. But you are saying in the future there would be for States that chose to do this.

Secretary THOMPSON. It would be a voluntary thing. It is based upon the very successful SCHIP model. It is not a per capita. There is no per capita increase on the mandatories. That goes on as usual. It is the optional that would have a definite appropriation, just like SCHIP, Senator. Big difference.

Plus, the Governors are not sending a letter up here for you not to consider my proposal. Instead, they are setting up a committee of 10 Governors, a bipartisan committee of equal numbers, to work with me to develop the program for you.

Senator BINGAMAN. How much of a reduction in the baseline for States for Medicaid would this result in?

Secretary THOMPSON. None. Zero.

Senator BINGAMAN. None? States do not save any money on this?

Secretary THOMPSON. The States will save money in the future. Right now, the States have a base budget. All right?

Senator BINGAMAN. Right.

Secretary THOMPSON. Each year, they have to increase the amount of money they contribute.

Senator BINGAMAN. Right. And you are saying it will only require you to increase it 3 percent.

Secretary THOMPSON. It will increase only one of the three factors instead of all three factors.

Senator BINGAMAN. I understand that.

Secretary THOMPSON. But each one of those factors are different amounts, so you cannot quantify it. I can quantify it on a State basis.

Senator BINGAMAN. Under current law, there is a baseline for what States are expected to spend on Medicaid over the next 10 years.

Secretary THOMPSON. That is correct.

Senator BINGAMAN. I am just wondering, how does that baseline change under your proposal?

Secretary THOMPSON. The baseline is rising at approximately 9 percent for the States and the Federal Government. We do not compute out the baselines on a State level each year under the current law. We will do that in the future.

But on the baseline right now for States, the Federal Government baseline is 9 percent, which is recomputed each year in October or November. With States, it is September and October. Then the State baseline will probably go up, at the rate instead of 9 percent, probably 7.5 to 8 percent.

Senator BINGAMAN. But you do not have a figure as to how much in billions of dollars that would be.

Secretary THOMPSON. Over 10 years?

Senator BINGAMAN. Yes.

Secretary THOMPSON. No, we do not.

Senator BINGAMAN. The State contribution to Medicaid.

Secretary THOMPSON. We do not, because it varies every year based upon population, utilization, and the indexing of the medical costs. So, you cannot quantify it.

Senator BINGAMAN. You do not think your proposal would result in the States putting less money into Medicaid over the next 10 years than they otherwise would?

Secretary THOMPSON. It will. Yes, the States will put in less dollars.

Senator BINGAMAN. And the Federal Government will put in less dollars.

Secretary THOMPSON. No, the Federal Government will put in more dollars.

Senator BINGAMAN. Over the 10 years?

Secretary THOMPSON. The Federal Government will put in the same amount as they will under the old law, as under the new law. The States' contribution will not be as much over 10 years. Future costs.

Senator BINGAMAN. I have used my time, Mr. Chairman. I am glad to keep talking, but Senator Jeffords is next.

Secretary THOMPSON. Let me just make sure that I am clear.

Senator BAUCUS. Briefly, please.

Secretary THOMPSON. All right. Thank you, Senator. The Federal contribution is a trend line of 9 percent, and that will maintain the same amount, although we readjust the trend line each year. So, it could go up. It could go up to 10 percent or 11 percent, which means that the Federal dollars would increase.

The State trend line will be more stable. They will probably go up at the rate of 7.5 percent instead of 9 percent over the 10 years, Senator.

Senator BINGAMAN. Is this in writing? Could we ever get a copy of this?

Secretary THOMPSON. Yes. You will be able to very shortly.

Senator BINGAMAN. That would be useful.

The CHAIRMAN. Senator Jeffords.

Senator JEFFORDS. It is a pleasure to be here with you, and look forward to working again this year on our prescription drug benefit. Hopefully we will come up with one.

On Medicaid, I applaud the administration's proposal to give the States more flexibility. But I am concerned about the capped Federal contribution and the proposal to front-load added funding to the States, only to require the States to pay that back in out years.

Clearly, what will be needed, especially in this economic downturn, is more, not less, help for the States. I just want to express my concern about that.

Secretary THOMPSON. Senator Jeffords, you and I have always been able to work together, and I really appreciate that and thank you for that.

The States do not have to pay it back. First off, this is not a block grant because the trend line continues to grow at the rate of 9 percent, adjusted annually, and sometimes it will be maybe adjusted up to 10 percent. But right now, the trend line is 9 percent.

The States will get the advance forwarded funded of $12.7 billion. They do not have to pay that back. That is not correct. What

happens in years 8, 9, and 10, the trend line is going up at this rate of about 9 percent.

The States would go below the trend line in years 8, 9, and 10, and they would get less from the Federal Government, maybe at 7 percent, 8 percent, 7.5 percent for those last 3 years, which would be less if they voluntarily go into it.

They do not have to go into it. It would be completely voluntary. States would take a look at this thing and say, is this good for my State for 10 years? Is this good for my programs? So, it is completely voluntary, but they do not have to pay it back. They would just get less dollars in the last 3 years if they voluntarily go into the program, Senator.

Senator JEFFORDS. Thank you for that information.

Vermont finds itself in a similar situation as Iowa and Montana in Medicare funding equity, that is, we are at the bottom of the list for Medicare reimbursements. This is largely a result of the reimbursement formulas. We will work with you. I just want to bring your attention to that to try and correct that.

Secretary THOMPSON. Senator, this is something that is near and dear to my heart, because Wisconsin is part of that, as Iowa and as Vermont is. But I just want to point out, last year we allowed for sole community hospitals—there was a request for Senator Baucus—in order to get higher benefits. These are just administrative things that I have done over the last year in order to help rural hospitals.

Inpatient rehabilitation facilities. We made it more flexible and incorporated a special adjustment for rural providers, which we put in so that rural hospitals and rural providers would be able to get additional dollars.

Then there was another program, physician assistant ownership of rural health clinics, that could not be. We changed the law so that physician's assistants could operate their own clinic in rural areas where they could not get other coverage. We did that.

There was a pass-through payment for nurse anesthetist service, another Senator Baucus request that we put through for individuals that would be able to get it, and expressed concern. We were able to do that.

We then had a program phase-out of certain graduate medical education which was in the mix on reimbursement. Since rural areas do not have graduate medical education, it was actually working as program that would hurt rural areas. We took that out of the mix so that actually that money would flow to rural areas.

We had staffing flexibility for certain critical access hospitals, which was another request by Senator Baucus. Senator Baucus had a lot of requests this year.

Senator BAUCUS. For which we are very appreciative.

Secretary THOMPSON. Very appreciate. We have worked together. This is another thing that we did administratively to help rural hospitals. Then the wage index, which I have talked to Senator Grassley about.

The actuaries wanted us to raise the amount of money going into the wage index from 71 percent to 72 percent, and in the flexibility I had we maintained it at 71 percent, which also inured to the ben-

efit of rural hospitals. So we did at least eight positive things to allow for more money to go to rural hospitals administratively.

Now when you have got to go to the next step, and we have to, as Senator Grassley put in the Omnibus Appropriate Bill this year, there is a discrimination of about 1.5 percent between urban hospital reimbursements to rural hospital reimbursements.

Senator Grassley, in his proposal, costs $300 million until September 1, put it in there, to change that discrimination and be able to have people paid the same. That is something else that we should consider.

We should also consider the reimbursement formula on a bipartisan basis to see what we could work on. Since there are more rural Senators on the Finance Committee, it seems to me this is the one area on which there could be tremendous bipartisan support. I have got several ideas we could advance, CMS has several ideas, and we could work together to accomplish that.

Sorry I took such a long time to answer, but I was hoping that Senator Grassley or Senator Baucus would ask that question so I could tell them, especially Senator Baucus, with all the things we did this past year for him. [Laughter.]

The CHAIRMAN. I hope you will give me equal treatment. [Laughter.]

Secretary THOMPSON. All you have to do is ask, Senator Grassley.

The CHAIRMAN. All right. Thank you.

I am going to call on Senator Baucus. I am going to put any questions I have in in writing.

The CHAIRMAN. Would you like to go forward with some questions?

Senator JEFFORDS. Excuse me. I had one other question. I would like to get it to him writing, or whatever you want.

The CHAIRMAN. Yes. We will keep the record open for that purpose, so expect some questions from Senator Jeffords.

Secretary THOMPSON. Thank you so very much, Senator Jeffords, Senator Lincoln.

[The questions, with the Secretary's responses, appear in the appendix.]

Senator BAUCUS. I have another list, which I hope the Secretary will pay attention to. I deeply appreciate it.

Essentially, these are very complicated and these are very important matters. I just hope the administration, and sooner rather than later, gives us some of their ideas on the plan, whether it is Medicare, or Medicaid, in particular, because that is generating so much discussion right now. It will clear up a lot of difficulties once we hear from the administration as to what is going on.

Secretary THOMPSON. Senator Baucus, I would love to be able to sit down with you and Senator Grassley and explain my ideas on Medicaid. I am confident that, if we had an opportunity to do that, we could reach an agreement on it. I think it is the right direction. I only hope that I can convince you to support it, Senator Baucus.

Senator BAUCUS. Thank you.

The CHAIRMAN. Senator Lincoln. Then when you are done, he has to leave at noon. So, you can have five minutes.

Senator LINCOLN. Can I just ask a quick question?

Secretary THOMPSON. Yes.

Senator LINCOLN. It goes back to what Senator Bingaman brought up. You were explaining the optional parts of Medicaid and you compared it to SCHIP. I guess the question I have, is there are Federal standards in the SCHIP program. In the optional, there would not be, right?

Secretary THOMPSON. No.

Senator LINCOLN. That is the flexibility you are giving the States.

Secretary THOMPSON. Yes.

Senator LINCOLN. So you would not have those Federal standards.

Secretary THOMPSON. No, those Federal standards are going to stay.

Senator LINCOLN. So they would be there?

Secretary THOMPSON. Yes.

Senator LINCOLN. So that is not necessarily the flexibility. I guess it kind of goes back. I was curious, because when you were Governor of Wisconsin you signed into law to require insurance plans in the State to cover the diabetes supplies and services. You mentioned diabetes earlier.

Secretary THOMPSON. Yes.

Senator LINCOLN. And certainly other members of the Cabinet. I know Governor Whitman.

Secretary THOMPSON. I think I was the first State Governor to do that.

Senator LINCOLN. Right. Right.

But I guess, as a result of those laws like yours, diabetes-related complications like blindness, kidney failure, and amputation are on the decline in Wisconsin, and in other States, too. Governor Ridge, Governor Whitman, and President Bush, when he was Governor, did the same.

But judging from your own State's experience, does it not make sense to ensure that private insurance plans are going to cover diabetes supplies and services in order to keep people healthy and keep costs down?

If so, does it not make sense to ensure that Medicaid does that? I mean, those guidelines are not going to be in the optional part, if my understanding is correct.

Secretary THOMPSON. The truth of the matter is, Senator Lincoln, that States right now only have two choices, either maintain the program as is or drop it. Most States are dropping it. Forty-two States are going to drop it.

We want to give them additional avenues in order not to drop the diabetes testing and treatment programs. We want to be able to give them the flexibility and the additional Federal dollars in order to keep that. That is the beauty of the optional program. Most people are trying to find some hidden, insidious thing wrong with it.

Senator LINCOLN. We are not looking for anything like that.

Secretary THOMPSON. All I want to do is to tell you, this is a program that is very good for States. It is very good for people that you want to cover and that I want to cover. I do not want to see States reduce their Medicaid populations by a million this year, which they are expected to do.

I want to give them some tools so they are going to find ways in which they are going to be able to maintain that coverage. I know that is what you want, and this bill is going to do that. That is why you should be as enthusiastic and as passionate for it as I am.

Senator LINCOLN. If I had read it, I might be.

Secretary THOMPSON. All right. Thank you.

Senator LINCOLN. If I had something on paper, I might be.

Secretary THOMPSON. You certainly are no fossil, I want you to know that. The administration is coming out clear on that point.

The CHAIRMAN. Once again, thank you very much. We look forward to having dialogue with you on welfare on March 12, and on all these issues, working with you and the administration.

Thank you, Secretary Thompson.

Meeting adjourned.

Secretary THOMPSON. Thank you very much, Senator Grassley.

[Whereupon, at 12:00 p.m., the hearing was concluded.]

APPENDIX

PREPARED STATEMENT OF HON. JIM BUNNING

Thank you, Mr. Chairman, and I would like to thank Secretary Thompson for being here today.

The two programs we will be discussing today—medicare and medicaid—provide health care to the most vulnerable in our society, including our seniors, and low-income and disabled individuals. Both of these programs, however, are at a cross roads.

Medicare is facing significant long-term financial problems that must be addressed.

The unfunded liability for medicare over the next 75 years is estimated to be $13.3 trillion, and medicare "part A" will begin spending more than it is taking in as early as 2016.

On top of those concerns, Congress has been struggling for years to add a prescription drug benefit to the medicare program, and I hope this year we can finally do it.

In his budget for 2004, the President set aside $400 billion over the next ten years to modernize the medicare program, which includes adding a prescription drug benefit for seniors.

Too many seniors struggle each month to buy their prescription drugs while we continue to bicker about this issue in Congress. The time to act is now. I hope we can work together to craft a strong and responsible bill that provides a real benefit to our seniors.

Medicaid faces its own set of problems, since many states, including Kentucky, are struggling with their state budgets.

States are finding that they cannot continue to afford many of the optional benefits they have added to their programs, while at the same time tightening enrollment standards for beneficiaries. These are hard decisions to make.

In the budget, the administration has proposed giving states more flexibility with their medicaid and "S-CHIP" dollars, along with providing additional money up-front.

I know there has been some concern about the long-term effects of this proposal, and I am looking forward to hearing from Secretary Thompson on this issue.

We have a busy year in front of us, and I look forward to working with my Senate colleagues and the administration as we address these issues.

Thank you.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV

Good morning, Secretary Thompson. I look forward to your testimony. From the little information that we have been given about plans for privatizing Medicare and block-granting Medicaid, I believe that the Administration is going in the wrong direction on health care.

On Medicare, I am particularly concerned about the President's proposal to force seniors into private managed care plans in exchange for a drug benefit. History has already shown us that it doesn't work and that seniors pay the price.

As I am sure you recall, many believed the Medicare +Choice program would be the answer to Medicare's problems—it would offer seniors more health benefits, while also controlling the government's bottom line. That is not what has happened. Instead, we have seen private insurers flee this program in droves. We pay more for and get less from these plans.

Given our experience with Medicare+Choice, it seems to me unconscionable to hold a prescription drug benefit hostage by linking it to enrollment in private managed care plans. Not only would privatizing the Medicare program hinder progress on a prescription drug benefit, it could actually reduce or eliminate affordable and meaningful health care coverage for 40 million seniors and people with disabilities.

The President said in his State of the Union address that his proposal would offer seniors a "choice." In reality, under his proposal, if a senior wants a prescription drug benefit they would have to give up their family doctor and join a private managed care plan. That's not the kind of choice most seniors want.

Secretary Thompson, if the President wants bipartisan support for a prescription drug benefit, it must be a benefit guaranteed to all seniors regardless of where they live or how sick they are. Private managed care plans can participate but we must offer the same drug benefit through traditional Medicare. That is true integrated care.

Unfortunately, we cannot hope to work together on Medicare when the very foundation of our health care system is being threatened in the President's Medicaid proposal. Block-granting Medicaid would fundamentally undermine health care for those who need it most. In my opinion, the path that the President has chosen on Medicaid has the potential to shut down bipartisan discussion on all health issues this year.

Under your proposal, states can eliminate coverage of certain populations and optional services under Medicaid. We are talking about groups like elderly and disabled people with annual incomes below $6,650. We are talking about people who would go uncovered without the Medicaid program. If a state runs out of money from the block grant, they will be forced to choose between seniors, disabled people, pregnant women and children or eliminating coverage entirely for these groups. That is a choice I do not want West Virginia or any other state to make.

What's worse is that you are offering this to states as their only chance for fiscal relief when states are in their worst budget situation since World War II. The President's budget for the Medicaid block grant provides an insufficient $3.2 billion in fiscal relief, which must be paid back by the states in the last three years of the grant.

The Medicaid block-grant proposal is no substitute for *real* fiscal relief. That is why I continue to fight to advance the legislation I introduced, along with Senators Collins, Ben Nelson, Smith, Bob Graham and Hutchison, which will provide $20 billion in relief over the next 18 months. This legislation gives states *meaningful* relief through a temporary increase in the federal Medicaid matching rate as well as increases funding for the Social Services Block Grant.

Luring states into an arbitrarily capped block grant for Medicaid in exchange for a loan under the guise of relief is bad for states and providers and worse for beneficiaries. We need to work together to provide states with flexibility without block-granting the program.

I have serious objections to the President's proposals to restructure Medicare and Medicaid and to his refusal to provide meaningful fiscal relief to states. I hope that our discussion here today will bring us closer to a compromise that will result in stronger programs for seniors and low-income Americans.

I know this hearing is intended to focus on health care, but I also want to mention foster care. I agree that will need to discuss changing federal funding for foster care. But, I believe we need new investments to help abused and neglected children, and I doubt that flexibility is the sole answer to the problems for such vulnerable children. I will submit written questions and hope to have a serious discussion. In the past, states have not been responsive. We have made positive changes recently by stressing specific goals like adoptions and a safe, permanent home. I worry that "flexibility" doesn't work when states cannot even pass their child welfare reviews today.

Prepared Statement of Hon. Craig Thomas

Today the Senate Finance Committee is meeting to hear testimony from Health and Human Services Secretary Tommy Thompson regarding the President's fiscal year 2004 health care budget. I am very pleased Secretary Thompson is here today to discuss the Administration's health care funding priorities and its vision to reform our Medicare and Medicaid programs.

I believe the American health system is at a crossroads. If we continue along our current path health care costs will continue to rise rapidly and more Americans will be priced out of the system, which will only increase the financial burden on federal, state and local governments. We must begin acting today to make the difficult deci-

sions we face regarding the future of the Medicare and Medicaid programs. We have an unprecedented opportunity to work together to comprehensively reform these two outdated programs. It is also critically important to me and my state that we also ensure rural providers are paid adequately and rural residents have access to necessary health care services.

I would like to commend Secretary Thompson on his commitment to rural health. I understand the Department of HHS has recently begun implementing a "Rural Initiative" to improve the agency's responsiveness to our rural communities. Also, the decision by HHS to serve as the interested government agency that reviews J–1 Visa waiver applications so foreign doctors can practice medicine in America is crucial to many of our rural and frontier underserved areas. These remote towns have difficulties recruiting American doctors to practice in their area and the J–1 Visa waiver program has provided an important opportunity for these vulnerable communities to maintain physician services for their residents.

However, I am disappointed the Administration only provides a $5 million increase for the rural health programs that are administered by the federal Office of Rural Health Policy. Rural Health Outreach and Network Development Grants, Rural Health Research Grants, State Offices of Rural Health and Rural Hospital Flexibility Grants have proven to be effective and efficient programs that have a significant impact on the rural health care delivery system. While I understand the tight budget framework in which we are operating, I believe these programs should not be overlooked and deserve a funding increase.

This Congress faces no greater challenge than reforming the Medicare program and providing seniors with access to prescription drugs. I congratulate the Administration for thinking about the long term solvency and integrity of the program and recommending an ambitious overhaul of its current structure. Seniors should be able to choose the type of health plan that meets their individual needs, have protection against catastrophic health costs and have assistance from the federal government in purchasing necessary medications.

The Medicaid program is also at a critical juncture as its skyrocketing costs program have pushed the vast majority of states into budget deficit situations. However, governors have proven to be extremely innovative in delivering health care to their vulnerable populations and the federal government should expand their abilities to tailor programs that best meet the needs of their states.

I thank Secretary Thompson for his comments today and I look forward to working with the Administration on responsibly reforming the Medicare and Medicaid programs as well as strengthening our nation's rural health care delivery system.

Thank you Mr. Chairman.

PREPARED STATEMENT OF HON. TOMMY G. THOMPSON

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

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

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

Our proposal includes a $37 billion increase over the FY 2003 budget, or about 7.3 percent. The discretionary portion of the HHS budget totals $65 billion in budget authority, which is an increase of $1.6 billion, or about 2.6 percent. HHS' mandatory outlays total $475.9 billion in this budget proposal, an increase of $32.3 billion, or roughly 7.3 percent. Your committee will obviously be vital to achieving many of the Administration's most important priorities. I am grateful for the close partnership we have enjoyed in the past, and I anticipate working hand-in-hand with you on

an aggressive legislative agenda to advance the health and well being of millions of Americans.

Today, I am pleased to come before you to specifically discuss the President's proposals to strengthen and improve Medicare and to modernize the Medicaid program. A top priority for both the President and me continues to be strengthening and improving these vitally important programs that provide for the health care needs of many of our nation's seniors, low-income individuals and individuals with disabilities. We remain committed to delivering stronger, better Medicare and Medicaid programs to the Americans who rely on them. I look forward to working closely with this Committee and Congress to take meaningful action a reality this year.

Strengthening and Improving Medicare

As we are all aware, our Nation's Medicare program needs to be strengthened and improved to fill the gaps in current coverage. We remain steadfastly committed to ensuring that America's seniors and individuals with disabilities can keep their current, traditional Medicare, the President has proposed numerous principles for Medicare enhancements to ensure that we are providing our seniors with the best possible care. The budget builds on those principles by dedicating $400 billion over ten years to strengthen and improve Medicare, including providing access to subsidized prescription drug coverage, better private options and better insurance protection through a modernized fee-for-service program.

We are moving aggressively on many fronts to make the Medicare program more responsive to the needs of its beneficiaries, especially those who live with chronic illnesses such as diabetes, stroke, and congestive heart failure. Today, I am pleased to announce the launch of our newest Medicare initiative through capitated disease management demonstrations. HHS is seeking proposals to improve the quality of care provided to certain Medicare beneficiaries with chronic disease. The capitated disease management demonstration projects will create new programs to better manage the health care of beneficiaries that may have chronic conditions. This capitated disease management initiative is the latest in an ongoing series of disease management demonstrations.

Prescription Drug Coverage

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

Medicare Choices

Medicare+Choice was introduced to provide beneficiaries additional options for Medicare coverage. Over the past year, the Department has made significant strides in expanding beneficiaries' Medicare+Choice options by approving 33 new preferred provider organization (PPOs) through a demonstration. However, due to a variety of factors, in many parts of the country, few other new plans have entered the program.

More needs to be done to encourage plan participation. We believe that we should move away from administered pricing to set Medicare+Choice rates. The Administration believes that Medicare+Choice payments need to be linked to the actual cost of providing care. America's seniors and citizens with disabilities should have access to the same kind of reliable health care options others enjoy and that those choices should be provided through a market-based system in which private plans compete to provide coverage for beneficiaries. Those beneficiaries who select less costly options should be able to keep most of the savings. It is time we give our seniors and citizens with disabilities the choices they have been promised in Medicare.

Modernized Fee-for-Service

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

Medicare Appeals

Our budget also includes $129 million for strengthening the Medicare appeals process. The adjudicative function currently performed by the Administrative Law Judges at the Social Security Administration would be transferred to the Centers for Medicare and Medicaid Services (CMS). In addition, the Administration proposes several legislative changes to the Medicare appeals process that would give CMS flexibility to improve the appeals system. These changes will enable CMS to respond to beneficiaries and provider appeals in an efficient and effective manner.

Strengthening and Improving Medicaid

State Health Care Partnership Allotments

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

Building on the success of the State Children's Health Insurance Program (SCHIP) and the Health Insurance Flexibility and Accountability (HIFA) demonstrations in increasing coverage while providing flexibility and reducing the administrative burden on States, the Administration proposes optional State Health Care Partnership Allotments to help States preserve coverage. Under this proposal, States would have the option of electing to continue the current Medicaid program or to choose partnership allotments. The allotment option provides States an estimated $12.7 billion in extra funding over seven (7) years over the expected growth rate in the current Medicaid and SCHIP budgets. If a State elects the allotments, the federal portion of the SCHIP and Medicaid funding would be combined and states would receive two individual allotments: one for long-term care and one for acute care. States would be required to maintain their current levels of spending on Medicaid and SCHIP, but at a lower rate of increase than the increase of the Federal share.

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

New Freedom Initiative

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

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

The Administration again proposes four demonstration projects as part of the President's New Freedom Initiative. Each promotes home and community-based care as an alternative to institutionalization. Two of the demonstrations are to pro-

vide respite services to caregivers of disabled adults and severely disabled children. The third demonstration will offer home and communitybased services for children currently residing in psychiatric facilities. The fourth demonstration will test methods to address shortages of community direct care workers.

Medicaid Coverage for Souses of Disabled Individuals

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

Extension of the QI–1 Program

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

Transitional Medicaid Assistance (TMA)

TMA provides health coverage for former welfare recipients after they enter the workforce. TMA allows families to remain eligible for Medicaid for up to 12 months after they lose welfare related Medicaid eligibility due to earnings from work, and was scheduled to sunset in September 2002. TMA has been extended through June 30, 2003, through the appropriations process. This budget proposal would extend TMA for five more years, costing $400 million in FY2004, and $2.4 billion over five years. This program is an important factor in establishing independence for former welfare recipients by providing health care they could not otherwise afford.

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

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

State Children's Health Insurance Program (SCHIP)

As you know, SCHIP was set up with a funding mechanism that required States to spend their allotments within a three-year window after which any unused funds would be redistributed among States that had spent all of their allotted funds. These redistributed funds would be available for one additional year, after which any unused funds would be returned to the Treasury. An estimated $830 million in FY 2000 funds are expected to go back to the Treasury at the end of FY2003. The Administration proposes that States be permitted to spend redistributed FY2000 funds through the end of FY2004. Extending the availability of SCHIP allotments would allow states to continue coverage for children who are currently enrolled and continue expanding coverage through HIFA waivers.

Medicaid Drug Rebate

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

Improving the Health Well-being and Safes of our Nation

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

and healthy America. I know this is a goal we all share, and with your support, we are committed to achieving it.

RESPONSES TO QUESTIONS FROM SENATOR BAUCUS

Question: In your statement at the hearing today, you noted that your use of Section 1115 waiver authority in Medicaid and the State Children's Health Insurance Program (SCHIP) has allowed you to extend health insurance to 2.2 million Americans and to add benefits to more than 6 million who were already covered. I would like to understand better how your use of Section 1115 waivers has resulted in extending health insurance coverage to individuals who were previously uninsured and in improving benefits to those who already had coverage, and also to understand where the use of other authorities in Medicaid and SCHIP has extended health insurance coverage and benefits. For waivers, extensions and SPAs approved since January 2001, I am interested in knowing:

- The total number of people projected to be covered as a result of newlyapproved SPAs. For each SPA providing for expanded optional coverage (e.g., the breast and cervical cancer act option), please indicate which have actually been implemented by the state;

Answer: Of the 2.2 million people who have received health insurance coverage through Medicaid and SCHIP since January 2001, approximately 1,000,000 people received coverage through SPAs. All of these SPAs, including those submitted as a result of the Breast and Cervical Cancer Prevention and Treatment Act, have been implemented.

- The total number of people covered as a result of new (as opposed to extended or renewed) waivers or waiver amendments. Please separately identify the numbers covered by section 1115 pharmacy plus waivers, Independence Plus waivers, other section 1115 waivers and section 1915(b) and 1915(c) waivers.

Answer: Of the 2.2 million people who have received health insurance coverage through Medicaid and SCHIP since January 2001, approximately 1.1 million people have received coverage under section 1115 waivers. An additional, 696,000 people have received access to a partial benefit package under the Pharmacy Plus waivers. The people gaining access through Pharmacy Plus waivers are not included in the 2.2 million figure because the Pharmacy Plus waivers do not offer complete benefit packages.

In addition, approximately 24,000 people received health insurance coverage under 1915(b) waivers and approximately 65,000 people received coverage under 1915(c) waivers. These people are included in the 2.2 million figure.

- The total number of people covered as a result of extensions and renewals of section 1115 waivers and section 1915(b) and (c) waivers. As above, please separately identify whether these were renewals of section 1115 waivers or section 1915(b) or (c) waivers.

Answer: There were no expansions of coverage under extensions and renewals of existing 1115, 1915(b) and (c) waivers as those extensions and renewals simply extend or renew existing programs. Any submission that includes an expansion in coverage would be considered an amendment.

- For the new section 1115 waivers, please identify which waivers have been implemented (in whole and in part) and how many people are projected to be covered by the portion of each waiver that has been implemented. Among those that have been implemented, please identify how many of the people covered under the waiver were covered under Medicaid, SCHIP or a statefunded health coverage program prior to coverage under the waiver.

Answer: The 2.2 million figure only identifies people who have received coverage under Medicaid and SCHIP since January 2001, and were not previously covered under these programs. The following comprehensive section 1115 waivers and Health Insurance Flexibility and Accountability (HIFA) waivers approved since January 2001 expand coverage:

Arizona's HIFA waiver was approved on 12/12/01 and expanded coverage to 50,000 adults. This waiver has been implemented.

California's HIFA waiver was approved on 1/25/02 and would expand coverage to 275,000 adults. This waiver has not been implemented.

Colorado's HIFA waiver was approved on 9/27/02 and expanded coverage to 13,000 people. This waiver has been implemented.

DC's 1115 waiver was approved on 3/7/02 and expanded coverage to 1,200 adults. This waiver has not been implemented.

Illinois' HIFA waiver was approved on 9/13/02 and expanded coverage to 29,000 people. Of this number, 12,000 people previously received coverage under a state-only program. This waiver has been implemented.

Maine's HIFA waiver was approved on 9/13/02 and expanded coverage to 11,500 previously uninsured adults. This waiver has been implemented.

New Jersey's HIFA waiver was approved on 1/31/03 and expanded coverage to 12,000 people. This waiver had been implemented.

New Mexico's HIFA waiver was approved on 8/23/02 and would expand coverage to 40,000 previously uninsured individuals. This waiver has not been implemented.

New York's 1115 amendment entitled "Family Health Plus," which was approved on 6/29/01, expanded coverage to 619,000 low-income uninsured adults. This waiver has been implemented.

Oregon's HIFA waiver was approved on 10/15/02 and expanded coverage to 60,000 individuals, 30,000 of which were previously covered in a state-only program. This waiver has been implemented.

Utah's 1115 demonstration, "Primary Care Network," was approved on 2/8/02. This demonstration expanded Medicaid coverage to 25,000 adults, 3,000 of which were previously covered in a state-only program. This waiver has been implemented.

In addition to the waivers identified above, the following Pharmacy Plus and Family Planning waivers approved since January 2001 have also expanded coverage. These expansions are not included in the 2.2 million figure because the people receiving coverage under these expansions only receive a limited benefit.

Florida's Pharmacy Plus demonstration was approved on August 1, 2002. This demonstration expanded coverage to approximately 12,000 people. This program has been implemented.

Illinois' Pharmacy Plus demonstration was approved on January 28, 2002. This demonstration has been implemented and expanded coverage to 368,000 people. This program has been implemented.

Maryland's Pharmacy Discount Program was approved on July 30, 2002, and expanded coverage to 90,000 people. This program has been implemented.

South Carolina's Pharmacy Expansion Demonstration was approved on June 28, 2002, and expanded coverage to 50,000 people. This program has been implemented.

Virginia's Family Planning Demonstration was approved on July 22, 2002, and expanded coverage to 18,000 people. This program has been implemented.

Washington's Family Planning Demonstration was approved on March 6, 2001, and expanded coverage to 70,000 people. This program has been implemented.

Wisconsin's SeniorCare Pharmacy Demonstration was approved on June 28, 2002, and expanded coverage to 177,000 people. This program has been implemented.

Question: The political rhetoric surrounding the need for Medicare reform posits that the program is going broke with the approaching retirement of the baby boom generation. But the political rhetoric does not correspond with the reform proposals under consideration, as none of the reform options on the table would actually save any money. In fact, some of the proposals cost money. What is the Administration's goal for Medicare reform? Can you explain how and to what extent the Administration intends to extend the life of the Medicare trust fund? How much money does the Administration estimate will be saved by its reform proposals? Can you explain how moving seniors into managed care without adding any new funding to the program will save Medicare for future generations?

Answer: The goals of Medicare reform are to expand beneficiary choices and to add a meaningful prescription drug benefit, while updating the structure of Medicare for the 21st century. Of course, addition a prescription drug benefit will cost a great deal of money—that's why the President has proposed spending an additional $400 billion over 10 years on the package. CMS actuaries have estimated that vigorous participation by private plans will generate a modest savings to the program over time. It's not a magic bullet, by any means, but it will help. The estimate

is based on the expectation that private plans will be relatively more intelligent purchasers of health care services. Private plans will be better able to channel utilization in the most cost-effective directions. They will also be more adept than the federal government at identifying and shutting down fraud and abuse where it occurs. Both of these strengths will generate some savings to the program.

Question: What does the Administration mean when it talks about making Medicare more like FEHBP? Does that mean making more private plans available? Or does it mean eliminating, phasing-out, or easing beneficiaries out of the traditional fee-for-service program so that Medicare would eventually be based solely on private competing plans?

Answer: Traditional Medicare will be there for those who want it—both current and future enrollees. Those who are happy with their coverage can keep that coverage without any changes. In addition, those remaining in traditional Medicare will receive help with their drug costs. They will receive immediate help through a Medicare-endorsed drug card, which will provide them with discounts of 10–25 percent or more on their prescription drugs costs. And, beginning in 2006, beneficiaries will have protection against high out-of-pocket drug expenses—for no additional premium. The government will pay the entire cost of this benefit.

The Administration believes that FEHBP is a good model for Medicare because of the choices the program affords federal employees all across the country. Seniors and those with disabilities deserve the same types of health care options enjoyed by Members of Congress and Cabinet secretaries.

Question: For the last three years, FEHBP premiums have increased at a rate of over 11 percent per year. In contrast, Medicare spending has increased by an average rate of 5 percent. Given these figures, can you explain how a system of private health plans would hold down costs for Medicare or extend Medicare solvency?

Answer: It is important to look at long-term trends when comparing programs. A review by the CMS Office of the Actuary recently found that, adjusting for differences in prescription drug coverage, FEHBP premiums per enrollee grew an average annual rate of 10.3% from 1969–1997, exactly the same as Medicare over the same period. More recently, Medicare's cost growth has been lower, due to cost-cutting provisions enacted in the Balanced Budget Act. Many regard those price cuts as unsustainable, and, indeed, Congress has embarked on a series of giveback provisions intended to undo cuts in the BBA.

CMS actuaries have estimated that vigorous participation by private plans would generate a modest savings to the program over time. It's not a magic bullet, by any means, but it will help moderate the growth of Medicare spending while updating the benefit structure. The savings estimate is based on the expectation that private plans will be relatively more intelligent purchasers of health care services. Private plans will be better able to channel utilization in the most cost-effective directions. They will also be more adept than the federal government at identifying and shutting down fraud and abuse where it occurs. Both of these strengths will generate some savings to the program.

Question: The President's FY 2004 budget proposes $400 billion in new spending for Medicare of the next 10 years, and includes a table outlining the amount of new spending in each of fiscal years 2004 through 2013. Can you provide some details on the policy corresponding with the spending stream?

Answer: The Framework to Strengthen and Improve Medicare is exactly that, a Framework. The specific benefits and proposal are for Congress to decide. Consequently, the year-to-year budget numbers may change depending on the specific form that the bill takes. The budget numbers represent one illustrative path and reflect the timetable envisioned in the framework. In 2004 and 2005, the drug discount card and assistance for low-income beneficiaries become available for costs of $6 billion and $10 billion, respectively. Then, in 2006, the full program reform begins, costing $33 billion and rising to $64 billion by 2013. The costs included here include bringing a new system of regional PPO plans online in Enhanced Medicare with a prescription drug benefit, as well as the addition of a prescription drug benefit to Medicare Advantage plans and catastrophic drug coverage in Traditional Medicare. The Administration looks forward to working with Congress to flesh out this proposal.

Question: Private insurance companies tell us that their biggest fear in participating in Medicare is adverse selection. If a drug benefit were only offered in private plan options or if a more generous drug benefit were offered in private plans than in the traditional fee-for-service program, what would be the implications for adverse selection? Would beneficiaries who have higher drug costs on average be more likely to enroll in private plans offering drug benefits? Would private insurers be willing to participate in this new program if they were required to offer more generous benefits than the traditional fee-for-service program?

Answer: There are several ways to deal with any selection issues that arise in the Administration's framework. First and foremost, the best way to mitigate selection pressures is to get a large share of beneficiaries into the program. The Administration believes that the enhanced benefits—including prescription drugs—and fairer cost sharing in Enhanced Medicare and Medicare Advantage could prompt large majorities of Medicare beneficiaries to choose these options. Such widespread participation would ensure that adverse selection between program choices does not present a large issue. Secondly, Enhanced Medicare and Medicare Advantage will be run on a system of competitive bids. These will, in a natural way, take the risk pool into account and adjust costs accordingly, encouraging plan participation. And finally, the Administration is open to using tools of risk adjustment, wherever they may be necessary, to take any remaining selection pressures out of the picture.

Question: Do you still support the drug bill that the House passed last year, which was a stand-alone drug benefit available to all Medicare beneficiaries, including those in the current fee-for-service program? If not, what has changed?

Answer: The Administration is of course very interested in working with the House to craft a bill that enacts the principles embodied in the Framework to Strengthen and Improve Medicare. We opted to include the prescription drug benefit in a broader insurance package in Enhanced Medicare and Medicare Advantage for sound insurance reasons. The Administration believes that providing a stand-alone drug benefit through an insurance mechanism is not a technically sound proposal. Such a stand-alone insurance product would suffer from severe problems with adverse selection, and it would be highly difficult to get an insurance contractor to bear any risk. Without a risk-bearing insurer, cost control becomes even more challenging. Consequently, the Framework folds the drug benefit into an overall insurance benefit package in Enhanced Medicare and Medicare Advantage. We believe this approach makes more actuarial sense and will prove both easier to administer and save money over time.

Question: As part of a reformed Medicare program, does the Administration support prohibiting Medicare beneficiaries from purchasing private supplemental insurance to cover any new combined A/B deductible or any coinsurance imposed under a new drug benefit?

Answer: Participants who are satisfied with their current coverage could also continue receiving coverage from supplemental sources, including former employers, Medigap or Medicaid. The President's framework will add two new Medigap plans to the existing ten standardized plans. These new plans will include prescription drug assistance, additional protection against high out-of-pocket costs, and would reduce, but not eliminate, deductibles and co-payments.

Question: Last year the Administration opposed provider payment adjustments except changes made on a budget-neutral basis across provider types. This year, the Administration not only opposes any increases in provider payments, but has suggested that reductions in provider payments should be used to finance a new drug benefit. Can you detail which Medicare providers should experience payment cuts in order to finance a new Medicare drug benefit?

Answer: As you know, the President has proposed committing $400 billion over the next ten years to modernize and improve Medicare. The President's proposal will provide more choices and better benefits for seniors including meaningful prescription drug coverage.

In regard to provider payments, to ensure strong provider participation, we must make sure that we are paying providers adequately and appropriately. We have no compelling evidence that there is a problem with the overall adequacy of provider payments, but we believe that certain provider payments may benefit from some adjustment. The Administration wants to work with Congress to consider limited modifications to provider payment systems in order to address payment issues and help ensure that beneficiaries continue to have access to the high quality care they need and deserve.

Question: What is the Administration's position on cost-sharing for Medicare home health care?

Answer: The Administration supports the concept of cost-sharing for Medicare home health. Currently, home health care is the only Medicare-covered service, with the exception of clinical laboratory tests, for which there is no cost-sharing. Copayments in home health would be consistent with other Medicare programs, would control utilization by making individuals aware of the cost of care, and would offset program costs. To avoid discouraging Medicare beneficiaries from using home health services, any home health copayment imposed on home health should take into consideration both the affordability of out-of-pocket costs and consistency in the cost-sharing amounts for other Medicare services.

The President's Framework to Strengthen and Improve Medicare endorses fairer cost sharing for all covered services, including home health. These include a combined deductible for Part A & B services and free preventive services. In this context, the Administration looks forward to working with Congress to define a fair cost-sharing level for home health as it crafts a prescription drug and Medicare reform bill.

Question: Every significant piece of Medicare legislation has passed the Senate with wide bipartisan support. This is one reason Medicare has been so successful. Would you agree that any prescription drug proposal and Medicare reform plan should pass the Senate with wide bipartisan support? How does the Administration plan to build this consensus in order to ensure that any changes to Medicare are successful?

Answer: The Framework to Strengthen and Improve Medicare takes the best of several models for Medicare reform and packages them in a way that guarantees all beneficiaries more choices and better benefits. We think this is the right formula for winning broad bipartisan majorities in the Congress. Traditional Medicare will not change for those who want to hold on to their benefits. Enhanced Medicare and Medicare Advantage will offer a more modern health insurance structure to take the program into the 21st century. And all beneficiaries will get access to drug discounts and meaningful prescription drug coverage. We hope to work with Congress to make the proposal one that all can support.

Question: In the interest of finding middle ground on Medicaid, has the Administration identified ways that Congress might give states more flexibility without requiring them to participate in the capped funding option?

Answer: Since its inception, the Administration has been committed to increasing states' flexibility in administering their Medicaid programs. The HIFA, Independence Plus and Pharmacy Plus waiver initiatives have given states significantly more flexibility to expand eligibility and to tailor their programs to meet the needs of their beneficiaries. The Administration's Medicaid modernization proposal represents the next step in these efforts.

Much of the modernization proposal is modeled on the SCHIP program, which gives states far more control over their programs than Medicaid and which has proven to be extremely successful. One of the reasons that SCHIP can afford states this broad flexibility is that the program is funded through an allotment and federal liability is limited. Without a limit on federal liability, many of the ways in which the modernization proposal relaxes federal constraints on state flexibility would not be possible.

We recognize that not all states will find it advantageous to implement the modernization proposal, despite the extremely broad flexibility it would confer. The Administration remains committed to working with such states to enable them to reform their programs through waivers or state plan amendments, and to give them as much flexibility as possible. But, in the context of open-ended federal outlays, it would be irresponsible to grant states the full extent of the flexibility and control which would be conferred under the modernization proposal.

Question: For states that opt into the block grant program, federal contributions would be tied to Medicaid spending in 2002. Montana reduced its Medicaid spending in 2002 to address state budget shortfalls. At the same time, Montana has not taken full advantage of loopholes like the upper payment limit arrangements and intergovernmental transfers that would have artificially inflated state spending. Wouldn't the block grant lock in these inequities?

Answer: To address your concern, the modernization proposal would require that the base year calculation exclude impermissible expenditures. UPL transition payments would be removed from the base year expenditures and would not be increased by an inflation factor. However, these UPL payments would be added to the allotments, once they are calculated, and would be phased out in accordance with current law.

Question: To my knowledge, none of the waivers approved under the HIFA, Pharmacy Plus or New Freedom initiatives has been formally and independently evaluated to determine what aspects of the different programs are effective, which are not effective, and what the impact of the different programs has been on beneficiaries, providers, or state budgets. Are there evaluations of these programs? If so, please provide the Committee with copies. If the programs have not been evaluated, please explain on what basis you would advocate replicating new programs that may or not be effective and may or may not result in harm to very vulnerable populations served by Medicaid and SCHIP.

Answer: We agree that it is important to evaluate major waiver programs. In September 2002, CMS awarded a one-year contract to the Urban Institute to conduct case studies of the development and early implementation experiences under the

HIFA waivers and to prepare an evaluation design for a comprehensive evaluation of the HIFA waivers. CMS anticipates releasing a Request for Proposal for this comprehensive evaluation this summer, with an award for a five-year contract in September. Also in September 2002, CMS awarded a three-year contract to Brandeis University to evaluate the Illinois and Wisconsin Pharmacy Plus waivers.

The Independence Plus demonstration template was developed based on the results of previous demonstration research, including the an evaluation of the effectiveness and efficacy of the Cash and Counseling Demonstration which was completed by CMS, the Office of the Assistant Secretary for Programs and Evaluations, and the Robert Wood Johnson Foundation. Theis most recent evaluation on the cash and counseling demonstration was released April 15, 2003 jointly by the Robert Wood Johnson Foundation and the Department of Health and Human Services. According to the report, Medicaid recipients with disabilities who direct their own supportive services were significantly more satisfied and appeared to get better care than those receiving services through home care agencies. With self-direction, the recipients' satisfaction and quality of life were improved substantially and unmet needs for care were reduced, without compromising health or safety, the study found.

We believe it is important to be able to evaluate different models of HIFA and Pharmacy Plus programs. Because we do not know which specific state designs would be most appropriate, we have emphasized state flexibility, and states have responded with different designs. The comprehensive evaluations, which have and we will be awarding, will assess which designs are most effective from the viewpoint of beneficiaries, providers, and Sstate budgets. The practice of awarding multiple Section 1115 demonstrations and then conducting a comprehensive evaluation of these demonstrations is one that CMS has followed in previous major Section 1115 demonstration initiatives.

Question: The Administration has proposed funding for "marriage promotion" grants. I am concerned that these grants would blindly promote marriage without taking due consideration of the plague of domestic violence from which all too many American women suffer. Will the Administration agree to require every single marriage promotion grantee consult with local anti-domestic violence coalitions and that participation in marriage promotion activities be wholly voluntary?

Question: In my State almost half of TANF recipients are Native American. So it is critical for us that welfare reform work on the reservations. With that in mind, last year I introduced a comprehensive bill, S. 2484, to address the welfare reform needs of Native Americans and I plan to reintroduce this legislation in the near future. Please describe how the Administration has helped Tribes operate TANF programs and how it would like to use TANF reauthorization to strengthen this ability.

Answer: We provide technical assistance, information, and program guidance to Tribal TANF grantees as needed. In addition, we provide technical assistance and information to Tribes that may be considering administration of Tribal TANF programs. For example, we recently consulted with representatives from Turtle Mountain and provided them with information that will be used by the Tribe to determine whether or not to implement a TANF program.

Under HR 4, Tribal administration of the TANF program is strengthened in a number of ways. In addition to extending the authorization of the Tribal TANF program through FY 2008 (the same period provided to States), HR 4 provides several new funding opportunities for tribes. First, section 103 makes Tribes eligible for the "Healthy Marriage Promotion Grants." Section 105 enables Tribes to compete for the "Bonus to Reward Employment Achievement." Section 115 makes Tribes eligible for funds related to research, demonstration projects, and technical assistance. Section 115 also provides a "set aside for demonstration projects for coordination of provision of child welfare and TANF services to Tribal families at risk of child abuse or neglect." Finally, in Part C—Fatherhood Program, section 443 provides that Tribes are eligible for competitive grants for demonstration service projects and activities designed to test the effectiveness of various approaches to accomplish the objectives of this initiative. These changes should contribute significantly to the enhancement of Tribal TANF programs.

Question: I recently wrote you about an issue regarding the method for paying child support incentive funds to States. States too often have made incorrect estimates and have run into financial difficulty as a result. Will the Administration review this method and consider if it could be improved?

Answer: The incentive payment system developed in the Child Support Performance and Incentive Act of 1998 works to reward States for improved performance on a variety of measures. This new incentive system has been phased in over a three-year period, with full implementation beginning last year. While we share your concern over the accuracy of States estimates which could result in negative

grant awards at the end of the year, we are hopeful that as States develop more practice with this new system, problems will be reduced. In addition, we will continue to offer technical assistance to States to assure their performance estimates are as accurate as possible.

Question: I want to better understand the Administration's foster care block grant proposal. It is supposed to allow States to simplify their administrative procedures by ending the need to do eligibility determinations for federal IV–E foster care. But this determination will still be required to get federal adoption assistance. Won't States have to do retroactive determinations of the financial circumstances of birth parents months or years after a child originally enters care? This would be more difficult than these determinations are currently. I'm concerned this will impair state adoption efforts.

Answer: Under current program rules, States have to determine a child's eligibility for the former Aid to Families with Dependent Children (AFDC) both at the time of removal from the home and also when the State files the adoption petition for the child. We realize that conducting eligibility determinations poses an administrative burden. Under our proposal, any State that chooses the child welfare program option would only be required to test for AFDC eligibility once at the time that termination of parental rights (TPR) proceedings are initiated rather than determining eligibility at two points in time, as is currently required.

Question: According to the documents we have so far, the Administration says that "existing protections" for children in foster care will be continued. Please specify which "protections" the Administration believes will be continued and how they will be enforced.

Answer: The Department will maintain existing child protections to ensure that States keep their focus on child safety and well-being when providing services. States will be required to maintain the essential child protection provisions of the Adoption and Safe Families Act. In particular, we will continue to require:

- Licensing requirements for foster homes and child care institutions to ensure children are placed in safe out-of-home placements.
- Criminal background checks for foster and adoptive parents to ensure the provider is fit to parent the child.
- Prior to removal from the home, judicial determinations that state it is contrary to the child's welfare to remain safely in the home.
- Judicial determinations regarding reasonable efforts to prevent the child's removal from the home and to achieve a permanency plan every 12 months.
- Permanency hearings through the courts every 12 months for each child in foster care.
- Administrative every 6 months for each child in foster care.
- Case plans for all children in foster care to identify the goals and steps the agency is taking to provide permanency.
- MEPA and Interethnic Adoption Provisions which prohibit discrimination on the basis of race, color or national origin in making foster care and adoptive placement decisions.

Question: If a State fails to demonstrate full conformity with the elements examined in a Child and Family Service Review, will it be able to take up the foster care block grant option? If so, aren't you undermining that review process?

Answer: A State that is not in substantial conformity with the elements examined in a Child and Family Services (CFS) Review will be able to take the child welfare program option. The CFS rReviews are designed to assist States in achieving positive outcomes for children in the areas of safety, permanency, and well being. We believe that the flexibility provided in by the option will provide States the tools they need to make the types of system improvements indicated in the CFS Program Improvement Plan (PIP) required of a State for failure to demonstrate substantial conformity. The Department plans to continue the Child and Family Services Reviews in all States to monitor the essential child protection provisions outlined above, regardless of whether the State has selected the child welfare program option.

RESPONSES TO QUESTIONS FROM SENATOR BINGAMAN

Question: Secretary Thompson, I would like to first commend you on your leadership on the issue of obesity and physical activity in this nation. I have been working on a bill sponsored by the Majority Leader, Bill Frist, that is called IMPACT and we hope to have your support for that legislation upon introduction. What are the varied proposal that you are making in this budget with respect to obesity and physical activity?

Answer: Poor diet and sedentary behavior cause obesity and increase the risk for other chronic diseases, including cancer, diabetes, and cardiovascular disease. These behaviors demand a concentrated effort to reduce their toll on the population. CDC is engaged in this effort through three related programs: state nutrition and physical activity programs that work in communities; coordinated school health programs that work with youth in school settings; and the Youth Media campaign, which promotes physical activity through media and marketing.

In FY 2003, CDC received approximately $34 million for its Nutrition and Physical Activity Program to Prevent Obesity. Of this, $5 million is directed to micronutrient malnutrition program and $29 million is for nutrition, physical activity, and obesity program activities. The 2004 budget request is approximately $27 million.

In FY 2002, CDC supported 12 states at the capacity building level ($400,000) to plan statewide nutrition and physical activity programs, and conduct demonstration interventions, particularly through population-based strategies, such as policy-level change, environmental change, and social marketing. Capacity-building states are developing plans to address state priority populations, establish critical partnerships to achieve program goals, and establish and evaluate programs for the state's priority populations.

In FY 2003, CDC plans to fund up to three additional states (for a total of 15) at the capacity building level. In addition, CDC plans to fund two to four states at an increased funding level for basic implementation programs ($700,000). These states will implement statewide plans; expand partnerships; develop and apply interventions and evaluate their effectiveness; develop resources and training materials; identify, assess or develop data sources to further define and monitor the burden of obesity; and evaluate progress and impact of the state plan and intervention projects.

Following are examples of intervention projects:

Create supportive environments for physical activity and healthy eating in communities. Examples include encouraging cafeterias to make vegetables and fruit more available; improving lighting, sidewalks, and crosswalks in neighborhoods; cleaning up and reclaiming vacant lots for use as physical activity and play areas.

Establish policies and standards to support physical activity and healthy eating in communities. Examples include rating day care centers for snack and meal quality, safe outdoor play areas, and limitations of TV watching; and developing guidelines for vending machine selections in work sites and schools.

Establish programs in communities to increase physical activity and healthy eating habits. Examples include increasing the number of children walking or biking to school; providing pedometers to office workers to measure and increase daily physical activity; encouraging boys' and girls' clubs to provide healthy snacks and limit television viewing time in their facilities and in events they sponsor.

Teach skills needed to encourage individual behavior changes and provide opportunities to practice these skills. Examples include training health care professionals to promote patient behavior changes; and incorporating healthy eating and physical activity to parenting and prenatal programs.

CDC is also conducting prevention research and health tracking that will provide national leadership in this area. For example, CDC is examining state-specific direct medical costs of obesity, and the "walk-ability" and "bike-ability" of communities. In addition, CDC is exploring strategies for a comprehensive nutrition and physical activity health tracking system.

In addition in FY 2003, $15 million was allocated to *Steps to a Healthier US*, a bold new initiative that advances President Bush's *Healthier US* goal of helping Americans live longer, better, and healthier lives. The FY 2004 Budget request for Steps is approximately $100 million.

A centerpiece of *Steps* is a five-year cooperative agreement program to improve the lives of Americans through innovative and effective community-based chronic disease prevention and control programs. Through the cooperative agreement cities, urban and rural communities, states, and a tribal group will be funded to address obesity, diabetes, asthma and related risk factors—poor nutrition, lack of physical activity, and tobacco use and exposure.

Question: While Medicaid costs are growing rapidly, they are doing so in line with the private sector. The problem is neither Medicaid nor is it Medicare . . . it is health care. Block grants do not reduce the costs of care for optional populations . . . they just reduce both the commitment of federal and state governments to the care of low-income populations.

Secretary Thompson, why should your Medicaid proposal be an all-or-nothing proposition in which states can only get flexibility if they agree to taking a block

grant? Why can't we work with states on a flexibility package without undermining the current Medicaid financing system? Will the Administration agree to additional flexibility for states on items such as eligibility, cost sharing, and home and community-based care for optional populations and services for states that do not opt into the block grant?

Answer: Since its inception, the Administration has been committed to increasing states' flexibility in administering their Medicaid programs. The HIFA, Independence Plus and Pharmacy Plus waiver initiatives have given states significantly more flexibility to expand eligibility and to tailor their programs to meet their needs. The Administration's Medicaid modernization proposal represents the culmination of these efforts.

Much of the modernization proposal is modeled on the SCHIP program, which gives states far more flexibility in designing their programs than is available in Medicaid and which has proven to be extremely successful. One of reasons that SCHIP can afford states the broad flexibility that they enjoy is that the program is funded through an allotment and federal liability is limited. Without a limit on federal liability, many of the ways in which the modernization proposal relaxes federal constraints on state flexibility would not be possible.

We recognize that not all states will find it advantageous to implement the modernization proposal, despite the extremely broad flexibility it would confer. The Administration remains committed to working with such states to enable them to reform their programs through waivers or state plan amendments, and to giving them as much flexibility as possible. But, in the context of open-ended federal outlays, it would be irresponsible to grant these states the full extent of the flexibility and control that would be conferred under the modernization proposal.

Question: The Administration has a regulation that phases out what it viewed as upper payment limit abuses by states over a period of years. If 2002 is a base year, are those dollars included in the base amount that is then inflated in the future or does the policy pull those dollars out over time?

Answer: The approved Medicaid UPL transition amounts for States are removed from the base year spending amounts that are trended forward. These transition amounts are then added back to the trended base year and these transition amounts are then phased out according to the current law UPL transition rules.

Question: Secretary Thompson, at the National Governors Association meeting, you stated that states that choose the block grant option in your budget proposal would no longer have to match federal expenditures in Medicaid. You stated at the NGA meeting and to Senator Smith that states will have to pay approximately $8 billion per year less than under the current projected expenditures. In year one, even with the added $3.25 billion loan you give to states to take up the block grant, there would be almost $5 billion less in Medicaid spending.

On the other hand, to me you testified that states would still have a 7‡% growth rate through your Medicaid maintenance of effort proposal.

Also, you stated that the reduction in the state share results in an effective increase in the matching rate—not because of federal increases but because of state reductions.

What will be the fiscal effort of states in your proposal? Also, what would be the effective matching rate for states adopting the block grant after 10 years?

Answer: States will be required to maintain a level of state funding each year as their maintenance of effort (MOE). This MOE amount will be computed by taking the state's expenditures in the base year and trending them forward by the CPIU-Medical to the year the state opts into the Modernization Program. That amount will be increased each year by the CPIU-Medical during the state's participation in the program. When the state satisfies its MOE for any year it is entitled to receive the entire Federal allotment for that year.

The state's effective matching rate over time will be slightly less than under current law since the state MOE will grow at a lower trend rate than the Federal allotment.

Question: At the press conference announcing the Medicaid proposal, a CMS official announced that current limits on mechanisms such as provider taxes and donations would be eliminated. As you know, these mechanisms largely benefited state budgets and not anybody's health and both the first Bush Administration, the Clinton Administration, and the current Administration have all worked hard to address these problems.

Via these mechanisms, couldn't the Medicaid program be rapidly turned into nothing more than a giant revenue sharing program?

Answer: We will establish guidelines to define what states will be able to use as their state share in satisfying the maintenance of efforts (MOE) requirements under

the proposal. It is our intention that states continue to contribute real state funding in satisfying their MOE requirements.

Question: When States recoup fraud and abuse expenditures, how is that money returned under both the mandatory and block granted optional programs?

Answer: States have the primary responsibility for minimizing the amount of improper payments made either due to inadvertent error or to fraud. States are required to operate a Medicaid fraud and abuse control unit that is separate and distinct from the state Medicaid agency unless the state demonstrates that there is minimal fraud in its Medicaid program and that beneficiaries will be protected from abuse and neglect. The President's Medicaid Reform proposal would maintain states' primary responsibility in this area. We look forward to working out the operational aspects of the program—such as how recoupments from fraud and abuse programs would be handled—with the Governors, Congress, and other stakeholders.

Question: You now seem to be talking about an integrated benefit for Medicare but are moving in the opposite direction in Medicaid by keeping some benefits, such as physician services, as a mandatory benefit with federal matching funds and standards, while separating out prescription drugs into a capped, block grant with, what you called "carte blanche" state flexibility because it is an optional benefit.

First, since the majority of Medicaid beneficiaries are in managed care, how will you separate out those capitated payments to health plans in mandatory and optional pots for 2002 and in the future? Second, under what pot are prescription drugs—acute or long term care—in light of the fact that prescription drugs are provided in both settings? And finally, will states have the flexibility under the block grant to establish their own fee schedules for prescription drugs or would the Medicaid drug program still be mandated?

Answer: We will work with states using the financial and statistical data they currently report—including capitation payments—to develop any necessary data we need to establish the base year allotments. Additionally, we will put in place the necessary reporting and tracking requirements at the state and federal levels to monitor the program in each state.

We will have the drug expenditures follow the current claiming process to establish the base year expenditures. If a drug is currently claimed as an acute care or a long-term care expenditure, it will be included in that portion of the allotment when the base year expenditures are established.

We would allow states considerable flexibility under the proposal to establish reimbursement methodologies for drugs and other expenditures that are consistent with quality of care and beneficiary access.

Question: For optional populations, would current managed care standards, such as prudent layperson, added protections for children with special health care needs, rural access standards, and translation services, be retained?

Answer: One of the cornerstones of the Medicaid modernization proposal is to provide states with much needed flexibility to design programs that meet the needs of their beneficiaries, without the need for states to seek waivers. That flexibility extends to both the fee-for-service delivery system as well as a managed care delivery system. Within this flexibility we intend to protect mandatory services for mandatory populations. The exact nature and degree of flexibility remains to be determined and we look forward to working with you and other Members of Congress, and Governors, to incorporate sufficient flexibility while maintaining appropriate standards to insure quality of care and access.

Question: The National Governors' Association policy passed earlier this week states, "The federal government should assume full responsibility for the acute, primary, long-term, and pharmaceutical care of the dual eligibles, individuals who are enrolled in the Medicare program, but because of their low-income, are also eligible for the Medicaid program."

Under your Medicaid plan, is the federal government assuming any new responsibility for health care costs for the dual eligible population, especially for long-term care and the Medicare Savings Programs?

Answer: Under the Medicaid modernization proposal, the federal government will maintain an overarching financial commitment to states over the course of the ten-year period, actually increasing federal funding over projections under the current program for the first 7 years. Federal funding also will be adjusted to reflect any change in the size of mandatory eligible populations, including dual eligibles. And states will be given broad flexibility in reforming their programs in order to meet the needs of all their residents, including the dually eligible population.

We recognize that coordinating Medicaid coverage of dual eligibles with Medicare can pose particular difficulties for states, and are committed, in the reform legislation, to providing states with the tools they need to manage coverage of this popu-

lation more effectively and efficiently. We look forward to working with Congress and the states on the details of how best to accomplish this goal.

Question: Are the federal projected block grant increases of 9% annually going to be provided to states equally or will individual states have different growth rates based on population changes, caseload growth, aging demographics, or other factors? Also, will the growth rates be adjusted so that efficient states, low-spending states, or states with relatively narrow programs are not forever locked into those restrictive spending levels?

Answer: Each state's allotment is trended forward using the same trend factor for each state. There are no state-specific trend factors or adjustments.

Question: What happens if expenditures are less than the federal allotment? Would a state get to keep the savings or carry over those funds? Also, what happens if expenditures exceed the federal allotments?

Answer: If a state meets its maintenance of effort requirement in a given year the state is entitled to receive the entire federal allotment for that year. If the state does not use that entire federal allotment in that year those funds can be carried forward and used in any subsequent year. If expenditures were greater than the available federal allotment the state would have to pay those expenditures with all state funds.

Question: If a state opts for the block grant and is scheduled to receive a 9% increase in the coming year but decides to add coverage to a population, such as expanding coverage to optional children, would that state get additional federal support above the 9% to help pay for this added population?

Answer: A state would not get any more federal allotment in a given year to pay for expansion populations than the previous year's allotment increased by the trend rate for that year. However, a state may use any unexpended allotments from previous years that may be available for these expenditures. Additionally, SCHIP expenditures are included in the state's base year allotment and trended forward by the inflation factor. Also, any unspent SCHIP allotments available to the state when it elects the allotment option will be added to the federal allotment amount for that year and remains available until expended.

Question: Under the Medicaid partnership allotments, if Congress or the Administration decides to impose new mandates, such as quality standards or payment standards, what would be the cost to the federal government?

Answer: At the time a new mandate was imposed Congress or the Administration would need to decide the appropriate manner for funding the new mandate.

Question: CMS has a policy requiring consultation with Native American tribes and tribal organizations prior to issuing a Medicaid waiver. What happens to that with respect to Native Americans who happen to be optional populations?

Answer: Both the Department and CMS have plans for how we carry out our Federal responsibilities for consulting and collaborating with American Indian and Alaska Native Tribes and Indian organizations in the development of Federal policies with Tribal implications. Within the context of these consultation plans, the methods of consultation used are tailored to address the particular nature of the policy or subject matter on which consultation is sought. At the Federal level, the Department sent a letter to Tribal Leaders and Tribal organizations on April 17, 2003, providing copies of the President's Medicare and Medicaid Reform Frameworks and encouraging their input to them, either at a CMS meeting to which they were invited on May 8, 2003, as part of the Department's budget consultation activities, or otherwise.

Your question more specifically refers to a CMS policy regarding State consultation with Tribes and Tribal organizations prior to approving a Medicaid waiver. That policy was issued in a letter the Department sent a letter to State Medicaid Directors on July 17, 2001. The letter noted the importance of providing Tribes access to Medicaid and SCHIP decision making processes and providing some guiding principles for consultation by States with Tribes. While the letter was developed with the waiver process in mind, we believe that the principles would be applicable to other significant policy changes States may consider, either under current law or under our Medicaid Reform approach.

Key principles set forth in the letter include: "Participation in the decision-making process can best be achieved through an ongoing and effective consultation process that ensures the inclusion of Federally-recognized Tribal governments while preserving the right of State Medicaid agencies to make appropriate decisions based upon the needs of all Medicaid and SCHIP beneficiaries. . . . Many States have established viable mechanisms to ensure an ongoing consultation process with Tribal governments. State experience has demonstrated that there is no single Tribal consultation process that can or should be imposed upon States. . . . We are

encouraging States to be as responsive as possible to the issues and concerns expressed by the Tribes during the consultation process."

Question: What happens to the Medicaid DSH program under your proposal? Will the low-DSH states and those that were not aggressively seeking to maximize federal funds continue to be disadvantaged or have that perpetuated well into the future?

Answer: Under the Medicaid modernization proposal, allowable DSH expenditures in the base year would be included in the base year expenditures and those expenditures would be trended forward during the period that the state is in the modernization program. States would have the flexibility to target payments to hospitals and other providers based upon the particular needs in the state.

Question: The Administration's proposal appears to roll SCHIP funds into the new Medicaid allotments. By folding SCHIP funds into the Medicaid cap, those funds would no longer be dedicated to children's coverage, thereby threatening much of the progress SCHIP has made over the past five years. What if a state has insufficient funding and has to choose between taking money away from children or paying for seniors in nursing homes? Also, for those states that choose not to take the Medicaid block grant, what happens to SCHIP over the 10-year period?

Answer: The Administration's Medicaid Reform proposal is completely optional for the states. If a state chooses not to participate, then its Medicaid and SCHIP programs would remain the same as today.

If a state did participate in the allotment option we believe that there will be sufficient funds to meet state health care needs. First, the proposal guarantees funding for mandatory services for the mandatory populations. Second, under Medicaid Reform states would have the flexibility to provide services without waivers and thus states would be able to modify the program to implement cost-effective changes such as preventing increased admissions to nursing homes while providing better community-based services.

BORDER HEALTH

Question: In October 2001, you went to the US-Mexico Border Health Commission and talked to them about the important role that the border plays with respect to bioterrorism and urged the Commission to submit a proposal for $25 million to improve the infrastructure along the border on the issue. At the meeting, you also toured the border and heard the multitude of public health problems facing communities along the US-Mexico border. I am pleased that Surgeon General Richard Carmona is a member of the Administration, as he understands the problems with face along the border.

I have two questions. First, I believe the border is likely the first line of defense with respect to bioterrorism. At your request, the Commission submitted that proposal to your office and I would be interested where that stands with the Administration.

Second, with your interest and the expertise of the Surgeon General and the members of the US-Mexico Border Health Commission, I would ask whether the Administration would make a commitment to doing a more thorough examination of how to proactively address the health disparities and problems along the US-Mexico border. The border desperately needs focus and an action agenda and your leadership would be important in the matter.

In our initial $1.1 billion dollars bioterrorism grants to the States, we requested that the Border States take special notice of the border bioterrorism needs. In FY 03 the Border States have received for bioterrorism and hospital preparedness a total of 213.3 million dollars. These funds have been made available to the States through Center of Disease Control and Prevention grants of 128.5 million dollars and Health Resources and Service grants of 84.8 million dollars. The States have provided some of these funds to the border as we requested, although more needs to be done. (FIGURES FROM CDC WEBSITE)

We will soon announce a second block of funds for the States. In this announcement, State and local Health departments sharing an international border with Mexico are again encouraged to use this funding to address preparedness for and response to bioterrorism, other outbreaks of infectious disease, and other public health threats and emergencies in border regions.µ Activities supported by these funds should foster collaboration and be coordinated with border counties and existing border agencies and institutions.µ We anticipate States may use funds to conduct necessary actions in support of binational planning, coordination, program development, and contracting in Mexico if such actions directly contribute to health security in the United States.

The U.S.-Mexico Border Health Commission has begun to assist Border States in identifying priorities in bioterrorism preparedness. It has allocated $140,000 dollars for a border wide risk assessment not currently programmed by any other Federal or State entity. An additional $50,000 has been provided for border regional strategic planning sessions. By providing the funds to facilitate the sub-regional and regional strategic planning for emergency preparedness, the Commission is fulfilling its role for which it was established, being an advocate for border health. Emergency Preparedness, whether for terrorism or otherwise, is a border wide public health issue. I am supportive of a regional plan that will assist the Commission, the Border States and my Department in allocating resources in an efficient and effective manner.

Answer: I share your concern and commitment to addressing health disparity that affect our U.S.-Mexico Border citizens. Active intervention is required to ensure sufficient access to health care for the U.S.-Mexico border region. Otherwise the high rates of communicable diseases and chronic illnesses in the region will continue to burden residents, the National health care system, and already overburdened regional health care.

This makes eliminating disproportionate shares of disease, illness, and injury among these populations a critical goal. Reducing these disparities should produce a significant improvement in the indicators measuring health status. These are the goals of the Department of Health and Human Services that supports vital State health programs and helps local communities maximize their limited local health care resources.

Health Resources and Services Administration (HRSA) within the Department of Health and Human Services forms the foundation of the nation's health care safety net by assisting State and local health officials in treating HIV/AIDS, preventing injuries, fighting high blood pressure and diabetes, immunizing children, and ensuring that health departments in the nation are appropriately prepared for bioterrorism. Its programs train doctors, nurses, and other health care professionals, also placing them in underserved areas. HRSA also works with rural communities and hospitals to enhance their health care delivery systems and assure access to care in America's isolated communities. Through the provision of primary medical care and many other health promotion and disease prevention activities, HRSA provides essential public health tools to America's communities—the place where health care services are actually delivered.

HHS Goals for the Border

HHS has given high priority to working with its many partners to reduce the disproportionate impact of disease and illness and increase the general health status of the region. The U.S./Mexico Border Health Commission, created in July 2000 by joint action of the U.S. and Mexican governments, exemplifies HHS's commitment to a multi-national framework. The commission's goals comprise the objectives and health indicators in "Healthy Borders 2010" program, as well as providing international leadership and optimizing health and quality of life along the U.S.-Mexico border.

HRSA is committed to determining how to more effectively use existing resources to resolve structural health issues in the region. Its mandate encompasses the primary care capacity and workforce development issues faced by communities in the border region. The Agency strives to create an initiative where success is measurable and significant, results are reproducible, efforts are sustainable, and the approach is cost effective. To accomplish this, HRSA has established a Division of Border Health (BHD) within its Office of International Health Affairs to organize, streamline, and promote sustainability HRSA services to residents of the four U.S. and Mexican Border States. The Division's mission is to promote sustainable development of a comprehensive, effective and accountable health infrastructure and services addressing the training, preventive, and primary care needs of populations in the border region.

The BHD currently stations five public health advisors along the border to work with State health departments in the four Border States. These health advisors are bilingual and bring epidemiological, environmental, and public health expertise to the border communities. Their work is essential to HRSA's border efforts, and their excellent working relationships with State and local health departments, NGOs, foundations, school districts, other Federal agencies, universities, schools of medicine, dentistry and public health significantly advances HRSA's ability to address regional needs.

Since 1996, HRSA has intensified its work along the U.S.-Mexico Border by designating border health as a priority crosscutting issue of increasing regional and na-

tional importance. Programs and activities developed to address the extensive needs of the region include:

- *Training*. HRSA-funded programs train 50 farm worker women to address HIV/AIDS prevention, education, outreach, and linkage to primary care services. HRSA's AIDS Education and Training Centers (AETCs) provide specialized clinical education and consultation covering essential up-to-date information on the transmission, treatment, and prevention of HIV/AIDS to health care providers, including those serving rural areas and hard-to-reach individuals along the US-Mexico border. Additional efforts are underway to improve communication, collaboration, and the sharing of resources among the three AETCs covering the border region.

HRSA also works with health officials in the region as well as the Centers for Disease Control and Prevention (CDC) to reduce the number of Tuberculosis (TB) cases along the border by improving the diagnostic and treatment skills of health care providers. An important focus is preventing the spread of multi-drug resistant TB and the provision of direct observed therapy (DOT).

- *Increasing access to health services*. Since 1998, HRSA has awarded grants to establish 13 new community health center clinics and access points in border communities. Recent grants will expand the capacity of eight existing border community health centers. Additional awards will fund several new or expanded school health, homeless, and public housing projects. These programs also include assistance provided by the Office of Special Populations, which provides vital strength to border issues addressing health insurance coverage, the uninsured and underinsured. Data has shown that Arizona and California have the highest uninsured patrons in the country.

Promotoras (local health educators) are used in the Border Vision Fronteriza program to enroll children into the Children's Health Insurance Programs (SCHIP) and Medicaid. This large outreach program is composed of several localized projects that include community and migrant health centers, Area Health Education Centers, and State health department Border Health Offices. Border Vision has enrolled over 21,000 children into SCHIP and Medicaid since 1999. Similarly, the Healthy Start Program utilizes promotoras to bring women into prenatal care earlier in their pregnancies to help reduce premature birth and death for newborns. These programs encourage women to seek earlier prenatal care, increase the involvement of fathers in the pregnancies, and help pregnant women obtain nutrition, education, and health care throughout their pregnancies.

Promotoras are also involved in the Healthy Start Program, in which four Healthy Start border projects enroll women into earlier prenatal care and assist them by providing transportation, translation services and support in navigating the health care system before and after delivery. For the two years following the infant's birth, the promotoras remain as home visitors and as a peer support system to help the young women obtain nutrition, education, and health care for themselves and their children.

Border HIV/AIDS SPNS Project. The overall goal of the five border SPNS programs and the HIV/AIDS Evaluation and Technical Assistance Center is to develop models of community-based health care networks that effectively reduce barriers to early identification of HIV disease. They also are intended to assure entry to high-quality primary health care for individuals who live and or work in the U.S. region of the U.S.-Mexico border area. The outcome will document how effective the models are in providing HIV outreach and care to high-risk border populations. Each project has established a unique network of coordinated services linking high-risk people to HIV counseling and testing as well as linking HIV positive people to primary care and other services. The models of care generally focus on two themes: improving access to HIV/AIDS care through the use of local, culturally relevant outreach activities using indigenous workers, and innovative and culturally relevant models of case management to support HIV primary care.

- *Spanish-language newspapers*. The Spanish radio news HealthLine Texas en Español will begin covering, in FY 2003, health news stories of interest to Texas' Spanish-speaking population, particularly those residing in the Texas/Mexico border region. Specific stories will focus on diseases identified by HHS in its initiative to reduce racial and ethnic health disparities, and other health and environmental concerns of importance to border communities.

Current CMS Activities

HHS's Centers for Medicare and Medicaid Services (CMS) is using its capabilities as an avenue in improving border health. Some of the progress made by CMS includes:

- *Programs*. Within CMS, the Centers for Medicaid and State Operations oversee the Medicaid and SCHIP programs jointly administered by Federal and State authorities. These programs provide medical assistance for various individuals and families with low incomes and resources. States have the option of using Federal SCHIP funding to help fund separate state child health programs, or to expand Medicaid eligibility for children. However, Medicaid limits coverage of otherwise qualified aliens, who are not permanently residing in the United States, only to treatment of an emergency medical condition. Such individuals are not eligible for benefits under a separate state child health program.

States have considerable flexibility in designing their SCHIP and Medicaid programs within a framework set for in Federal law. Medicaid requires each state to offer a set of mandatory services, such as inpatient hospital, physician, and nursing facility services. States may choose to provide a package of optional services legally defined for both programs, such as prescription drugs and dental services. Separate child health programs under SCHIP have additional flexibility to offer benefits based on commercially available benchmark products.

Each of the four Border States have instituted one or more of these projects to better enable their programs to expand services, cover additional populations, or implement new service delivery systems. These projects include:

- *Research and Demonstrations Waivers (Comprehensive State Health Reform Waivers)*. Section 1115 of the Social Security Act provides broad authority for states to implement experimental, pilot, or waiver projects. These waivers are sufficiently flexible to allow state testing of substantially new policy ideas for delivering care. Section 1115 authority allows expanded eligibility for those who otherwise would not be eligible for Medicaid. However, states would still be barred from extending eligibility to illegal aliens. Arizona runs its entire Medicaid program under this demonstration authority.
- *Health Insurance Flexibility and Accountability (HIFA) Waivers*. These waiver projects permit states to tailor benefit packages for different populations, thus maximizing utility of limited state funding. These waivers have been utilized to remove barriers that have made it difficult for states to creatively develop health coverage expansion approaches using private coverage options. Arizona, California, and New Mexico have approved waivers of this effect. HIFA will continue to be a very useful tool extending health care coverage to the uninsured.
- *Arizona's HIFA demonstration* extends coverage to two populations. The first is adults over age 18 without dependent children and with adjusted net family income at or below 100 percent of the Federal Poverty Level (FPL). The second is individuals with adjusted net family income above 100 percent FPL and at or below 200 percent FPL, who are ineligible for either program but yet are parents of children, enrolled in the Arizona Medicaid or SCHIP programs.
- *California's HIFA demonstration* expands health coverage to 300,000 uninsured Californians, primarily parents whose children are covered under California's SCHIP or Medicaid programs.
- *New Mexico's HIFA demonstration* will cover uninsured parents of Medicaid and SCHIP children, as well as childless adults, in a partnership with employers in the State. Those eligible for coverage will include uninsured parents of Medicaid and SCHIP children, who are themselves ineligible for Medicaid under the State's current rules, with incomes up to 200 percent of the Federal poverty level ($36,200 for a family of four). Adults without dependent children, who are otherwise ineligible for Medicaid, will also be eligible if their incomes are up to 200 percent of FPL. New Mexico estimates that up to 40,000 currently uninsured individuals may be covered under the demonstration.

SCHIP

SCHIP now insures nearly 4.6 million children and youth, including some parents of eligible children and youth, and is expected to cover many more of the approximately 10 million uninsured children and youth in the United States. Below are the outreach efforts of the four Border States to enroll individuals in SCHIP:

1. *Arizona* had a total of 86,863 children served by SCHIP in Federal FY 2001. The Governor's Outreach Work Group met several times to develop a comprehensive outreach plan. Outreach efforts and the distribution of applications target those agencies, organizations, and other entities that currently serve designated low-income children.
2. *California* reported having almost 700,000 children served by SCHIP during FY 2001. To ensure that health care providers currently serving low-income families are given the opportunity to participate in the program, the state encourages private managed care plans to subcontract with safety net providers. This is done by allowing the health plan in each county that has the highest

percentage of safety net providers in its network to charge a discounted premium. and by giving priority in awarding contracts to plans with significant numbers of providers who serve uninsured children. California also has taken a multifaceted approach to outreach. Its Department of Human Services administers a $20 million media and outreach initiative that includes a media campaign featuring Spanish advertising, and the use of community-based organizations, health brokers and insurance agents to directly identify and assist potential enrollees in filling out the joint application form for the Medi-Cal and the Healthy Families programs. Additionally, California is conducting a provider education campaign in support of its outreach campaign.

3. *New Mexico* reported that the Medicaid expansion program during FY 2001 served 10,347 children. The New Mexico Human Services Department (HSD) is partnering with the Department of Health to provide publicity campaign via a private contractor. SCHIP outreach will be coordinated with other public health outreach efforts. The Department issues *Salud!* Newsletters, which address SCHIP implementation, to a wide and varied circulation list.

4. *Texas* enrolled a total of 500,950 children in FY 2001, including 26,768 children in the Medicaid expansion plan. The State utilizes a number of mechanisms to identify and enroll eligible children in the health care system. The State works closely with the entire network of public health providers to disseminate outreach materials to providers in turn supply information to families with potentially eligible children.

HIV/AIDS

Medicaid is the largest single payer of direct medical services to PLWAs (persons living with AIDS) in the United States. The Medicaid program pays for the care of over 50 percent of all persons living with AIDS and up to 90 percent of those persons under 18 years of age living with AIDS. In addition, Medicaid pays for the care of about 60,000 persons with the HIV disease who have not yet progressed to AIDS. CMS estimates that the Medicaid program will serve 218,000 persons living with AIDS nationwide in FY 2002. State Medicaid agencies work with CMS and other Federal agencies to assure that those with HIV infection and AIDS are not subject to discrimination when seeking access to Medicaid and Medicare services.

AIDS is the fourth leading cause of death among women ages 25–44, and the seventh leading cause of death among children ages 1–4. Not surprisingly, experts predict that, the number of children infected will also rise with the number of childbearing women infected. Women with HIV are disproportionately minority and poor. The significance of this projection is most poignant for minorities; in El Paso and San Diego, the rate of persons living with AIDS is 16.7 out of every 100,000.

As with other states, the Border States are able to take advantage of the CMS-developed Maternal HIV Consumer Information Project, which both increases patient and provider knowledge about the availability of drugs that reduce HIV transmission and expands knowledge of Medicaid eligibility and coverage of prenatal care. CMS works with State Medicaid agencies and health departments to provide women of childbearing age with information regarding HIV testing and counseling which, in the event a woman is HIV-positive, enables her to make an informed decision about preventing transmission of the disease to her baby. When properly prescribed, the drugs can help prevent transmission of HIV to infants. The Maternal HIV project also stresses that Medicaid pays for HIV counseling, testing, treatment, and medications to prevent transmission of HIV from mother to child. Because there is a high percentage of minority women in Medicaid, CMS also believes this project will have a positive impact on minority women's health outcomes.

It is vital to continue the Department and HRSA priority emphasis on the border region, and maintain support for its programs. Advances made in disease prevention and health education must continue if disease transmission, morbidity, and mortality rates are to decrease in border communities. My Department is committed to continue its effort to improve health for those living along the U.S.-Mexico border.

Question: A number of the members on the Finance Committee, including the Chairman and Ranking Member, have close to 100 percent of their Medicare beneficiaries in traditional fee-for-service Medicare. Under your proposal, will beneficiaries be able to receive the Medicare drug coverage if they choose to remain in the traditional fee-for-service program?

Answer: Under the President's Framework to Modernize and Improve Medicare, all beneficiaries will get access to meaningful prescription drug coverage, and low-income beneficiaries will be helped the most.

Beneficiaries who choose to stay in traditional Medicare will receive a drug discount card that lets them save 10–25 percent off their drug bills, plus coverage for

catastrophic costs for no additional premium. Low-income beneficiaries will receive an additional $600 on their drug card.

Beneficiaries who opt for Enhanced Medicare or Medicare Advantage will have access to drug coverage that's integrated into their overall insurance. The Administration looks forward to working with Congress to determine the best design for this coverage.

RESPONSES TO QUESTIONS FROM SENATOR ROCKEFELLER

Question: This is an important issue to me and I have many questions regarding this alternative funding option. If a state takes this option, and invests 15% of its funding for the first year into innovative programs. Within 9 months, this innovative option reduces foster care caseloads by 5%. For many, this would be deemed promising, yet the state will have a 10% shortfall in maintaining support for children remaining in foster care. Since caseloads are not increasing, states would not be eligible for contingency fund help. What could states do to make up the 10% shortfall—Limit child abuse and neglect investigations? Reduce maintenance payments to current foster care parents? Cut back on caseworkers?

Answer: Under the child welfare program option, States may choose to have their funding front-loaded with level funding over a five-year period. For this reason, the hypothetical described does not necessarily hold. We have designed the proposal to allow States to receive up-front funding at their choosing and to save funds immediately from reduced administrative burdens. States claimed Federal reimbursement for approximately $68 million of these administrative costs in FY 2001. Although some activities that are linked to eligibility requirements will continue under the proposal, we expect significant savings in this area. Another area where we expect savings is in the area of cost allocation, as this process will be significantly streamlined. We believe that this initial influx of funding in addition to the longer-term savings generated from innovative programs that reduce foster care caseloads will allow States to fund new and improved services and maintain their responsibility for children in foster care. We have no reason to believe that States utilizing this program option would make decisions that could compromise children's safety, permanency, or well-being. This proposal is an opportunity for States to use Federal funds to improve the way they plan, organize, and invest in their child welfare system.

Question: The Administration seems to believe that the "1996 look-back" is a problem, yet it continues the 1996 look-back for adoption assistance. Doesn't this mean that the baseline for adoption assistance will continue to decline, and serve as a disincentive for adoption?

What is the Administration position on the policy of linking access to adoption assistance to the income and assets of the abusive parents whom the child is being taken from? Why doesn't the Administration support de-linkage of adoption assistance from the abusive parents income and assets, that was passed by the Senate by unanimous consent in 1997?

Answer: The Administration's child welfare proposal is designed to meet the needs of States for flexibility and innovation within their child welfare systems while preserving fiscal responsibility.

Unlike the title IV–E adoption assistance program, where spending continues to grow at a rate of approximately 10 percent per year, State title IV–E foster care expenditures are increasing at a much slower growth rate. Therefore, we are maintaining the entitlement to adoption in order to ensure that all children can grow up in a loving and permanent home. States have a financial incentive to move children into adoption, as the costs associated with maintaining a child in foster care—whether it they be IV–E or State only—far exceeds the costs associated with a child who has been adopted. Additionally, the Administration is seeking reauthorization of the adoption incentives program to provide specific fiscal incentives to States to increase all adoptions and in particular, adoptions of older children.

Under the Adoption Assistance proposal, States that choose the child welfare program option will do the eligibility determination at the time of the TPR petition when the child still has legal ties to their biological family. The current system requires the determination to take place at the time of adoption, which can occur long after the TPR has been finalized.

Question: How can States invest in innovative programs and prevention without jeopardizing basic investments for the current foster care population without additional resources?

Answer: As noted above, the child welfare program option provides States the opportunity to front-load ed, level funding over a five year period. Under this scenario, iIn the first several years of the program option, States willould receive funding

above the level required to support current caseloads. In this way, such States do receive additional resources in the near-term. These resources are intended to provide the means for innovation in prevention services—both protecting children and preserving families, while reducing caseloads over time.

Further, Wwe do not believe that additional funding is the only answer to achieving positive outcomes in child welfare. States have requested more flexibility in the title IV–E program in order to stimulate innovation, reorganize their programs, and better serve children and families. Some of the results from our demonstration projects confirm that States are able to reduce out-of-home placement by providing more intensive in-home services in a cost-neutral environment. We believe that our proposal will generate both immediate savings from reduced administrative burdens and longer-term savings as a result of State innovations in better targeting services to families in need, preventing child abuse and neglect, avoiding foster care placement, and expediting permanency. We anticipate that States will use the immediate savings in combination with up-front funding to invest in their child welfare programs in a way that will ultimately reduce the foster care caseload, lessen the duration of foster care stays and achieve positive outcomes for children and families. It is the confluence of reform activities and up-front funding that allows States to maintain and supplement their investments

Question: It seems that the Administration plan defines a foster care crisis only by caseload increase, but there can be an increase in child deaths, child maltreatment, and incidences of children lost within the child welfare system. Shouldn't these be indicators of crisis within a child welfare system, and shouldn't these factors be considered for access to the contingency fund? Shouldn't the contingency fund be increased so that adequate funding is available for both foster care and child welfare?

Answer: We considered a number of triggers for accessing the TANF contingency fund for child welfare purposes. We believe that a substantial increase in the foster care caseload should be the primary trigger because out-of-home placements continues to be one of the most expensive and taxing aspects of a State's child welfare system. Undoubtedly, increases in child deaths as a result of abuse and neglect, child maltreatment, and missing children in the system also indicate that State child protection and child welfare systems are not functioning well. However, these factors are often difficult to measure and can be influenced significantly by changes in policy. We want to ensure that truly needy States can access the contingency fund when a crisis occurs that is not of their own making. Rather than considering these as factors warranting access to the contingency fund, we would use information derived from our child welfare monitoring reviews to influence State decisions on reforming and strengthening their programs.

The TANF contingency fund is currently authorized at a level of $2 billion. Few States have requested access to this fund for TANF purposes and we anticipate that few States will need the fund for child welfare purposes. Therefore, we do not believe that we need additional funding for the contingency fund will be needed to serve the two programs.

Question: Doesn't this flexible financing option inherently disadvantage states with an increasing population?

Answer: Our alternative funding proposal is optional and thus leaves States to examine their circumstances and decide for themselves whether the program option will best meet their needs. In general, we have seen a trend of a declining percentage of title IV–E eligible children in the foster care caseload. We expect that since this program is an option, each State will conduct a very extensive analysis of its foster care data to decide whether or not to elect the program option. This analysis would look at caseload trends as well as opportunities provided with the funding flexibility features of the alternative child welfare program option.

Question: If States accepted the option, would all children served be eligible for Medicaid?

Answer: Our child welfare proposal does not impact Medicaid eligibility. Children that are currently eligible will continue to be eligible. The vast majority of children in foster care are either currently entitled to Medicaid under the existing title IV–E foster care maintenance payments program or would otherwise qualify for the program. With the exception of the child who has significant income of his own, all children who have been removed from their parent's home and receive services under the program option would eligible for Medicaid under an eligibility group that covers all children with incomes at or below the Federal poverty level.

Question: What safeguards are in the system to ensure that such flexible dollars are targeted to services to children at risk of foster care, and not re-directed to other family programs in states that face fiscal problems?

Answer: We have no reason to believe that States will not continue to protect children and provide the same level of funding to their foster care programs. States are legally responsible for and have an obligation to care for the children in foster care. That in itself ensures the States commitment to funding. We are, however, developing maintenance of effort provision to ensure that States continue to invest in child welfare services at their current levels.

Question: Child welfare and foster care programs receive funding from IV–E, IV–B, Medicaid, TANF and in some states Social Services Block Grants. How can we ensure a strong, effective maintenance of effort for a state's current child welfare/foster care funding from all resources? If only IV–E funding are covered by maintenance of effort requirements, won't it be easy for states to switch funding around programs?

Answer: As I mentioned in response to the previous question, we are developing maintenance of effort (MOE) requirement to ensure that States maintain their full investment in the child welfare system.

Question: How would the Administration restructure the adoption incentives so that states which are making real progress in promoting adoptions do not have a continuing increasing level needed to secure a bonus?

Answer: We commend States' success in moving more children who cannot return home into permanent and loving adoptive homes, but we believe that more can and must be done. We are, therefore, seeking reauthorization of the adoption incentive program in a way that continues the high expectation for surpassing previous year efforts in finalizing all adoptions from States' foster care systems while creating a new focus on the adoption needs of children aged 9 years and older.

While the overall number of children being adopted has grown dramatically, older children in foster care still face excessively long waits for adoption and in many cases are never adopted. Our analysis of AFCARS data suggests a need to focus greater attention on older children because they are less likely to be adopted and are likely to represent an increasing proportion of the pool of children waiting for adoptive families.

Under our new proposal, once a State has reached the baseline for the total number of adoptions for the year, the State will become eligible to receive a $4,000 bonus for each additional child who is adopted from the public child welfare system. Additionally, we will establish a separate baseline for the number of children age 9 and older who are adopted. Once the State reaches this new baseline for a year, the State will receive a $6,000 bonus for each additional child age 9 and above who is adopted from the public child welfare system. A State that surpasses the baseline for older children adoptions would be eligible for the $6,000 incentive even if the States does not qualify for an incentive for overall adoptions.

RESPONSES TO QUESTIONS FROM SENATOR HATCH

Question: Mr. Secretary, as you know, the biotechnology sector offers great promise for the development of cures for untreated disease. Today, Medicare does provide coverage for some of these therapies in the outpatient setting yet, at times, it appears that CMS is making it difficult for these new therapies to reach patients. In addition, some believe that the CMS Medicare hospital outpatient prospective payment rule is discouraging investment in the years of work and hundreds of millions of dollars needed to bring these products to market. For example, I believe that this rule includes troubling provisions that greatly impact the biotechnology sector. More specifically, the rule uses flawed methodology to cut Medicare payment for many important therapies by 35 percent.

In addition, CMS developed the functional equivalence policy, without notice and comment, to justify comparing two drugs or biologicals in order to reimburse them as the same rate—that of the lowest cost product—even if FDA says there are important differences between them. The rule also downgrades the status of radiopharmaceutical drugs that diagnose and treat life-threatening diseases, resulting in a sharp drop in payment to providers of care. Finally, CMS singled out four "orphan" products for exclusion form the OPPS payment rules—there are nearly 100 orphan drugs on the market—not just the four chosen by CMS—which are critically needed to treat exceptional diseases for which there is often no alternative therapy.

Taken together, theses policies are a very discouraging development for the biotechnology sector and the patients they hope to benefit. Mr. Secretary, I am interested in understanding the reasons behind the decisions that I just highlighted and, in addition, I would appreciate the opportunity to work with you to resolve these troubling issues.

Answer: As always, this administration looks forward to working with the Congress to help our Medicare beneficiaries. In the meantime, we will try to address some of your concerns.

I want to reassure you, as CMS indicated in the 2003 Outpatient Prospective Payment System (OPPS) regulation that "functional equivalence" is not a CMS policy in any way. It is merely a means of describing a relationship between two drugs that were being considered in the context of expiring pass through payments in the 2003 OPPS. As stated in the regulation, CMS regards the situation that led to the "functional equivalence" description as highly unusual. As you are probably aware, the two drugs in question, epoetin alpha (Procrit or EPO) and darbepoetin alpha (Aranesp) are distinguished structurally only in that the latter (Aranesp) has two additional carbohydrate side-chains, which affects the dosing schedule for darbepoetin alpha versus epoetin alpha. Both use the same biological mechanism to create the same effect in the body. As a result, CMS considered pass-through payments for Aranesp, which would ultimately affect payments for other outpatient services, an equitable adjustment that was justified δ1833(t)(2)(E) because the two drugs, for these purposes, were functionally equivalent.

The treatment of radiopharmaceuticals in the 2003 OPPS reflects CMS' implementation of the statute at § 1833(t)(6). The statute clearly and specifically required for the year 2000, that the then-current radiopharmaceuticals were to receive pass through payments. The statute also included pass through payments for "new" devices, drugs and biologicals. Pass through payments were not similarly extended to "new" radiopharmaceuticals in statute. Thus, pass through payments for radiopharmaceuticals expired at the end of 2002 in the OPPS.

It is true that CMS gave special treatment to four orphan drugs, excluding them from outpatient prospective payment. The drugs in question are those that are used solely for the FDA-approved orphan indication. These drugs clearly have no other source of payment other than from the orphan indication for which they were developed and approved.

In contrast, other existing drugs that had originally obtained FDA approval for a particular orphan indication now have additional approved indications that provide a significant patient base providing revenue. Once FDA orphan status is granted, such status is not revoked as uses for the drug expand. By way of example offered in the final rule, epoetin or EPO was originally approved as an orphan drug for ESRD. The ESRD population has expanded vastly beyond an orphan population since EPO was approved, in addition to which EPO is being used extensively for chemotherapy-induced anemia. While the orphan designation was meaningful to the original FDA approval for EPO and many other drugs, the orphan designation is meaningful for Medicare OPPS payment purposes only to the extent that the designation infers a limited patient and revenue base.

Question: Mr. Secretary, I am interested in your comments regarding the Medicare Plus Choice program. I agree with you, more needs to be done to encourage plan participation. I believe that linking Medicare Plus Choice payments to the actual cost of providing care is an important first step. However, as you may know, currently, my home state of Utah does not have Medicare Plus Choice plans—the plans that did participate eventually dropped out of the program. How do you encourage Medicare Plus Choice plans to offer coverage to beneficiaries in a state like Utah.

Answer: The Administration appreciates the difficulties that largely rural states like Utah have had encouraging plan participation in the Medicare + Choice program. That is why the President's Framework to Strengthen and Improve Medicare establishes an entirely new model for the Enhanced Medicare. The new model would make extensive use of Preferred Provider Organizations (PPOs) to provide health services to a multi-state region, including the regions' rural areas.

The absence of HMOs—which most Medicare + Choice plans are—in rural areas is due to a number of reasons, including the structure of HMOs and the types of populations that HMOs typically cover. HMOs typically cover only employer groups and generally do not offer individual coverage in the marketplace and are less likely to operate in the small group market. Rural residents are less likely to have employer-sponsored coverage, and therefore rural areas are not a "natural" market for HMOs. In addition, the administrative structure of an HMO and the administrative requirements imposed on providers participating in HMOs require a level of infrastructure investment that is not feasible for the HMOs or for providers seeing only a few of the health plan's patients.

Researchers who have examined the issue of what kind of network plans are appropriate for rural areas look to PPOs as the appropriate health plan model. A PPO can provide access to care in rural areas, from any provider, because PPOs reimburse enrollees for care obtained from *any* provider in any location, regardless of

whether the provider is a “network” provider or not. The vast majority of hospitals operating in rural counties—including in counties where there is only one hospital—have Blue Cross contracts. Contracting with a PPO makes economic sense for rural providers. Such contracts provide a stable, reliable source of revenue from an insured population in the areas of the country that have higher rates of uninsured individuals. A segment of the rural population that is also insured is the Medicare population, and rural providers are heavily dependent on Medicare revenues. If large numbers of Medicare beneficiaries enroll in the new PPO plans Medicare will offer, both incentives will operate to make rural providers more likely to contract with PPOs: the population is already a primary source of revenue for the providers, which they would like to retain, and the individuals will continue to be insured individuals offering a reliable, stable source of revenue.

At the request of the President, CMS Administrator Tom Scully spoke with the heads of several large insurers, who expressed support for the idea of PPO coverage for Medicare based on regional bidding. The Administration is convinced there will be vigorous plan participation in such a structure and aggressive bidding for Medicare’s business. That will be good for Utah and the rest of the country.

Question: When Senator Kennedy and I wrote the State Children’s Health Insurance Program, our primary intention was that the CHIP program would be a first step toward addressing the problem of uninsured children. The success of the CHIP program is evidenced in the number of children enrolled as of January 2003: approximately 5.3 million. However, many more children remain eligible for the program, but are currently unenrolled. By eliminating CHIP as a separate funding source, the original legislative intent of covering uninsured children could be lost. I would be interested in your thoughts on this important matter.

Will the Administration’s Medicaid proposal provide any terms or conditions to guide states in use of their CHIP money in order to guarantee that insuring children will continue to be the primary focus of the program?

Answer: The Administration’s Medicaid Reform proposal is completely optional for the states. If a state chooses not to participate, then its Medicaid and SCHIP program would remain the same as today. The Administration does not believe that the intent of SCHIP legislation—to provide coverage for uninsured children—would be compromised by the reform proposal. Rather, the President believes reform will produce efficiencies and enable states to cover even more of the uninsured children. Indeed, the reform proposal builds upon the successes found in SCHIP.

Experience has shown that the availability of open-ended federal funding has not enabled state Medicaid programs to grow in proportion to the increased need, because states simply do not have the resources to put up their share of the cost. By giving states increased flexibility in designing and administering their programs, the modernization proposal will enable states to avoid cutbacks, and even to expand eligibility without having to increase state expenditures. Any savings generated by the state under the reform proposal could be used to expand coverage—without the state having to appropriate additional state funds. These program savings can be used to then cover a greater number of beneficiaries in more appropriate settings.

The proposal includes SCHIP expenditures in the base year computation and these are trended forward. Any unspent SCHIP allotments are added to the respective state’s federal allotment at the time the state opts into the reform proposal and remain available until expended.

Question: Medicaid is an important insurer, whether primary or as a last resort, for children with special health care needs. EPSDT has been an integral component of their Medicaid coverage, providing access to therapies and medical equipment (such as wheelchairs, prosthetics and eyeglasses) unavailable to them in the private insurance market. EPSDT requires states to provide optional benefits to children if deemed medically necessary by their physician. (If optional benefits are capped, EPSDT is essentially capped.) How will children’s entitlement to EPSDT be impacted by the Administration’s Medicaid proposal?

Answer: The President’s Medicaid Reform proposal is optional for the states; it is not a block grant program and does not “cap” mandatory services for mandatory populations. Children would continue to be entitled to EPSDT on a mandatory basis under the Administration’s Medicaid proposal and would receive these services. Currently, EPSDT requires states to provide necessary follow-up services for children (regardless of whether the service is included as a mandatory or optional benefit in a state’s plan).

Question: In 1981, Congress established a law requiring state Medicaid programs, when setting reimbursement levels, to “take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs.” What eventually evolved is the Medicaid Disproportionate Share Hospital (DSH) payment program. Although the program was abused by states in the past, it is

back on the right track, and now a great majority of the funding is spent on hospital care and the Medicaid population. Safety net hospitals, such as public hospitals and children's hospitals, depend on DSH payments to continue providing a critical public service—treating all patients regardless of ability to pay. It appears that this Medicaid proposal eliminates the DSH program and folds DSH funding into the capped allotments. Can you clarify what the Administration intends for the DSH program and will there be any accountability for how states use their DSH allotments?

Answer: Under the proposal, for states that elect the modernization proposal, allowable DSH expenditures in the base year would be included in the base year expenditures and those expenditures would be trended forward during the period that the state was in the modernization program. States would have the flexibility to target up to 15% of their allotment for specific set-asides including disproportionate share payments to hospitals and other providers based upon the particular needs in the state.

Question: Of the 44.3 million Medicaid recipients, 24.2 million or 54.6% are children. Since Medicaid is the largest payer of health care for children, it is not surprising that Medicaid also is the largest payer of health care for the patients of children's hospitals. On average, children's hospitals devote more than 40% of their patient care to children assisted by Medicaid. Many children's hospitals devote more than 50% of their patient care to children assisted by Medicaid.

Medicaid payment falls far short of the cost of inpatient care provided by children's hospitals. On average, the Medicaid base payment is $0.69 for every $1.00 in inpatient care expenses a children's hospital incurs to care for a Medicaid-covered child. Even with Medicaid payments that on average amount to $0.80 cents for every $1.00 of expense, still significantly less than the cost of care.

Although they don't close the gap in Medicaid payment to children's hospitals, DSH payments are essential to the viability of children's hospitals. On average, DSH payments amount to about $6 million per children's hospital, in many cases they amount to more than the net operating revenue of the hospital. Mr. Secretary, I would appreciate your thoughts on this issue.

Answer: I share your concern regarding funding levels for children's health care. Children's hospitals provide a vital service in treating the special needs of children with serious medical conditions.

Unfortunately, we have no positive news on the DSH side. The only increase in the program is the 175 percent DSH provision in BIPA, which will actually work against children's hospitals. Since the overall DSH funding levels are capped and the 175 percent provision only applies to public hospitals (children's hospitals are rarely public hospitals), to the extent that states are spending their entire DSH allotments, they would have to decrease DSH payments to other providers in order to increase payments over 100 percent of DSH to public hospitals.

This is why I am such a strong supporter of the President's Medicaid reform initiative, which would offer states an alternative and more flexible approach to managing their Medicaid programs, including DSH payments. For participating states, Medicaid and SCHIP funds including DSH payments will be combined into a state health care allotment from which they will be able to set-aside 15% of expenditures for administration, DSH and special needs populations. This is a more effective way of letting states determine DSH needs—including payments to children's health care—than the current convoluted formula allows.

While it isn't directly related to Medicaid DSH, I do want to point out that the Department also provides financial support to freestanding children's teaching hospitals similar to that provided by Medicare GME to other teaching hospitals. Because freestanding children's teaching hospitals don't serve the elderly, they receive little or no graduate medical teaching funds (GME) through Medicare. The Health Resources and Services Administration (HRSA) administers the Children's Hospital Graduate Medical Education Payment Program (CHGMEPP). The CHGMEPP appropriation for FY 2003 was $292 million. The CHGMEPP is making payments to freestanding children's hospitals to help them educate and train the nation's physician workforce.

Question: Would you be willing to work with various employers, including those who offer retiree health plans, to gain their expertise and experience in offering health care benefits, like prescription drug coverage, to their enrollees? Don't you believe that employers and private health plans and the FEHBP can provide you valuable input into how to offer these private plan choices and how to integrate the benefits? How will the Administration encourage employers to continue their retiree health coverage through its Medicare prescription drug proposal?

Answer: The Administration agrees wholeheartedly that employers and the Federal Employees Health Benefits Program provide valuable models around which to

reform Medicare. Plan competition along the lines of FEHBP is a central feature of the President's Framework to Strength and Improve Medicare.

Many of the recent prescription drug bills that Congress has considered contain incentives for employers to maintain existing levels of prescription drug coverage. The Administration will gladly work with the Congress to explore ways to provide these incentives under the President's Framework.

Question: Mr. Secretary, I know that in 2000, Congress passed provisions to improve the appeals process, specifically, Section 521, dealing with individual appeals. I understand that the Administration has some concerns regarding implementation of these provisions. I would appreciate any comment you have on how these provisions could be amended to make the appeals process work more effectively. Both of us want to improve the appeals process for beneficiaries but we also need to ensure that the provisions in the 2000 BIPA law are workable and, even more important, will truly improve the appeals process. I am certainly willing to work with you and your staff on this important issue.

Answer: CMS has requested some amendments to the appeals process established in BIPA Section 521 that would allow the Agency to implement the law in a more efficient and less costly manner. These changes include:

- Extending the implementation timeframe to 16 months following receipt of funding the appeals provisions required by BIPA 521; we estimate that this amount of time is needed to award contracts to fund the Qualified Independent Contractors (QICs) and to proceed with final rulemaking.
- Changing the BIPA timeframes for decision-making. The current BIPA timeframes are extremely tight—30 days for a redetermination at the contractor level, 30 days for the QICs, and 90 days each for the ALJ and DAB levels. More realistic timeframes for decision-making, *even at the lower levels of the process (eg., contractor, QIC)* will reduce the number of cases that proceed to the higher, more costly, adjudication levels.

CMS has requested the following timeframes:

- 45 days for redetermination at the contractor level for Part B claims and 90 days for Part A claims
- 60 days for QICs
- 180 days for ALJs
- 180 days for DAB
- Reducing the number of QICs from 12 to "not fewer than 4". Twelve is costly, and we believe that "no fewer than 4" will maximize administrative efficiency.

Replacing the requirement for "de novo review" by the DAB to an "on the record" review. Currently, the DAB reviews the ALJ decision and generally will uphold that decision unless there was an abuse of discretion by the ALJ, an error or law, or the ALJ's conclusion was unsupported by the evidence. De novo review at this level would require the DAB to consider the case as if for the first time, which is inefficient and costly.

For example, under DRG 483 burn patients having tracheostomies (sic) are grouped together with non-burn patients having this same procedure. However, the hospital costs associated with burn patients is over twice has (sic) high as for non-burn patients. And Medicare reimburses the hospital at the lower amount, despite the significant differences I cost. Similarly, under DRG 504, patients with extensive burn injuries and inhalation injuries are grouped together with burn patients who do not have inhalation injuries, even though the former type of injury is must more costly than the latter.

The American Burn Association has submitted substantial information to CMS regarding these disparities and have suggested the need for two new DRGs that more closely correlate costs with reimbursement. I would appreciate your comments regarding whether very costly types of burn treatment are inappropriately grouped together with less costly procedures and your assessment regarding the effects of such inadequate reimbursement on the financial viability of burn centers, particularly in a time when the country faces not only terrorist threats but military burn victims as a result of war. CMS includes requested DRG changes in its Notice of Proposed Rulemaking every spring. I would appreciate it if CMS could expeditiously conclude it's review of these issues so that any changes made in the DRGs could be effective as soon as possible so as to ensure the financial well-being of burn centers at a time when the country is likely to require their services more than ever before.

Answer: Medicare pays for inpatient hospital care using prospectively set rates established by the prospective payment system (PPS). PPS started for hospital cost reporting periods beginning on or after October 1, 1983. PPS was enacted by the Social Security Amendments of 1983 (Public Law 98–21).

Medicare payments are made at predetermined, specific rates, which represent the average cost, nationwide, of treating a Medicare patient according to his or her

medical condition. The classification system used to group hospital inpatients according to their diagnoses is known as diagnosis-related groups (DRGs). If a hospital can treat a patient for less than the payment amount, it can keep the savings. If the treatment costs more, the hospital must absorb the loss. The system is designed to give hospitals the incentive to manage their operations more efficiently by evaluating those areas in which increased efficiencies can be instituted without affecting the quality of care and by treating a mix of patients to balance cost and payments.

CMS is aware of hospital concerns that payment for burn patients on mechanical ventilation is not adequate. CMS has been analyzing data regarding these issues, and will discuss the findings in the Inpatient Hospital Prospective Payment System FY 2004 Proposed Rule.

Question: Mr. Secretary, I commend you for creating the new Medicare disease management demonstration projects. In my opinion, with the baby boomers retiring in the near future, these types of initiatives are key to prolonging the health of our Medicare beneficiaries. Could you provide us with more details? I am interested in knowing how many demonstrations will be created and whether or not specific disease will be highlighted through these demonstration projects? How much money will be authorized for these demonstration projects?

Answer: The demonstration projects being developed and implemented by the Centers for Medicare & Medicaid Services (CMS) can help ensure that America's seniors and disabled beneficiaries receive high quality care efficiently. The demonstration projects are designed to explore a variety of ways to improve beneficiary care in traditional Medicare. We are looking to these programs to bring Medicare into the 21st Century and provide beneficiaries with greater choices, enhance the quality of their care, and offer better value for the dollars spent by beneficiaries and the government on health care.

Medicare beneficiaries with certain chronic diseases account for a disproportionate share of Medicare fee-for-service expenditures. These chronic conditions include, but are not limited to: asthma, diabetes, congestive heart failure and related cardiac conditions, hypertension, coronary artery disease, cardiovascular and cerebrovascular conditions, and chronic lung disease. Moreover, patients with these conditions typically receive fragmented health care from multiple providers and multiple sites of care. We need to find better ways to coordinate care for these patients and to do so more efficiently. Not only is such disjointed care confusing and ultimately ineffective, it can present difficulties for patients, including an increased risk of medical errors. Additionally, the repeated hospitalizations that frequently accompany such care are extremely costly to the patients, government, and private insurers, and are often an inefficient way to provide quality care. As the nation's population ages, the number of chronically ill Medicare beneficiaries is expected to grow dramatically, with serious implications for Medicare program costs. In the private sector, managed care entities such as health maintenance organizations, as well as private insurers, disease management organizations, and academic medical centers have developed a wide array of programs that combine adherence to evidence-based medical practices with better coordination of care across providers.

Currently, there are three operational disease management demonstrations and four additional disease management demonstrations that are in various stages of procurement. The attachment describes the operational and future disease management demonstration initiatives.

The operational demonstrations focus on high-risk, high-cost, chronic conditions, such as congestive heart failure, diabetes, and coronary heart disease, as well as the frail elderly. The three operational demonstrations have a target enrollment of 48,600 beneficiaries. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) Disease Management demonstration is targeted to enroll 30,000 beneficiaries; the Case Management demonstration is targeted to enroll 600 beneficiaries; and the Coordinated Care demonstration is targeted to enroll 18,000 beneficiaries. For the current demonstrations, providers are paid under fee-for-service with additional disease management fees that range from $80 to more than $500 based on the type and severity of conditions being treated and the services being offered.

The new disease management demonstrations will focus on high-risk, high-cost, chronic conditions, such as stroke, congestive heart failure, diabetes, and end-stage renal disease. We expect there to be substantial interest in these future models; however, we do not have enrollment estimates at this time. The new demonstrations test a variety of payment methodologies ranging from fee-for-service to full capitation with risk adjustment.

RESPONSES TO QUESTION FROM SENATOR LINCOLN

Question: Mr. Secretary, the administration has said that their goal of privatizing Medicare is to control the costs of the program by increasing efficiency. However, studies by the Inspector General of HHS, the GAO, and MedPAC have indicated that private plans have actually been *less efficient* than traditional Medicare. Given these findings, how much does the administration expect to save through market-based reforms? Will the real "savings" come from shifting more costs to beneficiaries?

Answer: The role of private plans in the President's Framework to Strengthen and Improve Medicare has received a lot of comment in recent months. First of all, I would like to stress that the administration is not proposing a full privatization: traditional Medicare will be there for those who want it—both current and future enrollees. In addition, those remaining in traditional Medicare will receive help with their drug costs. They will receive immediate help through a Medicare-endorsed drug card, which will provide them with discounts of 10–25 percent or more on their prescription drugs costs. And, beginning in 2006, beneficiaries will have protection against high out-of-pocket drug expenses—for no additional premium. The government will pay the entire cost of this benefit. And, the fact is that Medicare has had private plan options for decades—the President's plan just provides additional choices for beneficiaries.

Question: Mr. Secretary, the President has said that he wants to make Medicare look like the Federal Employees Health Benefit Plan, or FEHBP. Since Medicare premiums and spending have been growing at a much slower rate than under FEHBP, how do you expect to save any money by moving toward and FEHBP system?

Answer: As for the question of efficiency, we believe that the Federal Employee Health Benefits Program is a good model for comparison. A review by the CMS Office of the Actuary recently found that, adjusting for differences in prescription drug coverage, FEHBP premiums per enrollee grew an average annual rate of 10.3 % from 1969–1997, exactly the same as Medicare over the same period. More recently, Medicare's cost growth has been lower, due to provisions enacted in the Balanced Budget Act. Many regard those price cuts as unsustainable, and, indeed, Congress has embarked on a series of giveback provisions intended to undo cuts in the BBA. When evaluating various FEHBP-style proposals, CMS actuaries have estimated that vigorous participation by private plans would generate a modest net savings over time. These savings will not come from shifting costs onto beneficiaries—indeed, the Framework proposes co-insurance changes that would have beneficiaries paying less in most cases. Rather, we believe that private plans will be more intelligent purchasers of health care services, able to expand beneficiary choice and enhance health care quality.

Question: Mr. Secretary, if you want to move Medicare towards becoming an FEHBP system, why aren't you willing to pay for a prescription drug benefit as generous as that under FEHBP, where none of the plans have significant gaps or "donut holes" in coverage?

Answer: The President's budget proposal aims to spend $400 billion over 10 years to supply a meaningful prescription drug benefit to America's seniors and disabled Medicare beneficiaries. The Administration's Framework to Strengthen and Improve Medicare, however, did not specify a particular drug benefit design. We look forward to working with the Congress to design a benefit that makes sense at a price the country can afford.

Question: Mr. Secretary, on April 14, 1997, you and 40 other governors sent a letter to then President Clinton stating, "We adamantly oppose a cap on federal Medicaid spending in any form." Is that still your view? If not, what changed your mind?

Answer: You are correct in thinking that I was one of the leaders on that issue back in 1997. President Clinton was going to put a per capita limit on every individual in the program, taking $8 billion out of the system. However, our situation today is vastly different. Our Medicaid proposal does neither of those things. We do not have a cap, and we are not taking $8 billion out of the system. We are going to allow the mandatory population to continue just as they are. There is no per capita increase on the mandatory populations. The optional populations would have a definite appropriation, just like in the SCHIP program. However, our proposal will result in zero reduction in the baseline for States for Medicaid.

Question: Mr. Secretary, under the administration's Medicare plan, will seniors and individuals with disabilities be able to get prescription drug coverage if they choose to stay in traditional Medicare? If not, that concerns me. Last year, there was bipartisan consensus that all Medicare beneficiaries get prescription drug coverage, including those who are enrolled in traditional Medicare. Why is the adminis-

tration backing away from this bipartisan consensus? Why would the administration prevent the seniors in traditional Medicare from getting drug coverage?

Answer: The Administration is interested in reaching out in a bipartisan fashion to craft a Medicare bill with wide support. We believe the President's Framework to Strengthen and Improve Medicare can accomplish that goal.

Please keep in mind that about 76 percent of Medicare beneficiaries already have prescription drug coverage either through former employers, Medigap, and other sources. Under the framework, they can keep that coverage if they want. This plan does nothing to change that fact. In addition, those remaining in traditional Medicare will receive help with their drug costs through a Medicare-endorsed drug card, which will provide them with discounts of 10–25 percent or more on their prescription drugs costs. And, beginning in 2006, beneficiaries will have protection against high out-of-pocket drug expenses—for no additional premium. The government will pay the entire cost of this benefit.

The Administration believes that providing a stand-alone drug benefit through an insurance mechanism is not a technically sound proposal. Such a stand-alone insurance product would suffer from severe problems with adverse selection, and it would be highly difficult to get an insurance contractor to bear any risk. Without a risk-bearing insurer, cost control becomes even more challenging. Consequently, the Framework folds the drug benefit into an overall insurance benefit package in Enhanced Medicare and Medicare Advantage. We believe this approach makes more actuarial sense and will prove both easier to administer and save money over time.

Question: Mr. Secretary, your budget has proposed spending $400 billion for Medicare reform and prescription drugs. How much of the $400 billion would be spent on prescription drug coverage, and how much would be spent on reform? And where do the provider "givebacks" fit in? For example, does the administration support taking the $54 billion in new spending for physicians out of the $400 billion?

Answer: At the request of Congress, the Framework to Strengthen and Improve Medicare does not offer a detailed budget proposal. Rather, we look forward to working with the Congress to determine precisely how the $400 billion will be spent.

Question: Mr. Secretary, I am also concerned that the President's Medicare reform proposal would cause the federal government to pay much higher prices than every other federal program does for prescription drugs. Under the President's plan, HMOs and private insurance plans would be negotiating the price the federal government pays. However, under the federal law, HMOs can't negotiate prices that are lower than the Medicaid "best price." But currently, the federal government always pays a price that is much lower than the Medicare " best price" such as 340B hospitals and the Veterans Administration. Why would we want the federal government under Medicare to pay higher prices than every other federal program does for the exact same drugs?

Answer: The Administration is confident that private health insurance plans and their Pharmacy Benefit Manager contractors will provide the most cost-effective service for Medicare beneficiaries. As our experience with Medicare shows, price fixing by the federal government often gets prices wrong, and government structures are always very slow to adapt to changes in the marketplace. PBMs, on the other hand, have the freedom and experience to be savvy negotiators and lock in the best value for beneficiaries and the taxpayers. They manage costs by negotiating with manufacturers and pharmacies to secure price concessions, influencing drug selection, and maintaining a highly automated claims processing environment.

A recent GAO Report (*Federal Employees' Health Benefits: Effects of Using Pharmacy Benefit Managers on Health Plans, Enrollees, and Pharmacies, January 2003*), examined the effectiveness of using PBMs by three health plans that account for 55 percent of FEHBP enrollment. The GAO found that average price obtained by PBMs for 14 selected brand name drugs was 18 percent below the average price paid for by cash-paying customers. For 4 selected generic drugs, PBMs obtained prices 47 percent below the prices paid by cash paying customers. Mail order programs obtained prices significantly lower. PBMs were successful in lowering the cost of pharmaceutical benefits primarily by:

Answer: As I've discussed the Administration's reauthorization proposal, I have always emphasized that promoting healthy marriages cannot, intentionally or unintentionally, result in policies or practices that force people to enter or remain in abusive relationships. In announcing and awarding research, evaluation, demonstration and technical assistance funds that promote healthy marriage and family formation activities, we will encourage States to provide similar assurances and describe, in their proposals, consultations with domestic violence coalitions and how they intend to address domestic violence. The pre-marital and marital education activities and programs funded through our proposal will increase our knowledge base

about effective marriage promotion techniques through innovative programs, including programs designed to help couples constructively deal with conflict.

The marriage promotion grants do not affect the Family Violence Option, a current provision of TANF that requires participating States to screen all clients for domestic violence, to provide counseling and supportive services and where necessary waive any program requirements to victims of domestic violence and their families. Nearly all States have adopted this provision and are already screening for and providing services to victims of domestic violence.

I certainly agree that marriage programs and activities such as pre-marital education, marital education and divorce prevention services should be voluntary. The choice to marry and whom to marry is a private decision. Promoting healthy marriages *is not* about forcing anyone to get or stay married and government should not get in the business of telling people whether or whom to marry. Our emphasis is on "healthy" marriages that provide a strong and stable environment for raising children, not marriage for the sake of marriage.

We expect one component of an integrated, healthy marriage effort to entail broad public outreach and information dissemination to explain the benefits of marriage and enhance skills that improve a couple's ability to deal with conflict and succeed in marriage. With this information, clients can then freely choose whether they want available services and the types of services. We also want States to examine policies and remove disincentives to marriage that punish, rather than support low-income couples who choose to marry. Such changes will provide equitable treatment for all two-parent married families.

- Negotiating reduced prices with pharmacies,
- Using mail order pharmacy,
- Securing manufacturer rebates and passing the rebates on to plans, and
- Using various utilization management techniques common in the industry.

Earlier analysis (2000) by OPM indicated that FEHBP's discount experience with several PBMs was similar to this more recent work.

Question: Mr. Secretary, like it or not, Medicaid pays for two-thirds of the expenses in long-term care for the elderly and disabled. The federal government currently requires states to provide nursing home care for seniors who earn less than 75% of the poverty level or $6,645 a year, and states have the "option" to go higher. In fact, the majority of elderly nursing home residents covered by Medicaid earn more than this income level.

So, how will states be able to afford this growing population of elderly nursing home residents under a block grant? Especially over the next ten years as our elderly population is expected to increase? Also, would federal quality of care standards as laid out in OBRA 1997 still apply to this population?

Answer: A key element of the modernization proposal is to provide the states the flexibility to use more home and community-based and long term care options which will provide for less costly opportunities for beneficiaries to live in their homes or in their communities rather than normally more costly nursing homes, hospitals, or other institutions. These program saving can be used to then cover a greater number of beneficiaries in more appropriate settings.

Experience has shown that the availability of open-ended federal funding has not enabled state Medicaid programs to grow in proportion to the increased need, because states simply do not have the resources to put up their share of the cost. By giving states increased flexibility in designing and administering their programs, the modernization proposal will enable states to avoid cutbacks, and even to expand eligibility without having to increase state expenditures. Any savings generated by the state under the reform proposal could be used to expand coverage—without the state having to appropriate additional state funds. These program savings can be used to then cover a greater number of beneficiaries in more appropriate settings.

In response to your last question, the proposal retains existing federal quality of care standards for nursing home residents.

Question: Mr. Secretary, when you were Governor of Wisconsin, you signed a law to require insurance plans in the state to cover diabetes supplies and services. Several other Cabinet Members like Secretaries Whitman and Ridge, and even the President himself, signed similar laws when they were Governors.

As a result of laws like yours, diabetes-related complications like blindness, kidney failure and amputations are on the decline in Wisconsin and in other states. Judging from your own state's experience, doesn't it make sense to ensure private insurance plans are going to cover diabetes supplies and services in order to keep people healthy and keep costs down? And if so, doesn't it make sense then, to ensure Medicaid covers the same items?

Answer: The Medicaid modernization proposal provides states with much needed flexibility to tailor their programs to meet the needs of their beneficiaries. We are

committed to maintaining mandatory services for mandatory populations. For optional populations, states will have considerable flexibility in the design of benefit packages, including the ability to provide additional benefits tailored to special populations, such as diabetics. In addition, the modernization proposal emphasizes preventive care, such as that needed by diabetics to manage their care, thus avoiding preventable complications and their associated costs.

Question: Mr. Secretary, you testified recently that it would be a mistake for states to roll-back or eliminate coverage for diabetes supplies and services in the Medicaid and private insurance market. Is there anything in the administration's plan that would require states to cover basic items needed to manage diabetes? Things like glucose monitors, insulin, syringes, and other items?

Answer: The Medicaid modernization proposal provides states with much needed flexibility to tailor their programs to meet the needs of their beneficiaries. States will still be required to provide mandatory services for mandatory populations. For optional populations, states will have considerable flexibility in the design of benefit packages, including the ability to provide additional benefits tailored to special populations, such as medical supplies and equipment for the diabetic population. In addition, the modernization proposal emphasizes preventive care, such as that needed by diabetics to manage their care, thus avoiding preventable complications and their associated costs.

Question: Mr. Secretary, there are currently 41 million uninsured people in our country. A staggering 20% of adults in Arkansas are uninsured. Currently, if a state wants to expand coverage through Medicaid, it may do so and is guaranteed that at least 50% of the cost will be covered by the federal government. In Arkansas, nearly three-quarters of the cost is covered by the federal government. But under your block grant proposal, every dollar's worth of expansion will cost the state $1. Why, then, would you propose a system that provides states with a *disincentive* to expand coverage?

Answer: The President and I have proposed the Medicaid modernization option to assist states in dealing with their fiscal crises. Thirty-eight states have made program reductions in the past year: 13 cut eligibility; 19 cut services; 8 increased cost sharing; and 23 reduced provider payments. Seventy thousand beneficiaries already have lost coverage, and most states are considering new or additional eligibility or benefit reductions. Under the current financing methodology, in order to draw down the federal match, states must be able to increase state Medicaid expenditures as well. The reality is that states do not have the state funds needed to take advantage of the federal match to expand coverage. Despite the loss of federal funds that will result, tight fiscal constraints are forcing states to cut their programs and reduce coverage.

The Administration's Medicaid modernization proposal will enable states to avoid such cutbacks, and even to expand eligibility, within current budget limits. It is able to do The proposal does this not only by giving states an infusion of additional federal funds in the first seven years, but by removing rigid federal rules and regulations, leaving states with considerable flexibility to streamline and restructure their programs. This, in turn, will enable states to spend their Medicaid dollars more effectively. The greater flexibility afforded to states in designing their benefit packages alone will help states to avoid eliminating, and even to expand, coverage. Because they would be able to tailor benefit packages to meet the needs of different populations, states would not be forced to eliminate an optional service for all beneficiaries or an entire optional eligibility group in order to save costs. Conversely, states would be more likely to expand coverage to optional populations, even in tight fiscal times, because they could offer new populations a more modest benefit package—more in line with coverage in the private insurance market—rather than having to offer new populations all services covered under the state plan. In addition, the proposal requires maintenance of effort to ensure states' continued investment in health care.

The response to the August 2001 HIFA initiative undeniably demonstrates states' interest in expanding coverage to the uninsured, if given the flexibility to make appropriate programmatic reforms, even in these tight fiscal times. Moreover, the ability of states to streamline and simplify their programs under the reform proposal also will generate savings. Under the current funding mechanism, a reduction in state expenditures would result in a corresponding reduction in federal matching funds. Under the modernization proposal, however, the state's federal allotment would not be reduced. Thus, any savings generated by the state under reform could be used to expand coverage—without the state having to appropriate additional state funds.

Question: Mr. Secretary, under your block grant proposal, it is my understanding that the states are given "carte blanche" for their optional Medicaid services and

beneficiary populations. Does this mean that a state could choose to provide a service in one part of the state but not another? Perhaps in an urban area but not in a rural area? Could a state choose to charge large co-payments for optional services? What would prevent states from imposing harsh, new cost-sharing on the disabled, frail, and poverty-stricken people that receive Medicaid benefits through state options?

Answer: Under the Medicaid modernization proposal, states will have considerable flexibility in designing the benefit packages provided to optional populations. This includes the ability to offer benefits targeted to specific populations. States will be required to maintain mandatory benefits for mandatory populations. We look forward to working with you and other Members of Congress, and Governors, to craft a proposal that balances much needed flexibility and reform with appropriate beneficiary protections.

Question: Mr. Secretary, I am concerned about the effects of your proposal on the growing portion of our population with diabetes. 7.9% of the general population has diabetes, and that figure is even large in Arkansas with 8.9% of our residents with diagnosed diabetes. I understand that your proposal attempts to provide states with flexibility, but do you think the needs of a person with or at risk for diabetes are different in different states? Are the needs of diabetics in Arkansas different from the needs of a diabetic in Wisconsin? My point is, I fear that this flexibility will only end up giving states the flexibility to reduce coverage for expensive diseases and that the country will end up with 50 different coverage schemes for diseases like diabetes. How does your proposal address this concern?

Answer: As you know the Medicaid program has always been a partnership between the federal government and the states, with the federal government setting broad parameters for mandatory services and mandatory populations, and the states having flexibility to add, or restrict, optional populations and services. Thus, Medicaid programs have always differed from state to state. Under the current program when states seek to expand services, or fiscal circumstances force them to reduce services, they must do so for the entire Medicaid population. They do not have the ability to tailor benefit packages to special populations, such as diabetics, unless they seek a federal waiver. However, the flexibility provided in the Medicaid modernization proposal will actually make it easier for states to expand coverage tailored to special populations, such as diabetics, without the need for federal waivers. Additionally, as I have stated, the proposal also maintains mandatory services, such as medical equipment and supplies, for mandatory populations.

Question: Mr. Secretary, is the Administration open to considering the implementation of a diabetes-specific waiver process for the Medicaid program? Although I know it is your hope to get entirely out of the waiver process, the type of waiver program that I have in mind would closely parallel the breast and cervical cancer waiver program. Such a diabetes waiver would give states the ability to insure poor individuals with diabetes, who would otherwise go without insurance, within the Medicaid program. My hope is that such a program would reduce the number of cases of blindness, kidney failure and amputations attributable to diabetes. Do you have an opinion?

Answer: As you know I have been a great supporter of the breast and cervical cancer option for states, and I am pleased to say that even in these difficult fiscal times almost all states have elected to expand Medicaid coverage to this population. As structured by Congress, states have the flexibility to amend their state plans to expand coverage to this special population, without the need for federal waivers. Indeed, it is this type of state plan flexibility that we hope to emulate under the Medicaid modernization proposal by permitting states to expand eligibility and coverage to populations that may not fit into a currently specified optional eligibility category. In addition, our proposal would permit states to go even further in assisting these special populations by permitting states to design a benefit package tailored to the unique needs of special populations such as diabetics, and women with breast and cervical cancer.

States are implementing some exciting disease management programs in their Medicaid programs (both in managed care and fee-for-service environments). Currently, 14 states provide disease management programs targeted to individuals with diabetes. These programs promote physician adherence to evidence-based guidelines; enhance patient self-management skills and adherence to treatment plans; and provide a means to coordinate care across providers. Providing states with increased program and financing flexibility will enhance their ability to design and operate these kinds of innovative programs.

Question: Mr. Secretary, states are seeking to eliminate coverage for people with countless chronic medical conditions like diabetes. According to the Centers for Disease Control 7.9% of the United States population has diabetes. If people living near

the poverty level are not getting coverage for their diabetes drugs and supplies though Medicaid, where and how are they getting coverage for their needs do you think?

Answer: Our proposal provides states with an infusion of federal funds in the first seven years and the flexibility to streamline and restructure their programs. This combination will enable states to not only avoid eligibility cutbacks, but potentially to expand eligibility and services. With the ability to tailor benefit packages to meet the needs of beneficiaries, rather than having to totally eliminate an optional benefit to reduce costs, states would have the ability to continue optional services for those with the greatest need. Likewise, states have the flexibility to expand coverage to optional populations, even in tight fiscal times, because they could offer a more modest benefit package, rather than having to offer new populations all covered services. The problem of the uninsured in our country is of great concern to President Bush and me. It is for this reason that each year our budget has included an increase in federal funds to support community clinics that serve as safety-net providers for those without health insurance coverage. It is also for this reason that we are proposing to modernize Medicaid.

Responses to Questions From Senator Smith

Question: Secretary Thompson, one in seven people in Oregon live without health insurance—that's 14% of Oregon's population. At last count, 42 million Americans are uninsured. The Administration has proposed spending $89 billion over ten years to combat the rising number of uninsured Americans. Can you tell me how many—or what proportion—of Americans who are currently *uninsured* would the Administration's proposal cover?

Answer: The Administration continues its commitment to strengthen and provide for America's uninsured. The Administration's proposal spending $89 billion dollars over ten years would provide a refundable tax credit to subsidize up to 90 percent of coverage for low and middle income Americans. This would extend health insurance coverage to approximately four million uninsured people.

Question: I just can't get over that one in seven number. Mr. Secretary, I want to see that number disappear—I want to see the percentage of Oregonians without health insurance equal 0. Can you tell me how much this would cost?

Answer: The Administration shares your concern about the number of uninsured Americans, a number that both parties agree is too high. The President, everyone in Congress and I would like to eliminate the problems caused by a lack of health insurance. However, we do not have estimates on how much it would cost to provide coverage for all uninsured Americans. The problem of the uninsured is a multifaceted issue requiring a variety of solutions and it is difficult to estimate. However, I want to assure you that the Administration is committed to working with Congress so that we can expand health insurance coverage.

Question: We've heard a lot today and in recent days about the Administration's Medicaid proposal. My understanding is that the purpose of this proposal is twofold; first, necessary fiscal relief for states; and second, to promote long overdue improvements to the Medicaid program, and I have been a strong supporter of the flexibility needed to achieve this from the beginning. However, I have serious concerns.

The Administration's Medicaid/fiscal relief proposal is too little, too late. Mr. Secretary, given the increasing demands on state safety nets during this economic downturn, can you tell me how much additional money you think Oregon should receive this year to be able to serve its Medicaid-eligible population?

Answer: Under current law the Federal government will match all of the Oregon Medicaid expenditures. Under the modernization proposal states would receive additional federal funding amounting to $3.25 billion in FY 04 and an additional $12.7 billion over seven years as the federal trend rates would be higher in the initial seven years of the program. Based on our best estimates, Oregon would receive $2.3 billion in FY 2004 under the Administration's Medicaid reform proposal, compared to $1.9 billion given no changes to the program.

I would also note that under the recently enacted Jobs and Growth Tax Relief Reconciliation Act, which President Bush signed on May 28, 2003, Oregon is estimated to be eligible to receive an additional, combined $217 million through a temporary 2.95% increase in the Federal Medical Assistance Percentage (FMAP) effective for the last two quarters of FY 2003 and the first three quarters in FY 2004.

Responses to Questions From Senator Graham

Question: Under the President's Medicare prescription drug proposal, would the 35 million Medicare beneficiaries nationwide—and the 2.5 million beneficiaries in

Florida—who are enrolled in traditional fee-for-service Medicare have to give up the benefits to which they are entitled under traditional Medicare in order to gain access to a prescription drug benefit?

Answer: Under the President's Framework to Strengthen and Improve Medicare, all beneficiaries gain access to meaningful prescription drug coverage no matter what type of benefit provider they choose. It's important to remember that about 76 percent of Medicare beneficiaries already have prescription drug coverage either through former employers, Medigap, and other sources. They can keep that coverage if they want. This plan does nothing to change that fact. In addition, those remaining in traditional Medicare will receive help with their drug costs. They will receive immediate help through a Medicare-endorsed drug card, which will provide them with discounts of 10–25 percent or more on their prescription drugs costs. And, beginning in 2006, beneficiaries will have protection against high out-of-pocket drug expenses—for no additional premium. The government will pay the entire cost of this benefit.

Question: Does the Administration still envision a Medicare prescription drug plan with three options for beneficiaries in 2006: 1) traditional fee-for-service with no benefit; 2) modified M+C; or 3) enhanced private fee-for-service?

Answer: The President's Framework to Strengthen and Improve Medicare does give beneficiaries three choices, and they will have access to meaningful prescription drug coverage under all three.

In the first option, Traditional Medicare, those who are satisfied with the current Medicare system will continue receiving their care as they do today with help for the high costs of prescription drugs. These beneficiaries will gain access to discounted drugs through a prescription drug discount card—estimated to achieve savings of 10–25% on the cost of prescription drugs—as well as coverage to protect them against high out-of-pocket prescription drug expenses. These new benefits will be provided at no additional premium.

The second option, Enhanced Medicare, will give seniors the same types of choices that are available to members of Congress and other federal employees. In every area of the country, Medicare beneficiaries will have multiple health plans from which to choose. These plans will offer prescription drug benefits, full coverage of preventive benefits, protection against high out-of-pocket drug costs, and cost sharing that does not penalize participants who need the most medical care. Again, the decision to choose Enhanced Medicare will be entirely up to each senior, and participants will be able to choose any doctor or any hospital they want for the treatment and care they need.

The President's framework will ensure that the benefits offered under Enhanced Medicare are sufficiently attractive to seniors, relative to traditional Medicare, to guarantee that Enhanced Medicare is a viable system.

Finally, Medicare Advantage will give seniors the option of enrolling in low-cost and high-coverage managed care plans, similar to those available today under Medicare. Medicare Advantage will include plans that offer a subsidized drug benefit, and all plans will be able to offer extra benefits, as many private plans do today.

Question: What would be the cost-sharing requirements and stop-loss level under the Administration's prescription drug plan?

Answer: The Framework to Strengthen and Improve Medicare leaves the specific benefit package for Congress to decide. President Bush has set a target of spending $400 billion over 10 years, and the Administration remains flexible on how the benefit is structured under that target.

Question: Would an interim drug benefit be available for low-income beneficiaries in 2004 and 2005? What would be the subsidies for low-income beneficiaries?

Answer: To ensure that seniors are provided help as soon as possible, the Framework calls for a drug discount card to be offered in 2004. It is estimated to achieve savings of 10 to 25 percent on the cost of prescription drugs by pooling the buying power of Medicare participants. Low-income Medicare beneficiaries will additionally get a $600 annual subsidy for drug coverage, which will continue for low-income seniors who stay in traditional Medicare. This subsidy can be added to their discount card at the point of sale, or alternatively paid to existing Medicare+Choice health plans that enroll low-income seniors and provide them with prescription drug coverage.

Question: In January, the Centers for Medicare & Medicaid Services (CMS) ordered Medicare contractors to halt beneficiary outreach and education activities. Outreach and education activities include critical beneficiary services, such as telling beneficiaries about new benefits, advising them on appealing claim denials, helping them to select nursing homes, providing information on how to receive discounts on prescription drugs, and instructing them on how to report Medicare fraud

and abuse. Now that Congress has approved the FY03 omnibus appropriations bill, have all of these activities and services been restored?

Answer: For the first five months of the fiscal year, CMS operated under a Continuing Resolution and our Medicare contractors received ongoing Medicare operations funding based on their FY 2002 funding level. To stay within our budget constraints, CMS decided to reduce FY 2003 spending for limited Medicare contractor discretionary outreach activities from $155 million to $153 million.

Now that CMS has received its full-year appropriation, the $2 million will be restored and the Medicare contractors will be notified to re-initiate the discretionary outreach activities that had been reduced.

Question: Medicaid Director Dennis Smith has indicated that HHS believes approximately half the states and territories would take up the Medicaid block grant option. If more than half the states and territories take up the option, will the $12.7 billion figure increase?

Answer: The current $12.7 billion estimate is based upon the assumptions made by CMS actuaries. If more states opt to participate in the reform proposal the trend rates would need to be adjusted accordingly in order to maintain the proposal as budget neutral.

Question: How will states absorb federal funding cuts in FY 2011 and beyond when the baby boom generation will already have begun to retire and require more benefits and services?

Answer: There are no federal funding cuts under the modernization proposal. The total federal funding provided under the proposal will remain the same as if the proposal was not enactedThe reform proposal is budget neutral. Thus, total Medicaid spending will increase by the same amount under the baseline and under reform over the 10-year period. However, in order to provide immediate federal funding relief for the states beginning in FY 04, the federal trend rates will be higher in the first seven years of the proposal thean under the current baseline, and less thean the current baseline in years eight through ten. However, eEven in years eight through ten the federal funding will increase in absolute dollar amounts during those years. However, the rate of increase will be less thean the rates assumed in the current law President's 2004 budget.

Experience has shown that the availability of open-ended federal funding has not enabled state Medicaid programs to grow in proportion to the increased need, because states simply do not have the resources to put up their share of the cost. By giving states increased flexibility in designing and administering their programs, the modernization proposal will enable states to avoid cutbacks, and even to expand eligibility without having to increase state expenditures. For example, states can use more community-based long term care which is typically less costly than institutional care and preferred by most beneficiaries. Any savings generated by the state under the reform proposal could be used to expand coverage—without the state having to appropriate additional state funds.

Question: What happens to those states that do not opt into the block grant? Will they still receive their federal medical assistance percentage (FMAP) at the current rate?

Answer: Yes. The Medicaid modernization proposal is an option that we believe many states will enthusiastically pursue. However, there may be some states that determine that their particular circumstances are such that they should continue to operate their program under the current rules and regulations. For states that choose not to opt-in to modernization, the Medicaid program in its current form will continue, including the current federal matching percentage and structure.

Question: In a February 11 press release, Mr. Secretary, you stated that your Medicaid proposal "would help states avoid cutting off benefits to [optional beneficiaries] during difficult economic times, and would make possible wider coverage in the future." How would this be possible if a state could not cover the health care costs that exceed its block grant allotment? More specifically, how would a federal funding cut in FY2011 through FY2013 allow for wider coverage of optional populations in the future?

Answer: As you know, despite the availability of federal matching funds, 38 states have made program reductions in the past year: 13 cut eligibility; 19 cut services; 8 increased cost sharing; and 23 reduced provider payments. Seventy-thousand beneficiaries have lost coverage as a result of these actions. And most states are considering new or additional eligibility or benefit reductions. States *now* cannot afford to maintain current coverage levels, let alone expand coverage to meet increased need.

The Administration's Medicaid modernization proposal will enable states to avoid such cutbacks, and even to expand eligibility, within current budget limits. It is able to do this not only by giving states an infusion of additional federal funds in the

first seven years, but by removing rigid federal rules and regulations, leaving states with considerable flexibility to streamline and restructure their programs. This, in turn, will enable states to spend their Medicaid dollars more effectively.

The greater flexibility afforded to states in designing their benefit packages alone will help states to avoid eliminating, and even to expand, coverage. Because they would be able to tailor benefit packages to meet the needs of different populations, states would not be forced to eliminate an optional service for all beneficiaries or an entire optional eligibility group in order to save costs. Conversely, states would be more likely to expand coverage to optional populations, even in tight fiscal times, because they could offer a more modest benefit package—more in line with coverage in the private insurance market—rather than having to offer new populations all services covered under the state plan.

The response to the August 2001 HIFA initiative undeniably demonstrates states' interest in expanding coverage to the uninsured, if given the flexibility to make appropriate programmatic reforms, even in these tight fiscal times. Moreover, the ability of states to streamline and simplify their programs under the reform proposal also will generate savings. Under the current funding mechanism, a reduction in state expenditures would result in a corresponding reduction in federal matching funds. Under the modernization proposal, however, the state's federal allotment would not be reduced as long as the state meets its maintenance of effort requirement. Thus, any savings generated by the state under reform could be used to expand coverage—without the state having to appropriate additional state funds.

Finally, it must be emphasized that it is the rate of increase in each state's allotment that will fall in FY 2011 through FY 2013. Federal funds will not be cut in FY 2011 through FY 2013 under the modernization proposal. That is, each state's federal allotment will continue to increase each year during that period, but the size of the increase will be smaller. We are confident that, with an infusion of upfront cash and relief from complex and burdensome federal regulations, states will be able to run their programs much more efficiently than today, so that a slower increase in the federal allotment will be appropriate.

Question: The Medicaid program is extremely important in times of economic downturns as people lose their jobs and subsequently their employer-sponsored health insurance. Medicaid's open-ended financing structure allows the program to grow in proportion to need in times of crisis. Under your proposal, would states be solely responsible for any costs above their block grant allotment that are the result of a local or regional economic downturn, a natural disaster, or an epidemic that causes the Medicaid rolls to expand?

Answer: The President' proposal would continue to require mandatory benefits for those entitled to Medicaid under federal law, and it would continue uncapped federal funding for these mandatory populations. At the same time, it would give states more freedom in designing effective health care options for the additional Medicaid recipients that each state wishes to cover. In contrast, uPreliminarilynder the current financing structure, in order for a state to take advantage of additional federal funds to cover swelling Medicaid rolls, it must be able and willing to increase state Medicaid expenditures as well. Thus, if a state does not have additional funds to spend, the availability of additional federal match is meaningless.

In fact, the availability of open-ended federal funding has not enabled state Medicaid programs to grow in proportion to the increased need, because states simply do not have the resources to put up their share of the cost. To the contrary, 38 states have made program reductions in the past year, resulting in 70,000 individuals losing coverage, and most states are considering new or additional cuts, despite the significant loss of federal funds that necessarily results.

While protecting mandatory services for mandatory populations but giving states increased flexibility in designing and administering their programs, the modernization proposal will enable states to avoid such cutbacks, and even to expand eligibility without having to increase state expenditures.

Question: What happens to the Disproportionate Share Hospital (DSH) Program under the Administration's Medicaid proposal? What types of protections will remain in place for safety per hospitals if the DSH money gets folded into the larger block grant?

Answer: Under the proposal, for states that elect the modernization proposal, allowable DSH expenditures in the base year would be included in the base year expenditures and those expenditures would be trended forward during the period that the state was in the modernization program. States would have the flexibility to target up to 15% of their allotment for specific set-asides including disproportionate share payments to hospitals and other providers based upon the particular needs in the state.

Question: The Omnibus Budget Reconciliation Act (OBRA) of 1987 established nursing home standards to protect beneficiaries from patient abuse. In 1998, I, along with a group of bipartisan co-sponsors, introduced the Nursing Home Patient Protection Act to modify OBRA so that nursing homes could not indiscriminately dump Medicaid patients. That legislation ultimately became federal law (P.L. 106–004). Currently, 95% of Medicaid beneficiaries in nursing homes are optional because they do not meet categorical eligibility limits. Under the Administration's Medicaid plan, would the quality standards and protections implemented under OBRA and subsequent amendments apply to these optional Medicaid beneficiaries?

Answer: I would like to emphasize that the Medicaid modernization proposal will not take away current safeguards protecting beneficiaries from abuse or dumping from nursing facilities. Rather the modernization proposal is designed to provide states the flexibility they need to tailor benefit packages to special populations, such as the disabled and elderly. Under our proposal a state would have the ability to assess individual needs and design a uniquely crafted long-term care benefit package for that individual. This benefit package could consist of a variety of home and community-based services, or traditional nursing facility services. States would no longer have to seek federal waiver authority for this flexibility.

COMMUNICATIONS

STATEMENT OF THE TREA SENIOR CITIZENS LEAGUE

[SUBMITTED BY GEORGE A. SMITH, CHAIRMAN OF THE BOARD OF TRUSTEES]

On behalf of the entire Board of Trustees and our 1.3 million members nationwide, I thank Chairman Grassley, Ranking Minority Member Baucus, and the entire Finance Committee for the opportunity to present written testimony for the record on this country's health care priorities.

TREA Senior Citizens League (TSCL) consists of active senior citizens concerned about the protection of their Social Security, Medicare, and veteran or military retiree benefits. Approximately three-quarters of the membership are between the ages of 76 and 85. Nearly all are over the age of 60. Most either served in the Armed Forces during World War II or played apart in the war effort.

Given our membership, I have no doubt that you will understand our ardent interest in the topics covered today. First, I want to commend Secretary Thompson and the Bush Administration for moving the debate on Medicare and Medicaid reform forward. I also want to thank the Members of the Finance Committee for bringing the debate to the next step in opening it for discussion in the Senate.

Medicare:

TSCL conducts an annual survey of its members in order to fine-tune our legislative priorities. The February 2002 survey reported that almost 28 percent of our membership has trouble paying for their prescription drugs each month; 27 percent reported having trouble paying their health insurance premiums, deductibles and copayments. And nearly 52 percent of our membership said that the creation of a Medicare outpatient prescription drug benefit would be the most beneficial action Congress could take to improve their health care management situation. Thus, we are heartened by the Administration and Members of Congress' promise to make a prescription drug benefit a top priority in the coming months.

While we understand that the details of the Administration's Medicare reform proposal are not worked out, we have concerns about the possibility of a prescription drug benefit only being offered to individuals who leave the traditional Medicare fee-for-service program and sign with a private health care provider. We want all seniors to have access to an affordable prescription drug plan, without their having to give up traditional Medicare and, perhaps, their doctor of many years.

The Administration has stated that by "reforming" Medicare, it means strengthening the program and giving individuals more choices. We applaud that. We do want to make sure that those "choices" are truly that and are not, instead, forced by financial necessity. For example, the price of prescription drugs is so high for many TSCL members that they may not truly feel they have a choice in switching to a private insurer if that's the only way they will have access to a prescription drug benefit.

A second point we would like to comment on is the failure in the past of Medicare+Choice to provide everyone with an array of options. While we understand that Medicare+Choice is not a central element of the President's Medicare proposal, we want to add our voice to others who have said that the program has not worked out as it was intended. We feel that any system implemented must provide for fairness, and quality options for all seniors not just those in urban areas or certain states.

Access to affordable and reliable health care coverage is important to TSCL members. TSCL believes that, when private companies contract to offer services to seniors, it should not be for only a brief time. In the past, many insurance companies have left certain regions, leaving seniors high and dry with respect to their health care options. We want stability for our seniors, including assurances that they will

be able to continue to have access to their family doctor, in whatever reform is enacted.

TSCL members believe that a prescription drug benefit alone is not the entire solution to more affordable prescription drug costs. A prime aspect of a Medicare prescription drug program that many TSCL members would like to see is the requirement that drug companies price prescriptions for Medicare beneficiaries at the same price as prescriptions available through state Medicaid or veterans' drug programs are priced.

Many bills to reform Medicare introduced in the 107 'h Congress had some provision for low-income individuals. We applaud the inclusion of a reasonable and adequate stipend, tax credit or discount for low-income seniors for their prescription drugs, co-payments and other services. Should certain seniors begin receiving their prescription drugs through the Medicare program rather than the Medicaid program due to changes in legislation, we believe that full access and affordable prices for those seniors should be kept intact.

TSCL supports a competitive system for seniors to obtain prescription drugs. Prescription drug discount cards do not replace a prescription drug benefit either within traditional fee-for-service Medicare or private managed care plans. Still, TSCL does believe that prescription drug discount cards can offer some benefit to uninsured seniors. But because no one card offers discounts on all drugs, TSCL is opposed to measures that would lock seniors into one program for several months. In addition, many good prescription drug discount cards currently are very low priced or free. TSCL believes there is a potential for government-set enrollment fees to backfire. For example, companies could impose a fee where none existed before.

TSCL is not committed to a government system, private system, or some specific mix of responsibilities between the two—but more importantly, to a system that provides stable, affordable and appropriate health care choices for all of our seniors.

Medicaid:

The basis of the Administration's proposal, as we understand it, is the "forwardfunding" of the federal government's share of Medicaid costs to states for the first seven of the next ten years, with the final three years states receiving a lower level of funding. Under the proposal, states would also have more leeway in the "optional" part of Medicaid services the state provides to its residents.

Many states are suffering from monumental budgetary shortfalls, and they do need assistance and they need it now. However, we do not want to see a temporary fix and a burden left for future generations of governors and state elected officials.

As to the optional services provided by the state, here, too, we are concerned that programs not be implemented in such a way as to lead to unfairness and discrimination against those individuals residing in rural areas. We also want to ensure that certain federal regulations and standards remain in place for nursing homes and other care centers. It is also important to maintain protections for spouses of nursing home patients. The stay-at-home spouse should be allowed to remain in their homes, rather than being forced to sell their home to cover nursing home costs.

We do believe, as the Administration has outlined, that preventative care is important for all elements of society. In addition to the fact that helping our citizens stay healthy is the right thing to do, there is a financial incentive for the government and private insurers to be promoting preventative care. While supporting the Administration's efforts in this area in theory, TSCL is concerned that government not become "Big Brother" with respect to the health care of seniors.

Should a Medicare prescription drug program be implemented, TSCL understands that the "dual-eligibles" who are covered both by Medicare and Medicaid would receive their prescription drugs under the Medicare program. This would certainly assist in easing the financial burden of states. TSCL urges that this be done in such a way that the services and costs currently received and paid for, respectively, by seniors are not negatively impacted by this.

The flexibility to adopt "best practices" and common-sense solutions offered as a principle by the Administration should be commended. However, TSCL is concerned that this "flexibility" not lead to higher co-payments (or new co-payments) for those seniors who are already on Medicaid because they are impoverished. And while flexibility for states to implement new programs that work is important, so too is availability to a full complement of services to seniors, without discriminating against individuals who are not well-off.

TSCL suggests that economic forecasts on the growth of Medicaid appear optimistically low. Realistic budget forecasts could prevent more dire circumstances down the road. The nine percent growth figure given for the next 10-year timeframe, given recent years of 13–14 percent growth, seems—perhaps—to be too low, espe-

cially as health care costs continue to increase about three times faster than senior cost-of-living adjustments.

An overall cap on state Medicaid expenses causes TSCL to pause as well. We don't want to see any one of our senior citizens forced to be without service because the state is over a pre-determined limit, especially if that limit is put into place using an unrealistic forecast for growth.

Cuts in Medicaid would negatively affect seniors who were born in the years 19171926 especially hard, as they receive lower Social Security benefits than other seniors who have similar work and earnings records.

Finally, TSCL is concerned about the deficit and the effects it will have not only on Medicare and Medicaid, but also Social Security. Now is the time to make tough choices that allow for fairness and dignity for our seniors—and an array of quality, affordable healthcare options.

We believe that the sooner both the Medicare and Medicaid issues are addressed, the better. We appreciate the Finance Committee's efforts in taking a step in that direction by furthering the debate on possible legislative solutions.

Thank you, again, for the opportunity to submit a written statement for the record.

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-1000

OFFICE OF THE DIRECTOR

MAR 1 1 2003

The Honorable Max Baucus
Ranking Member
Committee on Finance
United States Senate
Washington, DC 20510

Dear Senator Baucus:

During your hearing on Thursday, February 27, 2003, you asked Health and Human Services (HHS) Secretary Tommy Thompson about recent Federal Employees Health Benefits (FEHB) Program premium increases. Since this program is managed by the Office of Personnel Management (OPM), I wanted to provide additional technical information for your hearing record which essentially elaborates on the answer provided by Secretary Thompson.

As you noted, we estimated average premium increases of 11.1% for 2003. Below is a table breaking down these increases for the last three years:

FEHB Program Premium Increases*

	2001	2002	2003
Utilization, Technology and Medical Inflation	3.8%	9.5%	8.1%
Drug Costs	4.5%	4.9%	3.5%
Demographics	1.2%	0.7%	1.0%
Change in Reserve / Other	0.6%	0.4%	0.3%
Benefit Changes	1.3%	-1.6%	-0.6%
Sub-Total w/o Enrollee Choice	**11.4%**	**13.9%**	**12.3%**
Enrollee Choice	-0.9%	-0.6%	-1.2%
Total	**10.5%**	**13.3%**	**11.1%**

**Premium adjustments are calculated on a calendar year basis and are determined prior to the actual start of the calendar year listed above.*

I understand that Medicare increases resulting from utilization, technology, and medical inflation are similar to the 8.1% increases we have seen for 2003 in the FEHB Program. When you consider this fact, it becomes clear, as you and Secretary Thompson correctly assumed, that the primary reason for our higher 11.1% overall premium increase for 2003 is due to the FEHB Program having a prescription drug benefit which has seen a 3.5% increase in drug costs.

Therefore, given the overall inflationary health-care environment, I believe the size of the FEHB Program premium increase for 2003 was positive news for Federal employees and retirees, as it is significantly less than the predicted average rate of increase nationally. I strongly believe that aggressive actions and tough negotiations with the FEHB plans in 2002 on the part of OPM have helped to hold the line on premium costs for 2003 while still maintaining quality.

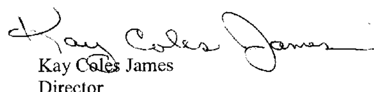
Nonetheless, it remains clear from the chart I have referenced in this letter that controlling utilization (ie: the "demand" side) is a serious challenge. We need to do more to educate our employees that the rising number of people using hospitals has an impact on premium costs. There are ways to contain the dramatic increases we have seen in hospital spending over the last decade. The centerpiece of our new demand strategy is OPM's "HealthierFeds" program, a user-education and health-promotion initiative. It is well established that physical activity, nutrition, preventive screenings, and healthy lifestyle choices all reduce demand on the health-care system. I am personally convinced that actively educating employees and retirees on healthy living, treatment, and prevention strategies can help keep costs down and ensure benefit dollars are spent wisely.

Let me also add that I have fully engaged the efforts of our Inspector General (IG) at OPM so we can aggressively weed out waste, fraud, and abuse and cultivate a culture of accountability within the FEHB Program. The budget we are submitting this year increases investigative oversight of the FEHB Program, providing broader audit coverage and developing computer-assisted audit techniques, in addition to a carrier-claims data warehouse that will help our IG do proactive investigations and provide us with raw data we can use to evaluate cost and utilization trends. I believe these efforts can also have a bearing on our premium costs in the FEHB Program.

I know you agree that we should continue to do everything possible to ensure we have an affordable health benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees, and I do thank you for your support of OPM's efforts in that regard.

While I realize your Committee hearing with Secretary Thompson focused on the President's FY2004 Budget for HHS and its relation to Medicare reform proposals, I hope the above information is useful as you look at the FEHB model and our efforts at OPM to constrain premium costs. If I can provide any further assistance to you or the Committee, please do not hesitate to let me know.

Sincerely,



Kay Coles James
Director

cc The Honorable Charles Grassley
Chairman, Committee on Finance