HENRY A. WAXMAN, CALIFORNIA
EDWARD J. MARKEY, MASSACHUSETTS
RICK BOUCHER, VIRGINIA
EDOLPHUS TOWNS, NEW YORK
FRANK PALLONE, JR., NEW JERSEY
BART GORDON, TENNESSEE
BOBBY L. RUSH, ILLINOIS
ANNA G. ESHOO, CALIFORNIA
BART STUPAK, MICHIGAN
ELIOT L. ENGEL, NEW YORK
ALBERT R. WYNN, MARYLAND
GENE GREEN, TEXAS
DIANA DeGETTE, COLORADO
VICE CHAIRMAN
LOIS CAPPS, CALIFORNIA
MIKE DOYLE, PENNSYLVANIA
JANE HARMAN, CALIFORNIA
TOM ALLEN, MAINE
JAN SCHAKOWSKY, ILLINOIS
HILDA L. SOLIS, CALIFORNIA
CHARLES A. GONZALEZ, TEXAS
JAY INSLEE, WASHINGTON
TAMMY BALDWIN, WISCONSIN
MIKE ROSS, ARKANSAS
DARLENE HOOLEY, OREGON
ANTHONY D. WEINER, NEW YORK
JIM MATHESON, UTAH
G.K. BUTTERFIELD, NORTH CAROLINA
CHARLIE MELANCON, LOUISIANA
JOHN BARROW, GEORGIA
BARON P. HILL, INDIANA

DENNIS B. FITZGIBBONS, CHIEF OF STAFF
GREGG A. ROTHSCHILD, CHIEF COUNSEL

ONE HUNDRED TENTH CONGRESS

U.S. House of Representatives
Committee on Energy and Commerce
Washington, DC 20515–6115

JOHN D. DINGELL, MICHIGAN
CHAIRMAN

JOE BARTON, TEXAS
RANKING MEMBER
RALPH M. HALL, TEXAS
FRED UPTON, MICHIGAN
CLIFF STEARNS, FLORIDA
NATHAN DEAL, GEORGIA
ED WHITFIELD, KENTUCKY
BARBARA CUBIN, WYOMING
JOHN SHIMKUS, ILLINOIS
HEATHER WILSON, NEW MEXICO
JOHN B. SHADEGG, ARIZONA
CHARLES W. "CHIP" PICKERING, MISSISSIPPI
VITO FOSSELLA, NEW YORK
ROY BLUNT, MISSOURI
STEVE BUYER, INDIANA
GEORGE RADANOVICH, CALIFORNIA
JOSEPH R. PITTS, PENNSYLVANIA
MARY BONO MACK, CALIFORNIA
GREG WALDEN, OREGON
LEE TERRY, NEBRASKA
MIKE FERGUSON, NEW JERSEY
MIKE ROGERS, MICHIGAN
SUE MYRICK, NORTH CAROLINA
JOHN SULLIVAN, OKLAHOMA
TIM MURPHY, PENNSYLVANIA
MICHAEL C. BURGESS, TEXAS
MARSHA BLACKBURN, TENNESSEE

February 28, 2008

The Honorable John M. Spratt, Jr.
Chairman
Committee on the Budget
207 Cannon House Office Building
Washington, D.C. 20515

The Honorable Paul Ryan
Ranking Member
Committee on the Budget
B71 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Spratt and Ranking Member Ryan:

Pursuant to clause 4(f) of Rule X of the rules of the House of Representatives and section 301(d) of the Congressional Budget Act of 1974, as amended, the Committee on Energy and Commerce is submitting Views and Estimates on the President's Fiscal Year 2009 budget. It is the custom of this Committee for the Majority and the Minority to transmit separate Views and Estimates. These are the views and estimates of the Majority.

The President's budget for FY2009 continues the trend of this Administration's budgets in which previous surpluses have been turned into deficits. At the same time, many critical domestic programs have been deeply cut. In particular, the budget makes very large cuts in our Nation's safety net. The common theme of this budget is its continued insistence upon further tax cuts for the wealthiest Americans while cutting programs critical to working families, seniors, and those most in need.

In the case of the healthcare budget, the President makes significant cuts in critical health insurance programs. The budget makes legislative and regulatory proposals that cut approximately $33.2 billion from Medicaid over 5 years and $82.6 billion over 10 years. The President further proposes legislative changes that cut $178 billion from the Medicare fee-for-service program over 5 years and $556 billion over 10 years. The President proposes another

$8 billion in regulatory cuts to Medicare over 5 years and $20 billion over 10 years. Therefore, the total Medicare cuts proposed in the budget are $186 billion over 5 years and $576 billion over 10 years. At the same time, the President proposes allocating $4 billion over 5 years for tax cuts related to Health Savings Accounts, a program that primarily benefits higher-income, healthy individuals, and other health tax proposals that weaken employer-based health insurance, and do relatively little to help the uninsured.

In addition, budget process changes sought in the President's budget would make it considerably more difficult to make positive improvements to Medicaid, Medicare, or the State Children's Health Insurance Program (SCHIP). The President's FY2009 budget would require any additional spending in these programs to be offset only by cuts in other entitlement programs. The President's budget also cuts many popular and vital public health programs. For example, under the President's proposal the budget for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR) would be reduced by $412 million from FY2008. While the Nation's top three causes of death are chronic diseases (heart disease, cancer, and stroke), the President proposes cuts in CDC's chronic disease prevention and health promotion programs of $29 million and elimination of almost $100 million in preventive health care and health services grants.

The President's budget also cuts or underfunds many vital public health programs. For example, funding for CDC would be reduced by 7 percent. Critical programs supported by the CDC, such as those designed to help local public health agencies respond to emerging health crises including foodborne illnesses, would be eliminated entirely. In addition, while the President's plan would increase funding for the Food and Drug Administration, the proposed funding level is wholly inadequate to address the ongoing resource shortfall at the agency and will do little to give American consumers greater confidence in the safety of the food and drug supply.

With regard to energy, the President's budget would increase funding for basic research by 18 percent. The increases are targeted primarily at nuclear energy and clean coal technologies. Energy efficiency and renewable energy programs that offer clean, carbon-free energy options, generally with shorter lead-times and greater technical confidence, are offered a mix of modest increases and decreases.

Nuclear energy plays an important role in our Nation's fuel mix, and the next generation of nuclear energy technology may prove significant in the effort to address climate change. It is unclear, however, whether more than doubling nuclear energy research and development funding in a single year (from $258 million in 2008 to $630 million in 2009) is the best allocation of our limited budgetary resources.

First, there is a legitimate question as to whether the Department of Energy (DOE) can manage such a dramatic increase. In addition, the Department's continued emphasis on obtaining funding for the ill-defined and costly Global Nuclear Energy Partnership (GNEP) threatens to detract from the necessary focus on providing for near-term disposal of commercial and defense waste.

Second, the Committee has good reason to be skeptical as to the alertness of the Department's management in light of evidence that it spent U.S. taxpayer dollars to support Russian nuclear institutes in the name of non-proliferation, when those same Russian institutes have supported development of the very Iranian nuclear reactor that the Department of State has cited as a significant weapons-proliferation risk.

In clean coal programs, one can debate the merits of DOE's recent decision to shift research on capturing and storing carbon-dioxide from a single major FutureGen project to several diverse projects, but it is harder to argue that DOE could appropriately reach such a decision only after spending five years exclusively pursuing the FutureGen approach to the point of finalizing a site. Until the structure and objectives of the restructured carbon-capture research program are finalized anew, and new projects are submitted and awarded funding, increasing the funding for the program 26 percent from $493 million to $624 million, as this budget proposes, does not necessarily inspire confidence that those objectives will be reached in a cost-effective and timely manner.

The President proposes to fill the Strategic Petroleum Reserve's (SPR) existing capacity at a cost of $171 million (including $21 million for administration), and then to spend an additional $170 million to add new capacity to the reserve about equal to the existing capacity through acquisition and preparation of new storage reservoirs. In light of the Department's obligation under the Energy Policy Act of 2005 to fill existing SPR capacity to the prescribed 1 billion barrel target, it seems unwise to initiate a new effort to build additional storage capacity at this time.

At the same time, the proposed budget would eliminate the Weatherization Assistance Program, which will result in the termination of $227 million in Federal support for upgrading some of our Nation's least energy efficient homes. Most of these homes are occupied by citizens who cannot afford the soaring costs of heating them. This is a program that the Administration touted in 2001 as a major element of its energy policy, promised to increase in funding, and still declared on its Web site earlier this year to be its "most successful" energy efficiency program. The Weatherization Assistance Program helps Americans now, not merely in the event of a future disruption. A parallel reduction of 22 percent ($570 million) in the budget for the Low Income Home Energy Assistance Program (LIHEAP, administered by the Department of Health

and Human Services) exacerbates the problem, reducing support for the ability of low-income Americans to pay their heating bills at the same time that they lose assistance in weatherizing their homes.

It is also worth pointing out that Congress vividly reasserted its own sense of priorities in energy policy and programs in passing H.R. 6, the "Energy Independence and Security Act of 2007", signed by President Bush on December 19, 2007. Recognizing that the Administration was far along in its preparation of its budget documents at that point, it is nonetheless striking to observe that the key program objectives established in H.R. 6 were ignored in the proposed 2009 budget for the Department of Energy published a little more than one month later.

Similarly, for the environment, the budget reflects the impact of domestic spending caps in order to provide for large tax cuts. In one such example, the President has requested just $93.5 million for Brownfields cleanups and assessment grants. The request reflects a 23 percent reduction from the FY2006 budget request, and just 58 percent of the amount authorized in the Small Business Liability Relief and Brownfields Revitalization Act. At the time of its signing, the President described the bill as "a good jobs creation bill." In FY2007, EPA was able to fund only 294 of 770 eligible project requests.

Additionally, the President's FY2009 budget request would cut grants for State and local air quality management by more than $30 million, or approximately 15 percent of the amount enacted for FY2008. These grants are a significant source of funding for core State and local air programs. They provide funding that is used to pay State and local employee salaries and other expenses necessary to develop and run State and local air programs, including air permit programs.

In the case of telecommunications programs, the President proposes to eliminate the $50 million Congress appropriated last year for the Interoperable Emergency Communications Grant Program (although the President would allow recipients to use funds from other grant programs for interoperability projects). Communications interoperability is a longstanding issue that has real world consequences, and lack of it endangers both the lives of first responders and those they have pledged to protect. Although the President's budget allows for other Department of Homeland Security grant programs to be used for interoperability efforts, those grant programs do not necessarily require compliance with the strategic statewide and national plans as does the Interoperable Emergency Communications Grant Program. Rescinding funds for the interoperability grant program will most likely result in further wasteful efforts as identified by the Government Accountability Office.

Areas of particular concern and a more detailed analysis prepared by the Committee majority staff are attached. If you have any questions, please contact me or have your staff contact Yvette Fontenot with the Committee on Energy and Commerce staff at ext. 5-2927.

With every good wish.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

Attachment

ATTACHMENT 1

VIEWS AND ESTIMATES ON THE PRESIDENT'S BUDGET FOR FISCAL YEAR 2009

Analysis prepared by Committee on Energy and Commerce Staff

HEALTH

MEDICAID

The Medicaid program will provide health insurance coverage for nearly 65 million Americans in 2009. Even though the Deficit Reduction Act (DRA) enacted 2 years ago cut $28 billion over 10 years, the Administration again is proposing significant cuts to Medicaid. The President's FY2009 budget proposes legislative measures that cut Medicaid by $18.6 billion over 5 years.

In addition, the President's budget proposes new regulatory changes in Medicaid that cut another $800 million from Federal Medicaid payments over 5 years, plus the 2009 baseline includes regulatory proposals issued during 2008 that would cut an additional $13.8 billion from the program. The budget would cut a total of $33.2 billion over 5 years from Medicaid, ballooning to $82.6 billion over 10 years. The budget proposes $1.2 billion in Medicaid spending initiatives, which merely continue currently operating programs, for a net legislative and regulatory loss of about $32 billion over 5 years.

Medicaid Legislative Proposals (-$18.6 billion/5 years)

Many of the legislative cuts are directly attributable to shifting costs from the Federal Government to the States. A number of these changes will restrict access to services, such as targeted case management or school-based health care for beneficiaries with disabilities.

Redesign Acute Care Benefits for Optional Long-term care (LTC) Groups (-$650 million/5 years)

The President’s FY2009 budget includes a new proposal to allow States to offer reduced Medicaid coverage for people with disabilities who have long-term care needs. The budget offers little other detail, except to say that it would allow States to offer private-sector-type coverage that in many cases is not as beneficial to those with disabilities as Medicaid. Given that one of the reasons Medicaid is so critical for people with long-term care needs is that it provides

benefits that are often unavailable under private insurance, this proposal would appear to allow Medicaid coverage of the most critical protections to be vastly reduced for those in need of the services.

Repeal Section 1932(a)(2) Special Rules (-$2.1 billion/5 years)

This proposal would repeal the Medicaid managed care protections enacted in 1997 that prevent mandatory enrollment in HMOs of children with special needs, frail Medicare beneficiaries, and American Indian and Alaska Native beneficiaries. These protections were enacted to ensure that vulnerable Medicaid beneficiaries had a choice of where to receive their care other than a managed care plan that may not provide access to the services or providers that special populations need. Finding physicians who can provide health care to children with special needs is often difficult and frequently are not available in HMOs. Under current law, these individuals may voluntarily enroll in an HMO; this proposal would take away the ability of these beneficiaries to choose the healthcare delivery system that best meets their needs.

Reduction in Medicaid Administrative Payments* (-$5.5 *billion/5 years)

The President's FY2009 proposal would reduce Federal spending on all Medicaid administrative activities to 50 percent, including Medicaid Management Information System (MMIS) used to process claims, utilization review, and systems review. Those activities are currently reimbursed at 90 percent, 75 percent, and 75 percent respectively. Medicaid administrative payments fund a variety of important activities such as nursing home survey and certification, quality inspections, Medicaid Fraud Control Units (MFCUs), and other activities that could be jeopardized as a result of this proposal. At a time when the Administration is asking providers and States to move forward with information technology activities to improve health care, it is inconsistent to simultaneously cut funding for those very activities that ensure improvement. Moreover, other proposals in the President's budget would reduce State funding for failing to meet improper claims recovery targets, which becomes increasingly more difficult if the proposal is implemented to reduce funding on those activities.

Elimination of State Flexibility on Home Equity Limits (-$480 million/5 years)

The FY2009 budget proposes to eliminate State flexibility in determining appropriate home equity levels for the purposes of qualifying for Medicaid long-term care assistance. The Deficit Reduction Act for the first time required States to count the value of a person's home as an asset when applying for Medicaid long-term care assistance. Previously, the value of one's home was not factored into one's assets. States were given the option to set the home equity limit at either $500,000 or $750,000. The Administration proposes to eliminate that State flexibility, requiring all States to include homes valued over $500,000 as an asset. Starting in 2011, this limit would be adjusted for the CPI inflation factor. This particularly penalizes those who live in areas where housing prices are higher than average, such as the North East, California, and the tri-State area and would require that people with virtually no income or assets except for their home to be unable to qualify for needed long-term care services under Medicaid.

Reduction in Federal Payments/or Targeted Case Management* (-$1.1 *billion/5 years)

The President's budget proposal would reduce by $1.1 billion over 5 years Federal payments for targeted case management (TCM). These cuts come on top of $760 million over 5 years ($2.1 billion over 10 years) in cuts for targeted case management in the Deficit Reduction Act. Additional cuts in the Administration's targeted case management regulation are also set to go into effect on March 3, 2008.

Section 1915(g) of the Social Security Act defines case management as services that assist individuals in gaining access to needed medical, social, educational, and other services. TCM involves assessment and facilitation of meeting service needs, not the provision of the services itself. States currently have the option of claiming case management services as a "service" that would be reimbursed by the Federal Government at the State's matching rate, or as an administrative activity, in which case the Federal match is 50 percent. The Administration's proposal would set the Federal reimbursement rate for all case management services at 50 percent. This change will affect only those States that have Federal matching rates in excess of 50 percent (38 States in 2009), shifting more costs to the States.

Targeted populations receiving case management services include children with developmental disabilities, the mentally ill, abused and neglected children in the child welfare system, people with AIDS, and foster children. TCM services are important for those living with disabilities to manage their care in the community and these services can eliminate or reduce the need for more intensive or expensive Medicaid services in the future. This change, coupled with the additional regulatory cuts to case management services being implemented this year, will make it increasingly difficult for States to maintain the necessary level of services for people with disabilities.

Remove Best Price and Replace with a Flat Rebate (budget neutral)

The Medicaid drug rebate program, under current law, requires all drug manufacturers to pay a rebate to States for drugs provided through Medicaid. For brand name drugs, the rebate amount is the greater of either (1) the average manufacturer's price (AMP) minus 15.1 percent (or 11 percent for non-innovator multiple source drugs) or (2) the difference between the AMP and the manufacturer's "best price" for that drug. According to the Administration, the best price requirement prohibits manufacturers from negotiating discounts with large non-Medicaid purchasers such as hospitals and HMOs, because otherwise that price would become the best price and then would be extended to all prescriptions paid by Medicaid. The President's budget proposes to replace the best price with a "budget neutral" flat rebate amount, which would then allow private purchasers to negotiate lower drug prices.

The Administration did not specify what level of "flat rebate" would be required for the proposal to be budget neutral, but eliminating the best price without a corresponding increase in the minimum rebate would erode Medicaid's ability to get larger discounts on certain kinds of

drugs. This policy is intended to allow private payers to receive a better price on prescription drugs than the Medicaid program. This proposal was also included in the President's FY2007 and FY2008 budgets.

Restructure Medicaid Prescription Drug Reimbursement (-$1.1billion/5 years)

The President's budget again proposes to limit payments for multiple-source drugs to 150 percent of the average manufacturer's price. This would save $195 million in 2009 and $1.1 billion over 5 years. The Deficit Reduction Act required that the Federal upper limit of multi-source drugs be re-calculated by the Centers for Medicare and Medicaid Services (CMS) to equal 250 percent of the average manufacturer's price as reported to CMS by the drug manufacturers. This proposal would lower the payment limit further. While CMS has issued the calculation of the new Federal upper limit in a proposed rule, the rule has been contested and CMS is prohibited from implementing its provisions until the court makes a final determination about its legality.

Reductions and Delays in Payments to Pharmacies (no cost)

The President's FY2009 budget proposes to require States to exhaust all other third-party sources of payments before paying Medicaid pharmacy claims. Today, States are able to pay claims as received and then later bill other sources of coverage. Current law ensures access to services is not delayed, and providers are promptly reimbursed for services. The proposed change will result in payment delays for pharmacies, and may reduce pharmacy participation in the Medicaid program, reducing access for beneficiaries.

Reduction of Medicaid Payments for Administrative Costs (Cost Allocation) (-$1.8 billion/5 years)

The Administration believes that Medicaid is inappropriately paying for certain administrative costs under the Temporary Assistance for Needy Families (TANF) program. When Congress replaced Aid to Families with Dependent Children (AFDC) with the TANF block grant, the link between Medicaid and TANF was severed. The TANF block grants, however, are calculated in part on the basis of pre-1996 Federal welfare spending, including amounts received by States as reimbursement for common administrative costs. The Administration believes that the TANF block grants are higher than they would be if common administrative costs were excluded from the TANF calculations. Therefore, the President's FY2009 budget proposes to reduce Medicaid administrative funding to reflect the portion of costs the Administration believes is included in the TANF program by the 1996 calculations, saving $1.8 billion over 5 years. States will become fully responsible for any costs excluded as a result of this policy under Medicaid, yet are unfunded under TANF. To that extent, this policy is another cost shift to States. With TANF having been enacted 12 years ago, it is difficult to argue that a flat cut in Medicaid reimbursement today would have any accurate relationship to spending 12 years ago, or even whether the funding under TANF is being spent on any Medicaid activity.

Extension and Modification of SSI Electronic Asset Verification Demonstration (-$1.2 billion/5 years)

The President's budget proposes to make technical changes to and make permanent a demonstration currently running in New York and New Jersey. This demonstration allows these two States to apply the SSI program's process for electronically verifying assets for SSI eligibility to Medicaid. The TMA, Abstinence Education, and QI Programs Extension Act of 2007 implemented this program only until 2012; the FY2009 budget would extend it permanently.

Reduced Federal Assistance for Failing to Meet Federal Goals (-$310 million/5 years)

The Administration proposes to reduce Medicaid Federal funding assistance to States that fail to meet certain goals, such as reducing the use of restraints in nursing homes, recovering improper payments, coordinating care, and reducing the use of nursing homes among those less than 55 years of age. While this proposal sounds reasonable on its face, it will be very difficult to actually measure these changes at the State level. Existing data are poor and individual States' success or failure will rest on the ability to come to agreement with CMS on the baseline from which they are measured.

Reductions in Payments to Providers for Third Party Liability, including Prenatal and Preventive Pediatric Care* (-$470 *million/5 years)

Federal law requires Medicaid to be the payer of last resort, meaning all other available third parties must meet their legal obligation to pay claims before Medicaid does. If a State believes that probable third party liability exists for a service provided to a beneficiary (i.e., insurance coverage from another source), the State must return that claim to the provider for the provider to determine the other party's liability. States are generally required to follow this rule (unless they receive a waiver from the Federal Government) except in the case of prenatal and pediatric care, where States are required to pay first, and then go after the third party coverage.

The President's budget request proposes to change this requirement for pediatric and prenatal services, and would require States to withhold payment from providers for prenatal and preventive pediatric care where a third party (i.e., insurance from a non-custodial parent or supplemental insurance) may be potentially liable for payment. While the budget States that it will protect providers, women, and children, it provides no details as to how this policy would be implemented without restricting access to care or reducing or delaying payments to pediatric providers.

The President's budget would also allow States to use liens against liability settlements to recover Federal matching payments, but no additional details are provided. Additionally, the States would also be required to collect for medical child support where health insurance is

derived from a non-custodial parent's obligation to provide coverage and recover Medicaid expenditures from beneficiary liability settlements (i.e., awards from another insurer in an injury cases).

Extend 1915(b) Waiver Period (no cost)

The President's budget proposes to extend the 1915(b), managed care waiver period from two years to three years. These waivers allow States to establish mandatory managed care programs that restrict the providers that a beneficiary may receive care, or create a special carved-out delivery system for specialty care as long as the program does not reduce access or quality of care for the beneficiary.

The President's budget proposal would extend the 1915(b) waiver renewal period from two years to three years, allowing States more time to operate their program before having to go through the administrative process to renew and renegotiate their waiver with CMS.

Annual Actuarial Report (no cost)

The Medicare Board of Trustees oversees the financial operations of the Hospital Insurance trust fund and the Supplementary Medical Insurance trust fund (which cover Medicare Part A and Medicare Part B and D services respectively). The Social Security Act requires the Trustees to publish an annual report on the financial and actuarial status of the two Medicare Funds each year.

The Administration is proposing to publish an annual actuarial report on the Medicaid program with an undefined administrative action. As Medicaid is not funded through a trust fund like Medicare, it makes little sense to have such an actuarial report, because there is no separate fund or designated payroll tax to monitor.

Require State Participation in Public Assistance Reporting Information System (PARIS) (-$135 million/5 years)

The President's budget proposes requiring States to participate in an electronic information reporting system that would allow States to verify eligibility for Medicaid services through State and Federal data sharing. PARIS is an information-sharing project used by State public assistance agencies (SPAA) and Federal agencies to help in verifying clients' public assistance circumstances. Currently, 42 States participate in PARIS in some form, but as participation is voluntary, commitment by the States using it varies considerably. The President's budget proposes to provide guidance on how best to collect and use PARIS data and to require States to participate in PARIS.

Mandate National Correct Coding Initiative (-$105 million/5 years)

In 1996, CMS implemented the correct coding initiative (CCI) for Medicare Part B claims. CCI contractors use automated edits to review these Medicare claims. These edits detect

things such as duplicate services delivered to the same beneficiary on the same date of service and or individual services billed erroneously. The FY2009 budget would require Medicaid providers to participate in the national correct coding initiative. No other details are currently available from the Administration on how this would work.

Reduce Federal Funding for Family Planning Services (-$3.3 billion/5 years)

The FY2009 budget proposes to reduce Federal funding for family planning services by $3.3 billion over the next 5 years by reducing the Federal matching rate from 90 percent to the a State's ordinary matching rate, on average 57 percent, for services. More than half of the States operate family planning programs that provide services to low-income women who are not otherwise eligible for Medicaid. These programs have been documented to dramatically reduce unintended pregnancies and abortions, improving public health and saving money on both the State and Federal levels. The Congressional Budget Office (CBO) estimated in 2007 that the provision in the Children's Health and Medicare Protection Act (CHAMP) to make these services a permanent State plan option would save the Federal Government $200 million over the next 5 years. Reduced Federal support for these programs will shift more costs to States, possibly causing them to scale back these effective programs.

Reduce Federal Funding for Qualified Individuals Program (-$200 million/5 years)

The Qualified Individual (QI) program provides assistance with the Medicare Part B premium for low income Medicare beneficiaries with incomes between $12,480 and $14,040 a year. The QI program is administered by the States but fully funded by the Federal Government. At the inception of the QI program in 1997, Congress determined that the program should be fully financed by the Federal Government to ensure States did not face any disincentive in enrolling beneficiaries in this program.

The FY2009 budget would cut Federal payments for the QI program by providing reimbursement to State Medicaid programs at the Federal Medicaid Assistance Percentages (FMAP), requiring a State share for the first time in the 11 year history of the program. This proposal would shift additional costs to States. Rather than enhance program enrollment, it would likely decrease significantly already low enrollment.

Increase Flexibility for Premium Assistance (-140 million/5 years)

Under Medicaid, States may pay to enroll a beneficiary in employer coverage where available, if that coverage is comprehensive and cost-effective for the State. The employer-sponsored coverage is considered cost-effective if the premiums, deductibles, coinsurance, and other cost sharing obligations and benefits covered under Medicaid, but not covered by the employer plan, are less expensive than the anticipated cost of the State providing the services through Medicaid.

The President's budget proposes to seek legislative and administrative action to provide States with greater flexibility in determining cost effectiveness, without further detail on what those modifications would be. This proposal would likely undermine protections for beneficiaries and potentially allow Medicaid funds to be used for coverage that would cost more than under Medicaid.

Medicaid Regulatory Proposals (-$14.6 billion/5 years)

The President's budget includes a number of regulatory changes that will reduce Medicaid spending by $14.6 billion over the next 5 years. Many of these changes will affect essential community providers and may negatively affect access to care both for those covered under Medicaid and others who rely on these providers for their care.

Reductions in Payments to Governmental Providers (-$5.7 billion/5 years)

Under current law, Medicaid can pay Government-owned providers up to the Medicare payment rate, which can more accurately reflect the actual cost to treat beneficiaries and can be higher than Medicaid rates (known as the upper payment limit or UPL). This funding helps sustain these safety net institutions that serve vulnerable populations and helps ensure beneficiary access in frequently underserved areas.

Incorporated into the President's budget, however, is the assumption of $5.7 billion in cuts to payments to providers over five years by prohibiting States from paying Government providers such as nursing homes and hospitals more than their "cost" to treat individuals and limiting the use of certain Certified Public Expenditures. This proposal was published as a proposed rule on January 18, 2007, and as a final rule on May 29, 2007. The rule would impose a restrictive new payment limit for public providers that would drastically limit Medicaid support for the mission of safety net providers.

Congress passed a moratorium on the implementation of this rule in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28), which expires on May 25, 2008.

Note that the Administration previously sent a legislative proposal to Congress on this matter, but it was not enacted because many questions remain, including how the Administration would define a provider's "costs" for this purpose and what kind of reporting burden this will place on providers and States to document costs. It now appears that the Administration believes it can do this through regulations.

Elimination of Graduate Medical Education Payments in Medicaid* (-$1.8 *billion/5 years)

The Administration proposes to eliminate payments for Graduate Medical Education (GME) in the Medicaid program. Medicaid GME payments are used by facilities to train medical residents, including pediatricians, in hospitals and other settings with a particular focus on the special needs of Medicaid patients. Medicare makes similar payments for training of

physicians treating Medicare patients. The Administration published a proposed rule with this change on May 23, 2007. Congress passed a moratorium on the implementation of this rule in the U.S. Troop Readiness, Veterans' Care, Katrina Recovery, and Iraq Accountability Appropriations Act, 2007 (P.L. 110-28), which expires on May 25, 2008.

Reductions in School-Based Administration and Transportation* (-$3.6 *billion/5 years)

The President's budget proposes administrative changes that would cut Federal payments for school-based administration and transportation services currently covered under Medicaid by $3.6 billion over 5 years. CMS published these changes in a final rule on December 28, 2007. Congress, however, enacted a 6-month ban on implementation of the rule in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

To the extent that States cannot secure funding for these Medicaid services and activities under other sources such as IDEA (Individuals with Disabilities Education Act), this proposal would be a direct cost-shift to schools, local governments, and States who are required by law to fund these activities. Of particular concern is the denial of Medicaid funding for outreach and enrollment activities conducted by schools to identify and enroll uninsured children who are eligible for needed healthcare benefits. This runs directly counter to the Administration's professed interest in enrolling eligible but uninsured children. In addition, the rule would ban Medicaid coverage of specialized medical transportation needed for a child with disabilities who is receiving a Medicaid-covered medical service in school.

Stricter Reimbursement Policies for Rehabilitation Services* ($2.3 *billion/5 years)

The Administration plans to clarify through regulation the definition of rehabilitation services under Medicaid. Currently, Medicaid's rehabilitation services option includes any medical or remedial services recommended by a physician for maximum reduction of physical or mental disability and restoration of a beneficiary to his or her best functional level. On August 13, 2007, CMS published a proposed rule narrowing the definition of rehabilitation services that would result in beneficiaries losing needed medical services, in particular by denying Medicaid rehabilitation services for beneficiaries with permanent disabilities who will never recover to the level of "normal." Congress, however, enacted a 6-month ban on the rule's implementation as part of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173).

Clarification of Allowable Provider Taxes (no cost)

The President's budget proposes to clarify the current allowable provider tax policy under Medicaid. In 1992 Congress passed a law that allowed States to tax providers and use those dollars for Medicaid matching payments. The Administration issues regulations in which they put requirements on what could count as a tax, but allowed for these requirements not to apply to provider taxes below 6.0 percent. In the Tax Relief and Health Care Act of 2006 (P.L. 109-432), Congress lowered the allowable provider tax rate from 6.0 percent to 5.5 percent. In implementing this law, the Administration rewrote the definition for an allowable provider tax, even though no such change was enacted in that legislation. States use revenues raised through

such taxes to increase provider payment rates under Medicaid. The proposal will curtail the ability of States to increase provider payment rates. This could decrease access to services for beneficiaries.

Issue Guidance Defining 1915(b)(3) Services (no cost)

The FY2009 budget proposes to clarify by regulation which services may be allowed under Section 1915(b)(3) of the Social Security Act. Section 1915(b) waivers allow States to establish mandatory managed care programs that restrict the providers from whom a beneficiary may receive care, or create a special delivery system for specialty care as long as the program does not reduce access or quality of care for the beneficiary. Under Section 1915(b)(3) of the Medicaid statute, States can use savings achieved by using managed care to provide additional health-related services to Medicaid beneficiaries.

The President's budget would, through administrative action, clarify which additional services could be provided under a Section 1915(b)(3) waiver out of the cost savings achieved through the program. There is little other detail available by which to evaluate this proposal.

Codify Disproportionate Share Hospital Provisions in Regulation (no cost)

The President's budget also mentions issuing new regulations on disproportionate share hospital payments (DSH) and provider taxes. Disproportionate Share payments go to hospitals, mostly safety net facilities that treat a disproportionate number of Medicaid and uninsured patients. The Administration plans to clarify through regulation the statutory DSH program provisions, ostensibly to ensure proper use of Federal funds, even though DSH payments are capped in the statute. The Administration will also take steps, including revising regulations, to clarify and codify existing policies used to determine whether provider taxes comply with the statute (see above). There is no score associated with these proposals and no further detail provided as to how they will affect different States.

Clarify Inflation Protection in Partnership Programs (no cost)

The Deficit Reduction Act added new requirements to the Medicaid Long Term Care Partnership program. Under this program States may extend Medicaid coverage, including long-term care (LTC) benefits, to certain persons who have purchased private long-term care policies, allowing those individuals to protect a larger portion of their assets and still qualify for Medicaid.

Under current law, long-term care policies must include protection against rising inflation eroding the value of the policy and its benefits. Some LTC policies allow consumers a choice to purchase inflation protection in later years, known as a future purchase option. The President's proposal seeks to prohibit LTC policies that have this future purchase option from qualifying under the Medicaid LTC Partnership program. If this change was accompanied with the requirement that LTC policies include adequate inflation protection upon initial purchase, this could benefit consumers. Otherwise, it could merely prohibit some consumers from getting needed protections later on.

Issue Free Care Regulation (no cost)

The "free care" principle prohibits Medicaid from paying for services that are generally available without charge. The Administration proposes to codify the long standing Medicaid "free care" policy whereby providers cannot bill Medicaid for services furnished to the public and other payers at no cost.

New Medicaid and SCHIP Spending Proposals of $5.6 Billion Over 5 Years

Extension of Transitional Medical Assistance (TMA)* ($665 *million/5 years)

The TMA program, which provides health insurance for working mothers as they transition from welfare to work, will expire in June 2008. The President's budget extends the program through the remainder of FY2008, and then would extend TMA for an additional year through 2009 at a cost of $485 million in 2009 and $555 million over 5 years. Unlike the rest of Medicaid, this program relies on year-to-year reauthorization, making long-term planning by States difficult, thus threatening the stability of the program.

Extension of Qualified Individual Program* ($470 *million/5 years)

The Qualified Individual (QI) program pays Medicare Part B premiums for Medicare beneficiaries with incomes between $12,480 and $14,040 a year (120 and 135 percent of poverty). Funding for this program is set to expire in June of 2008. The President's budget extends the program through the remainder of FY2008, and then would extend the QI program for an additional year through September 2009 at a cost of $470 million over 5 years. *Note:* elsewhere in the President's budget there is a $200 million cut in Federal funding to this program over 5 years (see above).

New SCHIP Funding* ($18.6 *billion/5 years)

The budget includes a total of $18.6 billion of new money, on top of the current spending of $5 billion a year, over 5 years for the State Children's Health Insurance Program (SCHIP). Starting in 2009, the President proposes to add $1.5 billion in new budget authority. Given this limited funding level, at best the Administration's proposal may fill the shortfalls for States that are running out of money, but would provide no additional funding to allow States to cover uninsured children who are currently eligible, but not enrolled. Considering that the Administration's guidance issued in August 2007 and its reauthorization proposal would force States to scale back eligibility, the Administration's proposal would not only fail to provide enough funding for currently eligible children, but would likely cause fewer kids to be covered. Estimates of the amount needed to fill the expected SCHIP shortfalls over the next 5 years and avert reductions in the number of children insured through the program vary from $21.5 billion to $19.2 billion.

The current budget "baseline" assumes a reduction in SCHIP funding below 2008 level and includes no adjustment for healthcare inflation in the coming years. Under the President's proposal, the baseline assumes annual Federal SCHIP funding will drop from $6.6 billion in fiscal year 2008 to $5.0 billion in fiscal year 2010, and remains at that level in all years thereafter without any adjustment for increases in healthcare costs or other factors such as growth in population. Thus, the President's budget falls far short of reaching the 4 million eligible but unenrolled children who would have been covered under the Children's Health Insurance Program Reauthorization Act (CHIPRA) that has been vetoed twice by the President.

Also, unlike CHIPRA, and despite the Administration's public pronouncements about the importance of "putting poor children first," the Administration's budget fails to include one of the most effective tools for doing so. It does not provide performance-based assistance to States that succeed in enrolling more of its lowest-income uninsured children. (The Administration's budget includes a modest amount of funding, $450 million over 5 years, for outreach grants.)

In contrast, Congress included such a proposal in each of the bipartisan SCHIP reauthorization bills it passed last year. CBO consistently scored performance-based incentives for enrollment as driving significant enrollment gains among the lowest-income uninsured children with minimal reduction in employer coverage "crowd out."

Moreover, the $450 million included in the President's budget for outreach grants will be of little use. States will be reluctant to undertake outreach activities because the President's budget does not provide sufficient SCHIP funding to cover additional eligible children found through such efforts.

Reductions in Federal Assistance for SCHIP Coverage (effect unclear)

In August 2007, the Administration issued a State Health Official letter that significantly restricts the ability of States to reach more uninsured children through SCHIP. The August 17, 2007, State Health Official letter set up new barriers to States that would extend SCHIP coverage to children in families with incomes above $44,000 a year for a family of 3 (250 percent FPL). It also requires States currently covering children at those levels to roll back coverage effective August 2008.

Because the Secretary of Health and Human Services does not have the direct legal authority to impose an income cap in SCHIP, the guidance attempts to accomplish this through a back door method by requiring States to meet certain conditions (such as requiring children to be uninsured a full year before qualifying for SCHIP or charging significantly higher cost-sharing for health care than States currently require) if they want to cover children in families with incomes above $44,000 a year (250 percent of the FPL). Few, if any, States will be able to meet these requirements.

As a result of the lack of legality surrounding the Secretary's August 17th letter, the President's FY2009 budget would attempt to make these changes legislatively. The changes proposed in the FY2009 budget, however, are even more restrictive than those proposed six months earlier in the August 17th letter.

The President's FY2009 budget proposes to set a hard income cap on SCHIP coverage, prohibiting States from covering any children in families with incomes above $44,000 a year (250 percent of poverty). The budget also proposes to reduce Federal funding available for States to cover children in moderate-income families through the SCHIP program. States that cover children in families with incomes greater than $35,200 a year (200 percent of poverty) would no longer receive enhanced Federal assistance for that coverage. This amounts to changing the rules of the game mid-stream, as the original SCHIP statute specifically allowed States the flexibility to reach uninsured children in families with incomes above $35,200.

While the number of children served by SCHIP in these income ranges remains relatively modest – fewer than 1 in 10 SCHIP children – the recent growth in the number of uninsured among families earning between $35,200 and $70,400 (200 percent and 400 percent of the Federal poverty level) is driving close to half of the recent increase in uninsured children, and has increasingly led States to seek the ability to offer these more moderate-income families an affordable product through SCHIP so that these children will have health care coverage. Some 26 States now cover some children in families with annual incomes above $35,200 (200 percent of the Federal poverty level) or have adopted plans to do so. This policy is more restrictive than the August 17th directive described in more detail below, which applied restrictions to States covering children in families with incomes above $44,000, rather than $35,200.

Thus far, four States that had enacted legislation to expand their SCHIP programs to cover more uninsured children have already been forced to halt or cut back their coverage plans as a result of the August 17th directive. Two other States have chosen to finance a portion of their expansion with State funds rather than not cover children in the expansion group. It is unclear how long these States will be able to sustain coverage without Federal financial support. If the new restrictions in the President's budget were adopted, the 26 States that already cover children in families with incomes above $35,200 a year would be adversely affected. Many of these States have covered children at those levels for years. These States will likely be forced to roll back their coverage plans, or assume the costs with State funds.

Redistribution of SCHIP Funding (effect unclear)

The Administration's FY2009 budget includes a proposal to change the way SCHIP funding is distributed to States. The budget does not include any details on what method the Administration would use to allocate the funding. Last year's budget included a proposal to shorten the length of time States had to spend their SCHIP funding from three years to two years, but this proposal is not included in the FY2009 budget.

Health Insurance Portability and Accountability Act Proposals Related to Medicaid and SCHIP (no cost)

Special Enrollment Period in Group Market for Medicaid/SCHIP

As in the past four years, the Administration's FY2009 budget would make eligibility for SCHIP and Medicaid a "qualifying event" for the purposes of enrolling in employer-sponsored insurance. A "qualifying event" would allow beneficiaries to enroll immediately in employer-sponsored insurance rather than waiting until the employer's open season; this would facilitate premium assistance programs where the State can use SCHIP or Medicaid dollars to enroll a beneficiary in employer coverage. The concern with this proposal is that for many beneficiaries who are eligible for Medicaid or SCHIP, employer-sponsored coverage may not be sufficient, either in terms of benefits or unaffordable out-of-pocket costs. This proposal was included in CHIPRA, which was vetoed twice by the President.

The Administration's budget does not appear to include a requirement that States provide "wrap-around" coverage for these children in premium assistance programs. In the event a Medicaid or SCHIP-eligible person were to enroll in employer-sponsored coverage, the State would fill in the gaps ("wrap around coverage") for missing benefits or excess cost-sharing to ensure that coverage under the employer plans meets the statutory requirements under Medicaid/SCHIP, thus making the coverage affordable.

While the Administration has encouraged States to use premium assistance to enroll Medicaid and SCHIP beneficiaries eligible for employer coverage in the employer-sponsored plan in order to reduce costs in the Medicaid and SCHIP programs, the Administration's approach does not guarantee that families will get either adequate coverage or that it will in any way reduce costs for the State. Medicaid and SCHIP were specifically designed to address the needs of the poor, those with disabilities, and chronically-ill individuals whose needs were not being met by the marketplace. Ensuring that an individual has access to needed medical services will improve public health and lower long-term costs to the Medicaid program. For example, Rhode Island and New Jersey have documented program savings and provided coverage through Medicaid for costs and services that employer-sponsored plans do not cover.

Moreover, in some of the other States that have pursued premium assistance programs, it is not clear that these States are saving money. For example, according to an analysis of audit figures provided by an audit by the Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA), the per-person monthly administrative cost in the State of Florida's premium assistance program is $9,171.48. This money is going to private vendors rather than ensuring that children have health insurance.

Creditable Coverage Certificates under SCHIP

The Administration's FY2009 budget also proposes requiring States to issue certificates of creditable coverage to meet requirements of the Health Insurance Portability and Accountability Act (HIPAA). This would ensure that beneficiaries who are transitioning from

SCHIP coverage to employer-sponsored or individual market coverage would not be penalized by insurers (i.e., charged more or have benefits excluded) because they failed to have had prior coverage as required under HIPAA in order to be eligible for protections against such things as pre-existing condition exclusions.

Refugee Exemption Extension* (*$92 million/5 years)

Under current law, most immigrants who entered the United States on or after August 22, 1996, are not eligible to receive Supplemental Security Income (SSI) benefits (and thus SSI-related Medicaid coverage) until they have resided in the U.S. for five years and have obtained citizenship. There is a special exception for refugees and asylees, however, who may qualify for these benefits during the first seven years they are in the country.

The President's budget proposal extends for an additional year the current seven-year exemption for refugees and asylees to complete the citizenship application process without penalty. It is a Social Security Administration proposal that has the effect of increasing Medicaid spending by $92 million over 5 years because a small number of refugees and asylees would be allowed to continue Medicaid coverage.

MEDICARE

The Medicare program provides health insurance coverage to nearly 45.5 million seniors and individuals with disabilities. The President's FY2009 budget includes substantial cuts to Medicare providers such as doctors and hospitals while protecting private plan overpayments to HMOs and PPOs. The budget proposes legislative changes that would cut $178 billion from the Medicare program over 5 years, as well as a number of regulatory changes that would make additional cuts to payment rates of $8 billion over 5 years for a 5-year total of $186 billion in cuts to Medicare. Over 10 years the President's legislative proposals would yield $556 billion out of Medicare and the regulatory proposals would yield an additional $20 billion. Hospitals bear the brunt of these provider cuts in the FY2009 budget.

Forty-five Percent Trigger for Cutting Medicare Across the Board

The President's FY2009 budget includes a program cap that would automatically cut Medicare provider payment rates by four-tenths of 1 percent in the first year in which general revenues are projected to exceed an arbitrarily set cap of 45 percent of program spending. The reduction would grow by four-tenths of 1 percent every year that the 45 percent threshold is exceeded until general revenue funding is brought back to 45 percent. This would mean payment cuts to all providers in Medicare.

In contrast, under the Medicare Modernization Act (MMA) of 2003, an expenditure cap of 45 percent is already required under law. When the Medicare trustees project for the second time that the general revenue funds share for Medicare expenditures will exceed 45 percent in any of the next 7 years, 2 things would occur: (1) the President would be required to submit

legislation to Congress, and (2) a new Senate rule would automatically go into effect barring consideration of any improvements in Medicare or any Medicare payments to providers unless any extra costs are fully offset. Even given this law, the President decided to put forward a more restrictive proposal in his budget.

Medicare Part D -- The Medicare Prescription Drug Program

The President's budget fails to address, either legislatively or administratively, the numerous problems that have plagued the new, privately-run Part D benefit. In fact, these problems are not addressed anywhere in the budget document. The budget fails to include any proposals that would: (a) address the confusion for beneficiaries associated with dealing with the privately-run benefit by increasing funding for beneficiary assistance or by simplifying choices; (b) address denials of prescription drugs through excessive prior authorization and confusing appeals processes run by the private plans; or (c) provide beneficiaries with the low prescription drug costs obtained through other Government programs.

Part Band D Premium Increase* (-$2.6 *billion/5 years in Part B; -*$3.2 *billion/5 years in Part D)

The President's FY2009 budget proposal increases Part B premiums for more beneficiaries. In 2003, the Medicare Modernization Act changed Medicare's universal social insurance structure by for the first time linking premiums to income. As part of the MMA, beginning this year, individuals with higher incomes will be forced to pay more for Medicare Part B than lower-income Medicare beneficiaries, phased in over five years through 2009. Higher-income beneficiaries were already paying a greater amount into the Medicare system through a payroll tax during their working years and are now being asked to pay more again. This was the first step in turning Medicare into a means-tested program.

The President's FY2009 budget now proposes another increase in premiums by eliminating the indexing of the income levels for individuals who will be subject to the premium increases. Even though inflation and other factors will increase a person’s income over time, the level established to determine whether a person would be required to pay higher amounts for the Part B premium does not proportionately increase. The result is that over time more beneficiaries would be required to pay the increased premiums.

For example, under current law only 4.2 percent of Medicare beneficiaries – more than 1.7 million people – will pay the higher premiums in 2008 and 4.2 percent of beneficiaries, or just under 2.2 million people, will be subject to this increase in 2017. Under the President's budget proposal, by 2017, almost double that number – 7.3 percent of beneficiaries or 3.8 million people – would be subject to these higher premiums. This is the health care equivalent of the Alternative Minimum Tax.

In addition, the FY2008 budget will also apply this ill-advised policy to Part D premiums as well.

Health Care Fraud and Abuse Control Program (HCFAC)* (\$6.5 b*illion/5 years)

The President's budget proposes to fund the HCFAC program through both mandatory and discretionary funding streams. The proposed FY2009 HCFAC program level is \$1.4 billion, an increase of \$200 million from FY2008. Of this total program level, \$1.2 billion is mandatory and \$198.0 million is discretionary. The majority of the additional discretionary funding would be for safeguarding the new Medicare prescription drug benefit and the Medicare Advantage plans against fraud and abuse. The remainder of the funding would be to expand financial management oversight of the Medicaid program.

It has been shown that the Government receives a return on investment of nearly 9 to 1 for every dollar spent on healthcare fraud and abuse activities. This does not even include a calculation of the deterrent effect these activities have on fraud and abuse.

The new Medicare prescription drug benefit is fraught with confusion as a result of the many private plan choices facing Medicare beneficiaries, the different benefit structures of these plans, formularies, marketing strategies, and the fact that many vendors offer not only a standalone Medicare prescription drug plan but also a Medicare Advantage plan. All of this confusion makes the Medicare prescription drug program particularly susceptible to fraud and abuse.

Medicare Contractor Reform

The President's budget highlights that CMS is on track to implement contracting reform, which will expand the pool of potential carriers, nearly two years earlier than the 2011 target statutorily directed under the Medicare Modernization Act.

Provider Payment Cuts in Traditional Medicare

The Medicare Payment Advisory Commission (MedPAC) annually recommends a number of payment changes, including cuts and freezes to a variety of Medicare providers. The President decided to integrate in his budget only a few of the recommendations into his budget that made cuts and freezes to providers such as hospitals and skilled nursing facilities. The President chose not to follow the MedPAC recommendation to eliminate the approximately \$50 billion of overpayments to HMOs and PPOs through the Medicare Advantage plans. The President's budget goes at the heart of the Medicare program. Rather than achieving savings by reducing the more than \$65 billion in overpayments to HMOs and private insurance plans, the budget cuts fall solely on providers serving beneficiaries in fee-for-service Medicare, which enrolls more than 85 percent of all seniors and people with disabilities. Below is additional details on the provider cuts in the President's budget:

- ***Physicians.*** For 2009, MedPAC is expected to recommend giving physicians an update that reflects the projected change in input prices less an adjustment for productivity growth. The President's budget includes no provisions on this matter, and does nothing to address the significant Medicare payment cuts that will be made to physician payments

over the next 10 years beginning in July 2008. The Medicare, Medicaid, and SCHIP Extension Act of 2007 eliminated a previously scheduled physician update of -10.0 percent and replaced it with a 0.5 percent update for 6 months. As of July 1, 2008, the previously scheduled -10.0 percent update will take effect for the remaining 6 months of 2008 and physicians will face 5.0 percent cuts thereafter. The Act also extends the Physician Quality Reporting Initiative. The President's budget fails to address the 10 percent cut in physician payments that is pending for 2008 or the 5 percent cuts that doctors are scheduled to receive in subsequent years.

- ***Hospitals.*** Hospitals bear the brunt of the Medicare payment cuts in the President's FY2009 budget.

- ***Cuts on Inpatient Hospital Update* (-$64.2 *billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter.

- ***Cut to Outpatient Hospital Update* (-$6.1 *billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter.

- ***Cuts to Indirect Medical Education (IME)* (-$12.9 *billion/5 years).*** The President's budget proposes eliminating payments to hospitals for Indirect Medical Education (IME) for beneficiaries covered by a Medicare Advantage organization. Prior to 1997, hospitals received IME payments directly from Medicare, regardless of whether the patient was in Medicare fee-for-service or a Medicare Advantage plan. The Balanced Budget Act of 1997 eliminated Medicare's payment for IME for beneficiaries in Medicare Advantage plans and instead added an IME payment to the Medicare Advantage payment rates. Unfortunately, the Medicare Advantage plans did not pass this bump in payment to the facilities providing the care. Congress later changed the policy returning Medicare's direct payments to hospitals for IME regardless of whether the patient was in fee-for-service or a Medicare Advantage plan. (Private plans kept their IME payment too, so Medicare in effect is double paying for IME.) MedPAC has recommended eliminating the IME add on to Medicare Advantage plans. Instead of following this recommendation, the President's budget proposes to again take the IME payment away from institutions, returning to the flawed policy of having IME flow through private insurance plans. The President's budget also proposes to adjust the IME add-on payment for beneficiaries in fee-for-service from 5.5 percent to 2.2 percent over 3 years, starting in FY2009.

- ***Reduce Hospital Capital Payments ($3.1 billion/5 years).*** The budget proposes to reduce hospital capital payments by 5 percent in FY2009.

- ***Reduce Hospital Disproportionate Share Payments ($20.7 billion/5 years).*** The budget proposes to phase-in a 30 percent reduction in hospital DSH payments, the payments

hospitals receive for serving a disproportionate share of Medicaid and uninsured patients, over 2 years starting in FY2009.

- ***Elimination of Payments to Providers for Bad Debt (-$8.5 billion/5 years).*** The President's budget eliminates bad debt reimbursements to providers over four years for unpaid beneficiary cost-sharing. Medicare currently pays 70 percent of unpaid beneficiary co-pays and deductibles for hospitals and skilled nursing facilities. Bad debt payments are intended to compensate providers when they are unable to collect beneficiary cost-sharing amounts, such as when a beneficiary does not have the means to pay the bill. It allows providers to continue to see Medicare patients but have a source of some relief from unpaid bills. The President's proposal will completely phase out these payments and leave providers with no options but to absorb the unpaid bills, pursue the sick and poor elderly and disabled individuals, shift bad debt costs to paying patients, or no longer see Medicare patients.

- ***Eliminate Payment for Never Events (-$190.0 million/5 years).*** The budget proposes prohibition of Medicare payment for preventable adverse events such as surgery on the wrong body part. Hospitals would be required to report occurrences of never events or receive a reduced annual update.

- ***Inpatient Rehabilitation Facilities (IRFs) (-$4.8 billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2010 and 2011 followed by a full update less 0.65 percent annually thereafter for these facilities.

- ***Long-term Care Hospitals (LTCHs) ($2.9 billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter for long-term care hospitals.

- ***Establish a Hospital Value-Based Purchasing Program ($1.7 billion/5 years).*** The President's budget proposes to establish incentives for hospitals to improve and attain high-quality care.

- ***Establish a Base Payment for Five Post-Acute Conditions Treated in SNFs and IRFs. (-$1.7 billion/5 years).*** This proposal would require Medicare to pay the same amount for post-hospital payments, regardless of where the care occurs. This policy is intended to limit inappropriate incentives for five conditions commonly treated in both skilled nursing facilities and inpatient rehabilitation facilities.

  In addition, numerous other providers receive significant cuts:

  - ***Skilled Nursing Facilities (SNFs) (-$17.0 billion/ 5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter for skilled nursing facilities.

- ***Home Health (-$11.0 billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2013, followed by a full update less 0.65 percent annually thereafter for home health.

- ***Hospice (-$5.1 billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter for Hospice services.

- ***Ambulatory Surgery Centers (ASCs) (-$450.0 million/5 years).*** The President's budget proposes a 0 percent market basket update in 2010 and 2011 followed by a full update less 0.65 percent annually thereafter for ASCs.

- ***Ambulance (-$1.3 billion/5 years).*** The President's budget proposes a 0 percent market basket update in 2009 through 2011 followed by a full update less 0.65 percent annually thereafter for ambulances.

- ***Clinical Laboratories (-$2.3 billion/5 years).*** Expand competitive bidding to include clinical lab services.

- ***Oxygen Rental (-$3.0 billion/5 years).*** The Deficit Reduction Act included a new rent-to-own payment policy for oxygen equipment. After a maximum of a 36-month rental period, all home stationary and portable oxygen technologies will be considered owned by the Medicare beneficiary. Medicare will continue to pay for reasonable and necessary maintenance and service along with gaseous and liquid oxygen contents. The President's budget proposes to reduce that policy to 13 months which ensures that a beneficiary does not pay more for oxygen rental than it is worth.

- ***Power Wheelchair Rentals (-$720 million/5 years).*** Establish a 13-month rental period for power wheelchairs so that a beneficiary cannot purchase the wheelchair unless they rent it for the full 13 months. This ensures that Medicare and its beneficiaries no longer pay excessively for the purchase of equipment that could have been rented.

- ***Extend Medicare Secondary Payer Status for ESRD from 30 to 60 months* (*$1.1 billion/5 years).*** Under the Balanced Budget Act of 1997, Medicare is secondary payer for end stage renal disease (ESRD) services for the first 30 months if a beneficiary has coverage for ESRD through a group health plan. After the first 30 months Medicare becomes the primary payer. The President's budget extends that to 60 months.

- ***End Stage Renal Disease (ESRD) Payment Modernization (-$1.1 billion/5 years).*** The budget proposes to align payment rates for certain dialysis services in hospital-based and freestanding facilities starting in 2009; bundle payments for dialysis services and rebase the first year of the new payment system starting 2011.

Finally, the President's budget includes several proposals with savings that are minimal to none:

- ***Budget Neutrality within State for Purposes of Geographic Reclassification (no savings).*** Hospitals currently receive payments that are partially based on prevailing wages in the area, referred to as the wage index. Because of an existing budget neutrality requirement, when a hospital has its index reclassified to a different (normally higher) area, the cost is redistributed across all other hospitals in the Nation. The budget proposes to apply the geographic reclassification budget neutrality requirement at the State level. Required budget neutrality would be achieved by adjusting the wage index for all hospitals within the State rather than reducing payments for hospitals nationwide.

- ***Quality Improvement Organization(QIO) Proposals:***

  - ***Allow Secretary to Determine Geographic Scope of Contracts (-$50 million/5 years).*** The budget proposes to move contracts with Quality Improvement Organizations from State-based only contracts to local, regional, or national contracts.
  - ***Expand Pool of Contractors (-$30 million/5 years).*** The budget proposed to expand the pool of eligible QIO contractors to include quality organizations other than State medical associations.
  - ***Allow for Early Termination of Contracts (no savings).*** The budget proposes to allow for early termination of contracts without panel review for poor performing QIOs.
  - ***Eliminate Conflict of Interest (no savings).*** The Institute of Medicine recently reported that there was a conflict of interest with the QIOs doing both the education of the providers and looking for overpayments or fraud. The budget proposes to eliminate this conflict of interest by separating the two functions.
  - ***Expand QIO Authority (no savings).*** The budget proposes to clarify the statutory authority of QIOs to do quality improvement activities.

HEALTH TAX AND UNINSURED PROPOSALS

More than 46 million Americans today have no health coverage. Under President Bush's Administration, six million more Americans are insured today than when he took office. The Administration is proposing a range of tax incentives and policy changes to promote greater enrollment in high-deductible plans that are linked to Health Savings Accounts (HSAs). These high-deductible plans primarily attract people in good health at higher income levels, pull the healthy out of the existing risk pool (usually the employer pool), and increase premiums for all of those who remain. This would also move families from comprehensive coverage to more restrictive coverage in an individual insurance market that is fraught with

problems today. These proposals drain from the treasury $110 billion over 5 years, with gains of $21 billion over 10 years. In addition, by increasing the deficit, the President's policies create a justification for further Medicare and Medicaid cuts that will only further increase the number of Americans who are uninsured and underinsured.

Health Savings Accounts (HSAs) Proposals (-$4.3 billion/5 years; -$11.5 billion/10 years)

A Health Savings Account (HSA) is a tax-exempt account used to reimburse certain medical expenses for people who also have high-deductible health plans (HDHP). Both individuals and employers may contribute to HSAs with pre-tax dollars. Account balances roll over from year-to-year and earnings on these accounts accrue tax free. Withdrawals from these accounts are not taxed if they are used to pay for qualified medical expenses, as determined by the Internal Revenue Service. The President's FY2009 budget includes a number of proposals related to HSAs.

Allow High-Coinsurance Plans

In lieu of satisfying the minimum deductible requirement with HSAs, a plan could qualify as a high-deductible health plan if it had at least 50 percent or higher coinsurance and a minimum (not maximum) out-of-pocket exposure as determined by the HHS Secretary.

Allow Expenses from First Day of HSA Eligibility

The budget proposal allows a taxpayer to use HSA funds to pay medical expenses before the HSA was established, so long as the taxpayer has a qualifying high-deductible health plan. This proposal only encourages the purchase of high-deductible plans and further erodes employer-based health insurance.

Allow Larger Employer Contributions for the Chronically Ill

HSA contributions for chronically ill employees (or employees with spouses or dependents who are chronically ill) would be exempt from comparability rules. Comparability rules require employers to treat all employees equally, meaning the high level, lower level, sicker, and healthier employees all have the same rules. This policy would allow the employer to contribute more into HSA accounts of wealthier or healthier individuals.

Allow Individual Deductibles in High-Deductible Health Plans (HDHPs)

The budget proposes to allow HDHP family policies to have individual deductibles embedded in the policy, so long as the deductible is at least as high as the qualifying deductible. this means that each individual in the family would have to satisfy a separate deductible in use of health services before insurers would have to begin paying for services.

Allow Spousal Catch-Up Contributions

The budget proposal allows one spouse to make catch-up contributions to the HSA of another spouse if both spouses are eligible to make catch-up contributions. This policy would disproportionately benefit the wealthy and could double the amount of money that a person can contribute to their HSA through their spouse, further sheltering income from taxes.

Allow FSA and HRA Contributions to HSAs

The budget proposal allows workers currently enrolled in a flexible spending account (FSA) or health reimbursement arrangement (HRA) to contribute those funds to an HSA, but lowers the maximum allowable HSA contribution by the amount contributed to the other policy. This change, too, would be of greatest benefit to higher-income households that can afford to contribute the most to a FSA to pay for out-of-pocket medical costs, and are more likely to have significant FSA balances that could be transferred to a HSA. They also derive the largest tax benefits from FSAs and HSAs.

This change would likely encourage more employers to switch from HRAs to HSAs. Many employers provide HRAs rather than HSAs, and employers (as well as their employees) may be reluctant to switch to HSAs without having the option to transfer existing HRA balances to employees' HSAs on a tax-free basis. This provision would facilitate these switches.

The President's HSA proposals spend a considerable amount of taxpayer dollars for covering few new people and provides a limited benefit to those who already have coverage. In addition, it could undermine existing employer-sponsored health insurance coverage because healthier and wealthier employees will have incentives to move to the individual market, leaving sicker, more costly people in the employer-sponsored health plans. In addition, these proposals have only modest abilities to control costs.

Standard Deduction for Health Insurance (-105.7 billion/5 years; $32.5 billion/10 years)

The President's FY2009 budget proposes a new standard deduction for health insurance ($7,500 for individuals and $15,000 for family coverage) for families with health insurance that meets minimal standards (conforming to HSA policies). Under this policy, taxpayers would pay no income or payroll taxes on the first $7,500/$15,000 of income, but insurance premiums paid by employees and employers would, unlike today's plan, be treated as taxable income. This deduction would be allowed regardless of whether the insurance was purchased through an employer or through the individual insurance market. As with any deduction (as opposed to a credit), the total value of the deduction increases with income because higher-income individuals are in higher tax brackets.

Given the current cost of health insurance premiums, the Office of Management and Budget estimates that 20 percent of people with employer-sponsored insurance would see an immediate increase in taxes under this plan. The value of the deduction is indexed to general

inflation, which rises more slowly than heath insurance premiums, causing more people to see an increase in taxes each year.

The proposal leaves in place current tax preferences for HSAs, giving a strong bias in favor of taxpayers selecting these plans and undermining the existing employer market. In addition, the budget proposes eliminating other deductions for purchasing health insurance under current law:

- ***Treats Employer-Provided Health Benefits As Taxable Income.*** Individuals would be taxed for the value of their employer-based insurance. Employers would still be allowed to deduct insurance premiums as a general business expense.

- ***Eliminates Medical Expense Deduction for Non-Medicare Taxpayers***. Under current law, taxpayers can deduct, as an itemized deduction, medical and long-term care expenses exceeding 7.5 percent of adjusted gross income. The President's budget eliminates this deduction for all taxpayers who are not also Medicare beneficiaries (over age 65 or people with disabilities).

- ***Eliminates Deduction for Health Insurance Premiums for Self-employed***. Current law allows self-employed workers to deduct health insurance and long-term care insurance premiums. President Bush's proposal would eliminate this deduction entirely.

- ***Eliminates Tax Preference for Flexible Spending Accounts.*** Current law allows workers to use pre-tax flexible spending account (FSA) dollars to pay either the employee portion of premiums or out-of-pocket healthcare expenses. President Bush's proposal would eliminate the pre-tax treatment for health care FSAs. This proposal would not affect dependent care FSAs that can be used for childcare and other dependent expenses.

Association Health Plans and Health Insurance Market Place Proposals

The President's budget includes two relatively similar proposals intended to "transform" the health insurance market place and provide access to low-cost health insurance for more Americans: Association Health Plans (AHPs) and "Health Insurance Market Place" initiatives. Unfortunately, neither is likely to benefit consumers, and instead will make it more difficult for those with disabilities and chronic or other illnesses to get insurance coverage.

Association Health Plans

Association Health Plans (AHP) would allow small businesses and the self-employed to pool together to purchase insurance without generally being governed by State consumer protection laws and oversight. Insurers could offer policies that exclude people with illnesses or disabilities such as diabetes or exclude important benefits such as maternity care or prescription drugs. Insurers could avoid State rules that require insurance companies to offer coverage to

everyone or laws that prevent insurance companies from discriminating against the sick by charging them more or denying them coverage. Similarly, health plans could avoid State-based oversight and solvency requirements that are in place to ensure that individuals and businesses are not left with medical bills if their AHP goes out of business.

Allowing these AHPs to operate outside of the protections in State insurance markets will create an unlevel playing field, which will be detrimental to sicker individuals. The American Academy of Actuaries noted, "The consequence of different rules for AHPs versus State-regulated insured plans is a fragmentation of the market." This is likely to lead to cherry-picking, adverse selection, and increased costs for sicker individuals.

We already have poor experiences with entities such as AHPs. Multiple Employer Welfare Arrangements (MEWAs) are very similar to AHPs. These entities have defrauded hundreds of thousands of Americans out of their health coverage, leaving them with hundreds of millions of dollars in unpaid medical bills. By 2003, the Government Accountability Office (GAO) reported that MEWAs accounted for more than $250 million in unpaid claims.

Moreover, AHPs will do little to reduce costs or increase coverage and could actually increase the number of uninsured. According to a 2003 Mercer study, by creating AHPs, the sicker population is left in employer pools that purchase insurance products that fall under State consumer protections. This will actually increase health insurance premiums for these employers. Moreover, the Mercer study concluded that four years after implementation of an AHP proposal, the number of uninsured would increase by one million. And, it is important to note, that those with employer coverage are already paying the price for Americans without insurance.

The Congressional Budget Office reports that AHPs would result in higher premium costs for 75 percent of employers. According to the American Academy of Actuaries, AHPs are not expected to generate the higher provider discounts and lower administrative costs necessary to produce sustained lower premium rates than premium rates currently available to small groups. Numerous consumer groups have expressed concern that AHP's will harm the existing insurance market place. For example, Families USA wrote, "We are very concerned that this law would encourage a race to the bottom in healthcare coverage, removing critical State consumer protections, creating unstable insurance markets, and increasing the potential for more insolvent plans."

Health Insurance Market Place Initiative

The President's FY2009 budget includes a proposal that would allow insurance companies to sell insurance across State lines without meeting consumer protection requirements or other laws in those States. This proposal is similar to the Health Care Choice Act (H.R. 2355) ordered reported out of the House Committee on Energy and Commerce in July 2005, by a vote of 24-23. Key concerns with this proposal are as follows:

- ***The Market Place Initiative would erode consumer protections by permitting insurance companies to be licensed in one State but sell insurance in any other State, without meeting the laws of that other State.*** Under this approach, insurers could circumvent State-enacted consumer and patient protections designed to ensure coverage of certain benefits or conditions such as cancer, diabetes, asthma, or mental illness. Insurers would be exempt from critical consumer protections such as guaranteed coverage for individuals with preexisting conditions, and required coverage of critical health benefits such as mammography screenings and preventive care. Insurers could also avoid HIPAA-guaranteed access protections for those losing group coverage and moving into the individual market.

  According to the Congressional Budget Office, this approach would cause those in poorer health to lose coverage in the individual market. CBO writes, "there would be an increase in the number of relatively healthy individuals, and a decrease in the number of individuals expected to have relatively high cost, who buy individual coverage."

- ***The Market Place Initiative would raise costs for employer coverage as well as cause loss of employer-sponsored insurance.*** According to CBO, "...some people with relatively low health care costs who, under current law, will obtain health insurance coverage through an employer, would choose instead to purchase individual health insurance coverage from an out-of-State insurer." This would increase the per-person cost of the employers' group health insurance and would result in additional employers deciding to drop group coverage. CBO estimates that about one million people would lose employer-sponsored health insurance coverage under such an approach.

- ***The Market Place Initiative would permit insurers to circumvent State consumer protection and patient protection laws such as those protecting consumers from unfair rates and rate hikes, or laws protecting coverage for particular health conditions or benefits.*** This would clearly promote a "race to the bottom" as insurers would be rewarded for licensing their individual products in States with less regulation and fewer personnel to oversee what could be a large influx of new products.

- ***The Market Place Initiative would create regulatory confusion and make it difficult for consumers to seek recourse for problems.*** Under this proposal, there would be no effective enforcement mechanism to protect consumers as an individual's State insurance commissioner (who today ensures the consumer's rights) would not have the jurisdiction or ability to enforce rules for a policy issued through another State. According to the National Association of Insurance Commissioners, "state regulators would be unable to assist their own constituents, leaving consumers to seek assistance from the insurer's home state." While that may be a theoretical possibility, in the real world of tight State budgets, it will be virtually impossible to assist a nonresident consumer in a distant State.

- ***The Market Place Initiative would hurt rather than help small employers afford coverage.*** According to BlueCross BlueShield Association, which operations 40 independently owned and operated BlueCross BlueShield companies insuring more than 90 million Americans: "Although the bill does not apply to the small group market or to small businesses, it would have a negative impact on the ability of small employers to purchase affordable insurance. By creating a regulatory race to the bottom in terms of the non group market, the Act would drain healthier employees from the small group market because they would be quoted very low (albeit unstable) premiums in the non-group market. When these healthy individuals eventually get sick, they would face dramatic premium increases from their unregulated insurers that would drive them back to the small group market. Federal law (HIPAA) requires that small employers accept these employees back onto their coverage plans. This would increase the cost of coverage for small employers purchasing coverage, as only higher risk employees remained in the pool."

PUBLIC HEALTH AND FOOD AND DRUG ADMINISTRATION

Agency for Healthcare Research and Quality (AHRQ)

The FY2009 budget request for AHRQ is $326 million, a net decrease of $9 million or 2.7 percent below the enacted level for Fiscal Year 2008.

The major concern with the AHRQ budget is that research supporting cost effectiveness and quality care has been reduced by 8 percent, to only $151 million. This reduction represents a significant decrease from both the FY2007 and FY2008 enacted levels, and will prevent the program from achieving its dual goals of improving clinical care and making health care more cost effective.

Administration on Aging (AoA)

The FY2009 budget request for AoA is $1.4 billion, a net decrease of $32 million below the FY2008 enacted level. This is a proposed 32 percent cut from the FY2008 enacted level.

The budget calls for the elimination of both the Preventive Health Services and the Alzheimer's Disease Demonstration Grants. Across the board, the President's budget pays short shrift to preventive care, and the AoA is no exception. Despite the fact that Alzheimer's Disease Demonstration Grants have "helped expand support services to victims of Alzheimer's, particularly for hard-to-reach minority, low-income, and rural families,"[1] the Administration recommends zeroing out funding for this valuable program.

[1] http://www.aoa.gov/eldfam/healthy_lifestyles/mental_health/mental_health_alz.asp

Administration for Children and Families (ACF)

The FY2009 budget request for the ACF is $45.6 billion, a net decrease of $1.8 billion below the FY2008 enacted level.

The Administration requests a total of $191 million for Abstinence Education activities, an increase of $28 million over the FY2008 enacted level. The budget includes $50 million in mandatory funds for the State Abstinence Education program in addition to $13 million for abstinence activities as part of the Adolescent Family Life program (outside of the ACF, located within the Office of Public Health and Science).

The Administration asks for increases in abstinence-only education programs despite the fact that numerous reports have found that the "abstinence-only" approach does not work. In April 2007, an independent research firm, Mathematica Policy Research, Inc., released a study – commissioned by the U.S. Department of Health and Human Services (HHS) – concluding that students in "abstinence-only" programs are no more likely to abstain from sex, delay initiation of sex, or have fewer sexual partners than students who did not participate.[2]

In October 2006, a GAO report found that the ACF does not review its grantees' education materials for scientific accuracy and does not require grantees of either program to review their own materials for scientific accuracy. The GAO further concluded that "because of these limitations, ACF cannot be assured that the materials used in its State and Community-based Programs are accurate."[3]

In 2004, a House Committee on Government Reform report found that not only have these programs demonstrated their inability to help teenagers abstain from sex, many are rife with scientific inaccuracies, factual errors, and troubling biases that put our young people at greater risk for unintended pregnancy and sexually transmitted diseases. The report found that more than two-thirds of the community-based grantees used curricula that "contain false, misleading or distorted information about reproductive health," such as stating that condoms fail more often than they actually do and that sweat and tears can transmit HIV.[4]

As a result of these and other evaluations, 16 States have rejected Federal "abstinence-only" funding, yet the Administration continues to request increases for these programs. According to the Sexuality Information and Education Council of the United States, this huge investment of taxpayer funds in abstinence-only programs conflicts with scientific and medical research: "2007 was a year when these programs were held up to closer scrutiny, and they failed miserably. Sixteen States have now rejected Federal funds for abstinence-only-until-marriage programming, and study after study shows that these programs don't work" (William Smith, Vice President for Public Policy).[5]

[2] http://aspe.hhs.gov/hsp/abstinence07/report.pdf
[3] http://www.gao.gov/new.items/d0787.pdf
[4] http://oversight.house.gov/documents/20041201102153-50247.pdf
[5] http://www.siecus.org/

Centers for Disease Control and Prevention (CDC)

The FY2009 budget request for the CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is $8.8 billion, a net decrease of $412 million below the FY2008 enacted level. The Administration is requesting this cut despite acknowledging that the CDC is the, "primary Federal agency for conducting and supporting public health protection through promotion, prevention, preparedness, and research."

The CDC, the premiere public health disease prevention and control agency in the world, is slated for a 7 percent cut below FY2008 that, if enacted, would return the agency to funding levels not seen since FY2003. The deepest cuts at CDC are proposed for the State and Local Preparedness Grants, a loss of $136 million on top of a cut of $100 million enacted in FY2006; the near elimination of the monitoring and treatment activities for World Trade Center response victims within the National Institute of Occupational Safety and Health; and the elimination of the Preventive Health and Health Services Block Grant (PHHSBG). The PHHSBG is a program that gives grantees the flexibility to prioritize the use of funds to fill funding gaps in programs that deal with leading causes of death and disability, as well as the ability to respond rapidly to emerging health issues including outbreaks of food-borne infections and water-borne diseases. The National Association of County and City Health Officials has found that eliminating this program will significantly curtail each State's ability to support disease prevention programs.[6]

Other deep cuts are proposed for infectious disease preparedness, detection, and control. In the President's FY2008 budget, the Administration recognized that, "Infectious diseases continue to threaten our Nation's health and that of every citizen in the world." Exactly one year later, the President is attempting to cut nearly $30 million from the CDC's efforts to prepare, detect, and control infectious diseases, despite the fact that in recent years, there have been many public health emergencies, including the steady progress of the West Nile virus in humans and animals around the United States, and the epidemic of SARS in China and beyond. In addition to new emerging public health emergencies, the U.S. must continue to address existing public health threats such as the ongoing fight against tuberculosis.

In the FY2009 budget, bioterrorism and public health preparedness programs also receive significant cuts. A net decrease of $60 million is requested for programs that conduct bioterrorism preparedness activities. Additionally, the Administration requests a cut of $137 million to the Bioterrorism State and Local Capacity Program. These programs are designed to support upgrading State and local capabilities and ensuring hospital readiness. Decreased funding will severely undermine emergency disaster response capabilities.

Additionally, the Administration proposes a net decrease of $64 million in the Vaccines for Children program. This program helps families by providing free vaccines to doctors who serve eligible children and is administered at the national level by the CDC through the National Immunization Program.

[6] http://www.naccho.org/

Food and Drug Administration (FDA)

The FY2009 Administration budget request for the FDA is $2.4 billion. While this is a net increase of $130 million over FY2008, it fails to even keep pace with inflation and is wholly inadequate to address the ongoing resource shortfall at the agency.

The President's budget provides an increase of $33 million for the FDA's Foods program, from $510 million enacted in FY2008 to $543 million in FY2009. For the Human Drugs Program, the Administration proposes an increase of $58 million, from $680 million enacted in FY2008 to $739 million in FY2009. The Administration proposes an increase of $9 million for the Biologics Program, from $236 million enacted in FY2008 to $245 million in FY2009. For the Animal Drugs and Feeds Program, the Administration proposes a $10 million increase, from $109 million enacted in FY2008 to $119 million in FY2009. Finally, the Administration proposes a $7 million increase for the Medical Devices Program, from $284 million enacted in FY2008 to $291 million in FY2009. As former FDA chief counsel, Peter Barton Hutt, stated in testimony before the Committee on Energy and Commerce, the FDA is "barely hanging on by its fingertips." The President's budget does little to remedy that precarious situation.

The Committee on Energy and Commerce's Subcommittee on Oversight and Investigations found that at current funding levels, FDA can only inspect foreign drug makers once every 13 years. There are now more than 700 firms in China making drug products and exporting them to the United States, yet FDA can only inspect about 10 to 20 facilities a year, meaning it will take the agency more than 50 years to inspect each firm once with present resources. Class II and III medical device makers are inspected every two years domestically. Yet abroad, FDA can only inspect class III device makers once every 6 years and class II manufactures once every 27 years. The budget does little to alleviate this public health concern.

The decrease in funding for food inspections has forced FDA to reduce its inspections by 78 percent, according to data presented in the FDA Science Board report. FDA estimates that at most it inspects food manufacturers once every 10 years and cosmetic manufacturers even less frequently. The Agency conducts no inspections of retail food establishments or of food-producing farms. FDA is physically inspecting less than 1 percent of food imports. While there is some new money dedicated to food safety, the budget does little to provide the overhaul that is needed to give American consumers greater confidence in the food supply.

According to the Alliance for a Stronger FDA, "the FDA's ability to fulfill its mission could be in serious jeopardy if additional increases aren't enacted. This proposed budget would likely force the agency into further staff decreases, at a time when it is urgent to increase staff."[7]

[7] http://www.strengthenFDA.org

Health Resources and Services Administration

The President's FY2009 budget request for HRSA is $5.922 billion, a decrease of $995 million below the FY2008 enacted level. This is a proposed 14.4 percent cut from the FY2008 enacted level.

The President's FY2009 budget proposes to increase funding for several programs, including health centers by $26 million, a 1 percent increase; health centers tort claims by $0.77 million, a nearly 2 percent increase; nurse loan repayment and scholarship program by $13.23 million, a 43 percent increase; and HIV/AIDS by $1.12 million, a 0.05 percent increase.

Although this proposal would represent increased funding for the Ryan White CARE Act, many organizations, such as the AIDS Institute, contend that such an increase is "measly" because it "does not even keep up with inflation" nor does it "take into account that more people need services due to new infections, new testing initiatives, and people are living longer."[8]

The National Association of Community Health Centers acknowledges the proposal's effort to "slightly expand the Health Centers program" but criticizes the proposed decreased funding for several programs below FY2008 that could "threaten to deeply undermine the significant progress made by health centers and others to improve access to care available for the nation's medically underserved."[9]

The budget proposes to cut funding for several programs below the FY2008 enacted levels, including rural health programs by $150.1 million, thereby eliminating funding for rural health outreach; network development and quality improvement grants, rural hospital flexibility grants, the Denali Commission; and the Delta Health Initiative. Furthermore, the Administration's budget proposes to decrease funding for several programs including: poison control centers by $17 million, from $27 million enacted in FY2008 to $10 million in FY2009; nurse workforce development programs by $59 million, from $126 million enacted in FY2008 to $66 million in FY2009; field placement activities within the Health Service Corps by $14 million, from $40 million enacted in FY2008 to $26 million in FY2009; and HIV/AIDS education and training centers by $5 million, from $34 million enacted in FY2008 to $29 million in FY2009.

The budget proposes to eliminate funding for several programs, including health professions training for diversity; loan repayment and scholarship programs for faculty; training in primary care medicine and dentistry; community-based linkages; public health workforce development; advanced education nursing; patient navigator; children's hospital graduate medical education; traumatic brain injury; universal newborn screening; and emergency medical services for children. The President's budget fails to fund the placement of more doctors, nurses, and other healthcare professionals in the regions of the country that face shortages.

[8] http:/www.theaidsinstitute.org
[9] http://www.nachc.com/

Indian Health Service

The President's FY2009 budget request for the Indian Health Service (IHS) is $4.26 billion, a decrease of $21 million below the FY2008 enacted level. This is a proposed 0.5 percent cut from the FY2008 enacted level.

The President's FY2009 budget proposes to increase funding for staffing and operating costs for new and expanded facilities by $25 million, the Indian Health Care Improvement Fund by $10 million. The greatest part of these increases would be realized for hospitals and health clinics with an increase of $37.92 million, or 2.6 percent increase.

The budget proposes to decrease funding for some programs below FY2008, including alcohol and substance abuse by $11.25 million, a decrease of 6.5 percent; Indian health professions by $14.43 million, a 39.7 percent decrease; and healthcare facilities construction by $20.78 million, a 56.8 percent decrease.

The budget would, for the third time, seek to eliminate funding for the urban health programs that ensures availability of or access to a comprehensive program of healthcare services for American Indians/Alaska Natives who reside in 41 cities. According to the National Council of Urban Indian Health, "a cut or zeroing out of funding would result in the near certain elimination of over half of the clinics providing services to 150,000 Native Americans annually."[10]

National Institutes of Health

The FY2009 budget request for the National Institutes of Health (NIH) is $29.5 billion, the same level as FY2008.

The Administration's FY2009 request for NIH funding provides no increase in the overall resources for the Agency and will not cover the cost of biomedical research inflation. This constitutes a cut in the actual level of resources NIH will be able to put forward to perform its public health mission. According to the Infectious Diseases Society of America (IDSA), "since 2004, NIH has lost ten percent of its purchasing power due to the rate of biomedical research inflation and stagnating annual budgets."[11]

The actual level of direct NIH activity is also significantly reduced by the fact that NIH provides a significant amount of resources to other Public Health Service agencies in the form of "planning and evaluation taps." While the FY2009 budget includes small increases for the NIH Institutes and Centers, these increases fail to reach the authorized funding level of $32.8 billion for FY2008 provided in the National Institutes of Health Reform Act of 2006.

[10] http://www.ncuih.org/
[11] http://www.idsociety.org/

The FY2009 budget for the NIH includes a decrease in research project grants of $19 million, including a $14 million decrease in new/competing grants. Funding is not included in the NIH budget for the National Children's Study. The Administration fails to fund this study in the NIH budget request despite acknowledging that the study will be "one of the richest information resources available for answering questions related to children's health and development and will form the basis of child health guidance, interventions, and policy for generations to come."[12]

Substance Abuse and Mental Health Services Administration

The FY2009 budget requests $3.2 billion for the Substance Abuse and Mental Health Services Administration (SAMHSA), a decrease of $198 million from the enacted FY2008 level. It is a cut of 5.9 percent from the FY2008 enacted level.

According to SAMHSA's National Survey on Drug Use and Health, "in 2005, over 22 million Americans, aged 12 or older, were classified with substance abuse or dependence; nearly 25 million adults, aged 18 or older, were living with a serious mental condition. The economic costs of undiagnosed and untreated mental and substance use disorders are staggering."[13] SAMHSA also provides important services for Iraq war veterans suffering post-traumatic stress and other disorders.

In spite of this acknowledgement, the President's FY2009 budget requests a substantial cut in resources for SAMHSA. The FY2009 budget decreases substance abuse treatment and prevention programs of regional and national significance by $99 million. This decrease includes the elimination of programs that target underage drinking, pregnant and postpartum women, and children and families. The FY2009 budget includes a decrease of $144 million for mental health programs of regional and national significance. This includes substantial decreases in youth violence prevention, youth suicide prevention, and trauma-informed services. This decrease includes the elimination of programs for older adults, and adolescents at risk.

Quotes from Statements by Various Public Health Advocates Regarding the FY2009 Budget for Public Health Programs

***Alliance for a Stronger* FDA**, *"Administration Request for FDA fails to meet U.S./Global Needs," February 4, 2008*[14]

> "Three independent reviews, including the FDA's own Science Board, have determined the FDA is in critical need of significant new resources," said Alliance spokesperson William Hubbard, a former Deputy Commissioner at FDA. "The amount in the Administration's proposed budget is not only inadequate, it is barely half of what FDA needs just to keep pace with inflation."

[12] http://www.nationalchildrensstudy.gov/about/mission/overview.cfm
[13] http://www.samhsa.gov/About/background.aspx
[14] http://www.strengthenfda.org/documents/admin_request_fails.doc

"The FDA's ability to fulfill its mission could be in serious jeopardy if additional increases aren't enacted. This proposed budget would likely force the agency into further staff decreases, at a time when it is urgent to increase staff," Hubbard said.

"FDA can't improve its science, prepare for the future, or protect American consumers without significant additional resources," said Don Kennedy, PhD, former FDA commissioner and editor-in-chief of *Science*. "The Administration and Congress are starting now on the FDA's FY 2009 budget and must fix this critical problem."

Coalition for Health Funding, "Last Bush Budget Slashes Public Health Programs by $1.6 billion," February 4, 2008

"The Coalition for Health Funding (CHF) is profoundly concerned at the depth and breadth of President's Bush's proposed cuts in his last budget request to Congress for public health programs aimed at preventing disease, promoting health, supporting the disabled, and providing safety net access to a range of health and behavioral health services for millions of Americans who lack health insurance. The Administration's FY 2009 budget is more of the same: a continued pattern of eliminating, seriously cutting, or flat-funding critical public health programs. CHF calls on Congress to reject the Administration's budget and pledge to work with the coalition to provide meaningful investments in discretionary health funding for prevention, services and supports, and research."

"In particular, the Administration would egregiously cut funding at the Health Resources and Services Administration by nearly $1 billion, including a 68 percent cut for health professions training as we face serious shortages across the board in health and public health professionals; total elimination of the graduate medical education program for pediatricians; near elimination of rural health programs; and complete elimination of several smaller, targeted programs such as Children's EMS, traumatic brain injury and newborn screening."

"In response to the President's FY 2009 budget request, Julio Abreu, President of the Coalition for Health Funding stated, "President Bush's last budget could have been an opportunity to make a meaningful investment in the health of all Americans. Instead, this budget leaves a lasting legacy of failure to meet the public health challenges facing us now and into the future. It is not only deeply disappointing, but harmful."

March of Dimes, "Giving Every Child a Healthy Start," February 4, 2008[15]

"The President's proposed budget is a backward step from the universal goal that every child has a healthy start in life. To advance this goal we need a sustained investment in public health programs and expansion of access to health care services for women, infants and children. The funding levels and programmatic proposals will translate into even more families suffering in anguish when their children are not able to receive essential, appropriate, quality care."

"The proposed funding levels for our nation's health agencies are inadequate to meet the medical problems confronting our children, such as preterm birth, birth defects and infant mortality. The

[15] http://www.marchofdimes.com/aboutus/22684_28697.asp

National Institutes of Health (NIH), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA) and Health Resources and Services Administration (HRSA) ability to support research, surveillance, oversight and prevention activities to improve the health of vulnerable populations would be severely constrained at the proposed funding levels."

NARAL Pro-Choice America, "Why is America Ready for Change?", February 4, 2008[16]

"Bush's misguided budget proposals just reinforce why Americans are universally calling for change," Nancy Keenan, president of Pro-Choice America said. "If there is a silver lining to the Bush budget, however, it's that it is his last one. President Bush once again puts a rigid ideological agenda first and rejects commonsense ways to help address our country's greatest challenges."

"Throughout the president's budget, he slashes funding for many health programs, and eliminates some altogether - such as the Prevention Block Grant and Health Professions programs."

"The president recommends a devastating cut of more than 25 percent to the USAID family-planning program. If the president were truly interested in reducing the need for abortion, as he claims, he would hardly be cutting funds for contraception."

"Under new leadership, Congress made progress last year, so I am confident that lawmakers will stand up to the president once again," Keenan said. "Even though many Americans want to close the book on this disastrous administration, this budget illustrates how, if left unchecked, President Bush can use the government's resources to undermine women's freedom and privacy and hand out favors to his far-right political base."

HIV Medicine Association, "2009 Bush Budget a Disaster for HIV/AIDS," February 3, 2008[17]

"The President's proposed budget for fiscal year 2009, if enacted, would spell disaster for the nation's health, and by extension, our national effort to respond to the HIV/AIDS epidemic in the United States."

"The Administration's budget flat-funds critical federal support for research at the National Institutes of Health (NIH), public health programs at the Centers for Disease Control and Prevention (CDC), and vital health care safety net programs funded through the Health Resources and Services Administration (HRSA) and the Medicaid program. After accounting for inflation, the budget proposal amounts to a cut in funding for HIV/AIDS research, prevention, care, and treatment."

"Adding insult to injury, the budget proposal increases funding for abstinence education programs that have no basis in scientific evidence, an irresponsible policy with potentially deadly consequences. Failure to adequately support evidence-based prevention programs diminishes our capacity to monitor the epidemic, to expand HIV screening to identify those who are already

[16] http://www.prochoiceamerica.org/news/press-releases/2008/pr02042008bushbudget.html

[17] http://www.hivma.org/Content.aspx?id=9740

infected but unaware of their status, and to prevent new infections through targeted programs directed to high-risk populations."

National Association of Community Health Centers, February 4, 2008[18]

"Regrettably, while the President's budget proposes to slightly expand the Health Centers program, his budget makes harmful cuts to vital programs and services, including substantial cuts to Medicaid and Medicare, that threaten to deeply undermine the significant progress made by health centers and others to improve access to care available for the nation's medically underserved. His budget shortchanges the public health of the nation by calling for steep cuts in several key federal health agencies, including the Health Resources and Services Administration, the Centers for Disease Prevention and Control, and the Substance Abuse and Mental Health Services Administration."

"At a time when the need for affordable, accessible, high-quality primary care across this country is extraordinary, the President's budget sends the wrong message. As our recent report with the Robert Graham Center found, 56 million Americans – nearly one in five – lack access to basic medical care because they do not have ready access to a source of primary health care. While they come from all income levels, racial backgrounds and ethnic groups, and with many having insurance, the toll of their unmet health care needs is steep: poorer health, higher disease rates and premature death."

Infectious Disease Society of America, "President's FY 2009 Budget Will Leave Many Infectious Diseases Programs in Shock"[19]

"The Infectious Diseases Society of America (IDSA) is deeply dismayed by the funding cuts proposed for leading federal health agencies in President Bush's fiscal year (FY) 2009 budget. Warning that the nation's ability to prevent, diagnose, and treat an ever-increasing number of infectious diseases threats will be severely diminished should the President's budget go into effect, the Society is calling upon Congress to reject the President's proposal and start from scratch to craft a budget that instead strengthens funding for U.S. and global infectious diseases research and public health activities."

"The President's proposal will move the nation backward in its battle to reduce the toll of many preventable and treatable infectious diseases that claim a disproportionate share of lives around the world" said Donald Poretz, MD, IDSA's president."

[18] http://www.nachc.com/pressrelease-detail.cfm?pressreleaseID=224

[19] http://www.idsociety.org/Content.aspx?id=9772

ENERGY

Climate Change

The Department of Energy (DOE) plays a lead role in the Administration's strategy for responding to the threat of climate change through development of low-carbon energy technologies. Effectively all of the research work the Department is performing can in some manner be linked to the climate change objective of reducing carbon emissions from clean energy production and use. There appears to be a disconnect, however, between the urgency of the need to begin to respond to climate change by reducing greenhouse gas emissions and the long-term horizon that applies to the energy technologies that are most fully funded. The shorter-term options of energy efficiency and renewable energy are relatively disfavored, and the only major program that directly achieves energy savings, the Weatherization Assistance Program, would be eliminated altogether.

The other stated element of DOE's role in climate change policy is as the lead agency in the Asia-Pacific Partnership on Clean Development and Climate, which attempts to broaden to an international base of concerned nations the effort to commercialize and deploy low-carbon energy technologies. While this effort may yield some positive results, it is no substitute for real engagement in full international negotiations.

Nuclear Power Programs

Counted within DOE's climate change programs are the Nuclear Hydrogen Initiative and other programs to maintain and expand nuclear capacity in the United States. The Advanced Fuel Cycle Initiative (requesting $302 million) is a part of the Global Nuclear Energy Partnership (GNEP), and the Nuclear Power 2010 program (requesting $241 million) focuses on domestic nuclear plant development and licensing to encourage a renaissance of domestic nuclear power generation. The Office of Nuclear Energy in total would receive a 35 percent budget increase from $1.03 billion to $1.42 billion.

Separately, the Administration proposes to spend $495 million in FY2009 to move forward with disposing of the civilian nuclear waste from nuclear power generation and defense activities, primarily in developing and licensing the proposed Yucca Mountain, Nevada, storage facility. This is an increase of $50 million from the Department's budget request last year of $445 million, of which only $386 million was appropriated in FY2008. DOE maintains its stated intent of filing for a license for the Yucca Mountain repository in 2008, pursuant to its authority under the Nuclear Waste Policy Act of 1982. Although not directly budgeted as a part of nuclear power development, a successful response to the issues of long-term storage or disposal of high-level nuclear waste is critical to retaining the option for nuclear energy to be part of the U.S. energy portfolio. The Committee continues to have serious doubts about the amount of funding requested for GNEP, and particularly about the potential for this ill-defined project to detract from the Department's focus on the nuclear waste repository program at Yucca Mountain.

Clean Coal Programs

Also included within the Administration's climate change response policies are various clean coal programs, promoting advanced generation coupled with carbon capture and storage. The requested funding for the coal-related research and development, $624 million, reflects a 26 percent increase over the FY2008 appropriation, and constitutes the largest part of the $754 million budget of the Office of Fossil Energy.

The major change for 2009 is the very recent proposed restructuring of the FutureGen project, a demonstration IGCC powerplant tentatively sited at Mattoon, Illinois. DOE proposes to fund instead a number of carbon-capture and storage projects in various locations, each capable of storing at least one million metric tons of carbon dioxide per year, that will be put out for bids later this year. This may diversify the carbon-capture and storage aspects of the technology; however, it remains to be seen whether the new approach could also delay meaningful results. The key question is not whether multiple projects will constitute a more diverse and useful research portfolio than one FutureGen plant, but rather why that question required five years to be asked and answered. If a multiple-project research program is so clearly superior that it warrants terminating the FutureGen project on the verge of a final siting commitment in 2008, why was it not also superior in 2003 when the decision to commit to the FutureGen project was first announced?

Efficiency Programs

Energy experts generally agree that improved energy efficiency offers the lowest-cost, shortest-term, and best-proven means of reducing greenhouse gas emissions. By contrast to nuclear and coal, however, the funding for energy efficiency programs are significantly decreased in the proposed budget.

DOE's largest and most effective program for engineering meaningful savings of energy has been the Weatherization Assistance Program, which supports upgrading low-income housing to be more efficiently heated and cooled. The Administration proposes to eliminate this program entirely from a 2008 appropriation of $227 million. The rationale offered is that its "payback" is not as great as would be achieved with the same investment in the research and development programs run within the Office of Energy Efficiency and Renewable Energy. This is an apples-and-oranges comparison that ignores the facts that (1) weatherization relies on proven technologies with proven cost-effectiveness and incurs no risk of failing to return an investment, unlike DOE's high-risk research and development (R&D) programs and (2) the program is clearly intended both to save significant quantities of high-priced energy and to have a social benefit for low-income citizens who are particularly exposed to high heating costs and the high costs of retrofitting inefficient buildings, also unlike R&D programs. R&D programs may, if successful, benefit the general public, but certainly tend to benefit those industries that incorporate the Federally-sponsored technical advances into their products to become more competitive and attractive to their customers. These industries, in turn, tend to advocate for such R&D programs. Weatherization programs, on the other hand, support a significant number of

relatively low-skilled jobs while preserving disposable income for the low-income recipients of the weatherization services, adding to their value during a period of economic slowdown. Thus the Administration's decision to cut back on efficiency programs and to "zero-out" the Weatherization Assistance Program not only cuts out the only program offering any short-term mitigation of climate change, but does so at a time when the economic benefits offered are particularly valuable.

Other efficiency programs survived, but only the Buildings Technology program was deemed worthy of an increase in budget, to $124 million (13.5 percent). This is appropriate, as the stock of existing buildings in the United States is woefully inefficient in general, and an unfortunately large number of new buildings are added to that stock without highly cost-effective efficiency measures. Even better efficiency materials and practices for buildings may overcome the market inertia. But there is at least some irony in increasing the budget for improving the energy performance of future buildings while cutting out entirely the only major program for improving the energy performance of the worst of our existing stock of buildings, the Weatherization Assistance Program.

The Vehicle Technologies program obtained a nominal 3.8 percent increase of $8 million to $221 million, but that includes a transfer from the hydrogen program of $32 million, without which a $24 million cut would have been incurred. As an example of the failure of the budget to reflect the passage of the Energy Independence and Security Act of 2007, there is no proposal for funding the Advanced Technology Vehicles Manufacturing Incentive Program adopted in Section 136 of that act. Yet such support for developing advanced technology vehicles could go far not only to achieving greater energy efficiency in the key transportation sector, with the most direct positive implications for reducing dependence on insecure sources of oil imports, but also to maintain a key sector of the U.S. economy. Similarly, the Industrial Technologies program experienced a 4 percent cut in proposed funding, notwithstanding widespread awareness that industrial use of energy could be much more efficient and that the Federal programs to propagate the awareness and methods of doing so have been effective. In total, energy efficiency programs are budgeted at $428 million, a decrease of 38 percent from 2008 appropriations levels.

Renewable Energy

Among the areas of renewable energy, a number are proposed for significant increases in funding, and a number for significant decreases. Among those receiving substantially greater funding:

- Biomass and biorefinery systems R&D, proposed to increase by $26.8 million (or 13 percent) to $225 million;

- Geothermal energy (proposed in FY2007 to be eliminated), increased by $10.2 million to $30 million (a 51 percent increase); and

- Program direction and support (including administration of efficiency standards) would increase 23 percent from $115 million to $142 million.

Among those receiving substantially lower funding:

- Hydrogen Technology, proposed to reduce by $65 million to $146 million from $211 million; half of the reduction reflects a budgetary transfer to the vehicle budgetary program, and half a rationalization of timing between hydrogen production and hydrogen utilization program targets;

- Solar Energy, proposed to reduce 7.3 percent from $168.5 million to $156.1 million; and

- Water Power, proposed to decrease 70 percent from $9.9 million to $3 million.

Also, Congressional-directed projects have been eliminated from the budget proposal, for a proposed reduction of $186 million.

To the extent the funding sought for various renewable energy sources or energy efficiency opportunities are linked to the size, timing, or cost of the energy opportunity implicit in those sources, there is nothing in the budget documents that sheds light on the connections or the rationale. As proposed by the Administration's budget, a number of renewable and efficiency energy sources are effectively expected to carry their own weight in terms of research, development, and demonstration, while the nuclear and coal industries, and to some extent the biomass industry, are able to count heavily on Federal funding to support their own competitive entries in the market for future low-carbon energy. For that matter, the research budgets for work on oil and natural gas production opportunities are proposed to be "zeroed out" from the Office of Fossil Fuels budget. Overall, the budget proposal lacks a reasoned explanation for the relative weights of Federal expenditures committed on the basis of the ultimate contributions that might be expected from various sources.

ENVIRONMENT

Environmental Protection Agency

The Environmental Protection Agency's (EPA) FY2009 budget request of $7.14 billion represents a $56 million dollar decrease from the FY2008 budget request of $7.19 billion and a more than $320 million decrease from FY2008 enacted levels $7.46 billion. Since FY2004, the President's budget requests for the EPA have decreased by an amount exceeding $480 million. A 5 year look-back shows the enacted levels have fallen from $8.365 billion in FY2004 to $7.461 billion in FY08 – a decrease of more than $900 million.

Overall, the President's budget for FY2009 devotes less than 1 percent of the total discretionary budget for all Federal agencies to EPA.

Leaking Underground Storage Tanks

The Energy Policy Act of 2005 included a major increase in the authorization for the Leaking Underground Storage Tank (LUST) program to $605 million for FY2009, including $400 million from the LUST trust fund for clean up of petroleum spills and leaks of oxygenated fuel additives such as MTBE. The law also continued a 0.1 cent per gallon tax on motor fuels that all motorists in America pay, which will add $200 million to the LUST Trust Fund in FY2009, bringing the total fund surplus to an estimated $3.2 billion. Interest on the Trust Fund is estimated to add an additional $114 million in FY2009.

The President's budget decreased the LUST account by $30 million and shifted some of the funding to a State and Tribal assistance grant account. Overall, the result was a $13 million reduction from the FY2008 enacted levels for cleanup of and leak prevention from underground storage tanks. The President's budget request for FY2009 of $95 million is less than one-third of the annual revenues coming into the LUST Trust Fund from tax receipts and interest. In short, the gasoline taxes paid by consumers are not going for their specified purpose: cleanup of spills and releases that are contaminating water supplies.

In the meantime, there is a backlog of 108,766 cleanups not yet completed, and completed cleanups have declined from 18,518 in FY2003 to a "performance target" of 13,000 in FY2009. A GAO survey of States released in February 2007 shows that it would cost $12 billion in public funds to clean up approximately 54,000 known releases where there is no viable tank owner or operator. The longer this contamination is left unaddressed, the greater the potential for it to spread, further putting human health and the environment at risk and increasing the ultimate cost of the cleanups.

Drinking Water State Revolving Fund Grants

The Drinking Water State Revolving Fund (SRF) is designed to support States in helping public water systems finance the costs of infrastructure improvements needed to achieve or maintain compliance with Safe Drinking Water Act (SDWA) requirements and to protect public health. To reduce occurrences of serious public health threats and to ensure safe drinking water nationwide, EPA is authorized to make capitalization grants to States, so that they can provide low-cost loans and other assistance to eligible public water systems. For fiscal years 2006-2009, appropriated funds are allocated to the States in accordance with each State's proportion of total drinking water infrastructure need as determined by the 2003 Needs Survey and Assessment. According to the 2003 Needs Survey and Assessment, released on June 14, 2005, the total State need, including the District of Columbia and Puerto Rico, is $263.8 billion.

The President's budget request for FY2009 of $842.2 million is the same as the FY2008 request, but down $7.8 million from the FY2002 budget request of $850 million. The 2008 enacted level after the 1.56 percent across-the-board reduction was only $829 million. While

budget requests have been relatively stable over time in nominal dollars, when adjusted for inflation in 2007 dollars, the President's budget request for FY2009 is the lowest in the history of the SRF program. The attached charts prepared by the Congressional Research Service (*see* Attachment 1A) show enacted levels over the history of the program and the President's budget request with adjustments for inflation to 2007 dollars.

Superfund

The Superfund program addresses public health and environmental threats from uncontrolled releases of hazardous substances.

Overall, the FY2009 budget request for Superfund is $1.264 billion or $5 million dollars more than the President's FY2007 budget request of $1.259 billion but $15 million less than the President's FY2006 budget request of $1.279 billion. The President's budget for FY2009, however, seeks a $4.5 million reduction from the FY2008 enacted level of $590.6 million for Superfund remedial activities, the part of the budget that funds actual construction and cleanup at Superfund National Priorities List (NPL) sites.

The reduced budget request for actual cleanups comes at a time when progress in completing construction activities at the Superfund NPL sites has slowed dramatically. The Superfund program averaged 86 construction completions at NPL sites for the 4 years from 1997 to 2000. For each of the 4 years from 2002 to 2006, however, the Superfund program achieved construction completion at exactly 40 sites per year. The President's budget request for FY2007 stated that he EPA "expects to complete cleanups at 40 Superfund sites" and further stated EPA will redirect resources from earlier phase activities toward construction to maintain progress in all Superfund response activities." EPA achieved, however, only 24 construction completions in FY2007, the lowest number in the past 15 years (*see* chart, Attachment 1B).

The Congressional Research Service has prepared the attached charts (*see* Attachment 1C) that demonstrate the loss of purchasing power for the Superfund program when the FY2009 budget request is compared to previous enacted levels after adjustments for inflation.

The President's FY2009 budget request fails to provide any justification for a reduction in the remedial program at a time when the lack of adequate funding is already preventing the start of many new cleanup actions, and forcing ongoing cleanups to be stretched out by years. On December 2, 2004, Assistant Administrator Thomas Dunne, the then-top Superfund program official, commented publicly in a speech at the University of Virginia on the effects of the funding shortfall:

> "For the last three years, we haven't started cleanup at some new sites. If we assume that EPA's budget will remain flat for the foreseeable future, construction funding could be delayed at more and more sites. Within a few years, unfunded cleanup work could total several hundred million dollars."

The goal of the Superfund remedial program, a primary component of the overall program, is to provide long-term human health protection at the Nation's most contaminated hazardous waste sites, those placed on the NPL. With an acknowledged backlog of remedial projects ready to begin construction, the budget requests $586.1 million for Superfund remedial activities, $4.5 million less than the FY2008 enacted level of $590.6 million.

Brownfields

The President's FY2009 budget request of $93.558 million represents an increase of approximately $40,000 from the FY2008 enacted level of $93.518 million for cleanup and assessment grants. The President's FY2009 budget request, however, is $27 million, or 23 percent less than his budget request of $120.5 million for FY2006. When the Small Business Liability Relief and Brownfields Revitalization Act was signed by the President in 2002, he talked about "requesting that Congress double EPA's Brownfield's funding" and described the bill as "a good jobs creation bill." The law provides an authorization of $200 million per year. But the President's budget request for FY2009, which includes a $22.7 million request for administrative costs, reflects just 58 percent of the amount authorized by law for cleanup and assessment grants (Section 104k).

The U.S. Conference of Mayors and the Real Estate Roundtable have for several years informed Congress that "at current funding levels, EPA can only fund about one third of the applicants for Federal Brownfields grants." In FY2007, EPA was able to fund only 294 of 770 eligible project requests in the amount of $70.7 million. EPA has turned away more than 1,200 applicants in the past 3 years.

Environmental Justice

Last year, $7.1 million was appropriated for the EPA Office of Environmental Justice. The President's FY2009 budget requests only $4.6 million for the program, proposing a cut of $2.5 million, or 35 percent, from the FY2008 enacted level.

Minority and low-income populations live in close proximity to industrial zones, power plants, and toxic waste sites. These conditions have serious implications for their health and well being. In Southern California, 50 percent of Latinos and 71 percent of African Americans live in non-attainment areas. In these communities Latinos are nearly 2.5 times more likely to develop asthma than Whites, and African Americans are also more than twice as likely to die from asthma as Whites. Nationally, people of color are three times more likely to be hospitalized or die from asthma and other respiratory illnesses linked to air pollution.

This budget cut will affect the EPA's ability to meet the requirements of Executive Order 12898. The Executive Order was written to address these disparities and ensure that no low-income or minority population is forced to shoulder a disproportionate burden of the negative human health and environmental effects of pollution or other environmental hazard. Unfortunately, this Executive Order has not been fully implemented. In 2004 and 2006, the EPA Office of Inspector General reported that the EPA cannot determine whether its programs cause

disproportionately high and adverse human health or environmental effects on minority and low-income populations. In 2005, the GAO found that the EPA failed to consider the effect of its air regulations on minority and low-income populations.

State and Local Air Quality Management

The President's FY2009 budget request would cut grants for State and local air quality management by more than $30 million, or approximately 15 percent of the amount enacted for FY2008.

State and local governments have primary responsibility for ensuring that areas that meet the health-based standards set by the Federal Government. State and local air programs provide cleaner air, reducing pollution that causes asthma attacks, premature death, and other respiratory and cardio-pulmonary problems. For the key air pollutants, the Federal Government sets the health-based level that is acceptable in outdoor air. States then are charged with developing plans and regulations to bring all areas in the country into compliance with these health-based standards. State and local governments, operating under Environmental Protection Agency guidance, also are responsible for issuing all new source review and other clean air permits for sources under their jurisdiction.

The grants that the President's budget request cuts by 15 percent are a significant source of funding for core State and local air programs. They provide funding that is used to pay State and local employee salaries and other expenses necessary to develop and run State and local air programs, including air permit programs.

Recent EPA actions have increased the workload on State and local air quality agencies. EPA tightened the fine particle standard in September 2006. As a result, States must develop implementation plans and additional local controls to meet this tighter standard. In March, EPA must also make a final decision regarding whether to follow the advice of its Clean Air Science Advisory Committee to tighten the ozone standard, which would increase the work load on States.

EPA has made the States' jobs more difficult because it is failing to meet its obligation to provide timely guidance regarding these State ozone and fine particle plans. States also were put through unnecessary work by EPA's decision to limit mercury emissions from power plants, which was vacated by the Court of Appeals for the District of Columbia Circuit.

EPA cites the great progress that has been made on meeting health-based standards for carbon monoxide (CO) and lead, and thus the resulting reduced workload on States, as justification for the 15 percent cut in State funding. Most of that progress was achieved quite a few years ago, and it is unlikely that States have spent significant time or money on CO or lead standards in the last few years. Thus, EPA has not identified a change in circumstances that would cause a decrease in workload for FY2009. More importantly, the budget justification fails to increase funding for the States' increased workload to meet the PM2.5 and ozone standards.

TELECOMMUNICATIONS

Public Broadcasting

The budget proposes a reduction in funding for public broadcasting. The Corporation for Public Broadcasting (CPB) customarily receives appropriations two years in advance. In 2007, Congress provided CPB with advance appropriations for FY2009 of $400 million. The budget proposes to rescind $200 million of that advance appropriation.

From FY2002 to FY2009, the President's budget has declined to request the traditional two-year advance funding for CPB, and the budget again declines to request the customary two-year advance appropriation for FY2011. The practice of advance appropriations imposes no financial burden on the Treasury but provides certainty for local stations as they develop programming and raise funding from other sources. For FY2011, CPB has requested $483 million. Although more than 80 percent of public broadcasting's annual funding comes from sources other than the Federal Government, stable advance Federal appropriations is the foundation on which local public stations rely. As the GAO found in its report on CPB funding (GAO-07-150), Federal funding maximizes the ability to leverage public dollars for additional sources of support. Advance funding could reduce waste by allowing public broadcasting to establish long-term commitments from other sources based on dedicated funding from the Federal Government. This leveraging could in turn potentially reduce the need for additional Federal funds in future years.

The budget also proposes no additional funding in FY2009 for public television and radio digital conversion or upgrades to the Public Radio Satellite System (although it permits CPB to use a portion of its FY2009 regular appropriation for these purposes). Denying separate additional funds for the digital television conversion is of particular concern given that Congress set a firm date of February 17, 2009, for the end of analog television. Additional funding for the digital television conversion could assist public television in making a smooth transition and continuing its investment in digital content. In addition, upgrades to the Public Radio Satellite System will help maintain the transmission system to more than 800 public radio stations throughout the U.S. and its territories.

Spectrum Matters

The budget proposes for matters relating to the use of the electromagnetic spectrum:

(1) ***Permanent Auction Authority***. -- To extend indefinitely the authority of the Federal Communications Commission (FCC) to auction spectrum licenses, this is currently set to expire in September 2011.
(2) ***Spectrum License User Fee.*** -- To permit the FCC to impose license fees on unauctioned spectrum license holders.

(3) ***Ancillary Terrestrial Component Spectrum License Fee.*** -- To permit the FCC to impose fees on the land-based component of hybrid terrestrial-satellite communications networks such as Mobile Satellite Services.
(4) ***Domestic Satellite Service Spectrum License Auctions***. -- To require the auction of spectrum licenses for predominantly domestic satellite services such as Direct Broadcast Satellite and Satellite Digital Audio Radio Services.

The Committee believes that all telecommunications policy matters, including rules regarding spectrum management, are best determined by the Committee through the normal legislative process. The telecommunications sector presents some of the most complex technical and public policy questions that Congress confronts. Creating sound policy in this area requires a level of expertise that the Committee is best able to provide. The Committee will work to ensure that the United States maintains a comprehensive and forward-looking spectrum management policy that inures to the maximum benefit of the American public.

Telecommunications Development Fund

The budget proposes to terminate the Telecommunications Development Fund (TDF). Having created TDF as part of the Telecommunications Act of 1996, the Committee continues to support the goals underlying the fund. The Committee will continue to monitor the fund to ensure that it continues to fulfill, in a prudent and responsible manner, its mission and goals as mandated by Congress.

Digital Television Transition Outreach

The budget proposes an additional $20 million for the FCC to conduct consumer education about the digital television (DTV) transition. The Committee welcomes the Administration's recognition of the importance of consumer education for the DTV transition. The Committee remains concerned, however, about the sufficiency of the Federal Government's efforts in preparing 300 million consumers for the transition. The Committee recommends that the Administration create an interagency task force to coordinate existing resources and relationships throughout the Federal Government to assist consumer education efforts about the transition. Coordinating these existing relationships through an interagency task force would also maximize government resources in a coherent manner, which could reduce duplicative efforts and thereby reduce waste.

FCC Inspector General

Congress provided that the FCC may transfer $21,480,000 from the Universal Service Fund in FY2009 to the Office of the Inspector General to prevent and remedy waste, fraud, and abuse in the Universal Service Fund program. The budget increases this amount by $4 million. These funds, used appropriately for audits and oversight of the Universal Service Fund, will help identify areas for improvement and reduce waste, fraud, and abuse.

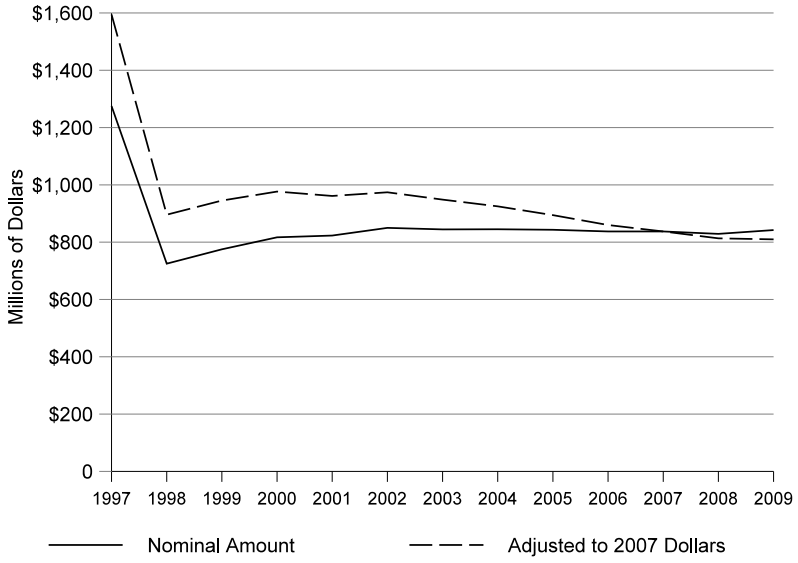
Interoperable Emergency Communications Grant Program

The budget proposes to eliminate the $50 million Congress appropriated last year for the Interoperable Emergency Communications Grant Program. The budget allows recipients to use funds from other grant programs for interoperability projects.

In response to the recommendations of the National Commission on Terrorist Attacks upon the United States (the 9-11 Commission), and in light of repeated instances of first responders being unable to communicate across jurisdictions during emergencies, Congress created a new, independent grant program at the Department of Homeland Security (DHS) to focus solely on achieving interoperability among first responders. Congress placed the grant program under the direction of the Office of Emergency Communications using existing Federal Emergency Management Agency (FEMA) grant processes. Communications interoperability is a longstanding issue that has real world consequences, and lack of it endangers both the lives of first responders and those they have pledged to protect.

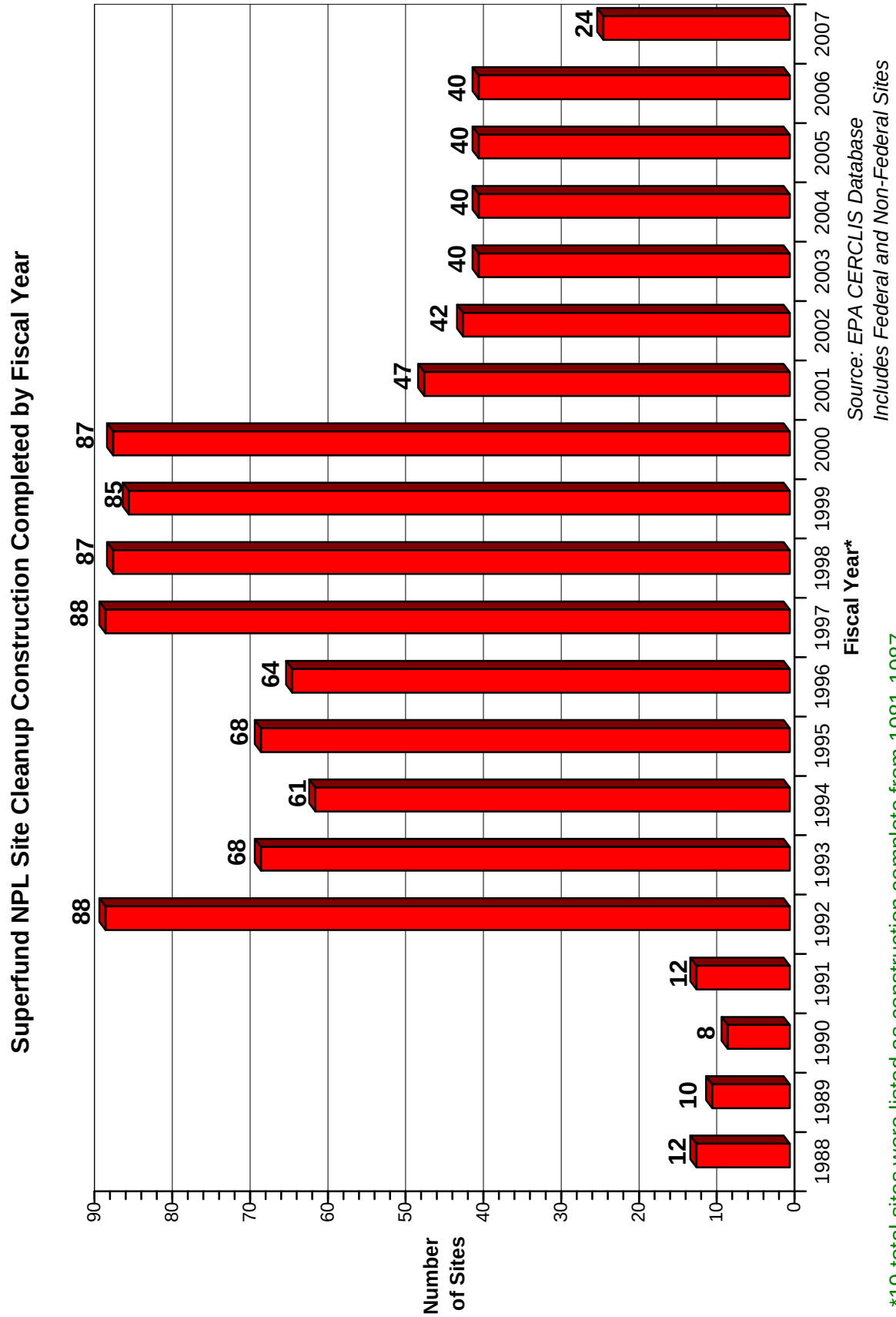
In its review of communications interoperability efforts at DHS (GAO-07-301), GAO found that grant funds expended on communications interoperability failed to use strategic planning to guide the investments. In keeping with GAO's recommendations, Congress established a separate grant program at DHS focused solely on achieving communications interoperability. The grant program requires that funds be used in keeping with statewide plans and the National Emergency Communications Plan. Although the President's budget allows for other DHS grant programs to be used for interoperability efforts, those grant programs do not necessarily require compliance with strategic statewide and national plans. Rescinding funds for the interoperability grant program will most likely result in further wasteful efforts as identified by GAO.

Drinking Water State Revolving Fund (SRF) Program: Appropriations in Nominal Dollars and 2007 Dollars FY1997 — FY2008 Enacted and FY2009 Requested



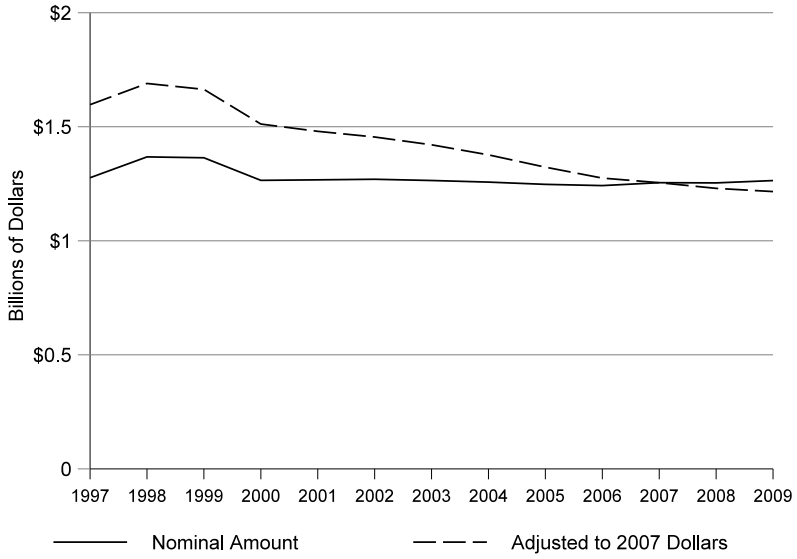
Fiscal Year	(in Millions of Dollars)	
	Enacted Appropriations in Nominal Dollars	Adjusted for Inflation in 2007 Dollars
1997	$1,275.0	$1,594.6
1998	$725.0	$895.9
1999	$775.0	$945.2
2000	$816.9	$976.6
2001	$823.2	$961.4
2002	$850.0	$974.1
2003	$844.5	$948.6
2004	$845.0	$925.1
2005	$843.2	$894.5
2006	$837.5	$859.9
2007	$837.5	$837.5
2008	$829.0	$813.3
2009 Request	$842.2	$809.9

Sources: Prepared by the Congressional Research Service using information from the following sources: FY1997 – FY2000 and FY2002 are line items from the enacted appropriations bills for those fiscal years, adjusted by CRS to reflect a rescission in FY2000. FY2001 is from the prior year enacted amount in EPA's FY2002 congressional budget justification, reflecting rescissions. FY2003 – FY2004 are from EPA's Office of Water, reflecting rescissions. FY2005 – FY2007 are prior year enacted amounts specified in House Appropriations Committee reports on subsequent year appropriations bills, reflecting rescissions. FY2008 enacted amount is as specified in the House Appropriations Committee Print of the Consolidated Appropriations Act for FY2008 (P.L. 110-161), reflecting rescissions. FY2009 request is from EPA's FY2009 congressional budget justification. Enacted amounts and the FY2009 request were converted into 2007 dollar values using the GDP Chained Price Index from the Office of Management and Budget, *Budget of the United States Government Fiscal Year 2009, Historical Tables*.



*19 total sites were listed as construction complete from 1981-1987

Hazardous Substance Superfund Account: Appropriations in Nominal Dollars and 2007 Dollars FY1997 – FY2008 Enacted and FY2009 Requested



Fiscal Year	(in Billions of Dollars) Enacted Appropriations in Nominal Dollars	Adjusted for Inflation in 2007 Dollars
1997	[a] $1.277	$1.597
1998	[a] $1.368	$1.690
1999	[a] $1.364	$1.664
2000	[a] $1.265	$1.512
2001	$1.267	$1.480
2002	[b] $1.270	$1.455
2003	$1.265	$1.421
2004	$1.258	$1.377
2005	$1.247	$1.323
2006	$1.242	$1.275
2007	$1.255	$1.255
2008	$1.254	$1.230
2009 Request	$1.264	$1.216

[a] For comparative purposes, amounts for FY1997 – FY2000 exclude funds for the Agency for Toxic Substances and Disease Registry and the National Institute of Environmental Health Sciences, both of which were funded in separate accounts beginning in FY2001.

[b] For FY2002, Congress provided an additional $41.3 million in supplemental appropriations for the Superfund account to respond to the September 11, 2001, terrorist attacks on the United States, and to support activities related to countering terrorism.

Sources: Prepared by the Congressional Research Service using information from the following sources: FY1997 – FY2007 enacted amounts are prior year amounts as specified in House or Senate Appropriations Committee reports on subsequent year appropriations bills, reflecting applicable rescissions, except for the FY2000 rescission calculated by CRS. FY2008 enacted amount is as specified in the House Appropriations Committee Print of the Consolidated Appropriations Act for FY2008 (P.L. 110-161), reflecting rescissions. FY2009 request is from EPA's FY2009 congressional budget justification. Enacted amounts and the FY2009 request were converted into 2007 dollar values using the GDP Chained Price Index from the Office of Management and Budget, *Budget of the United States Government Fiscal Year 2009, Historical Tables*.