DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2003 BUDGET PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

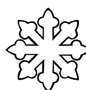
ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, FEBRUARY 28, 2002

Serial No. 107–25

Printed for the use of the Committee on the Budget



Available on the Internet: http://www.access.gpo.gov/congress/house/house04.html

U.S. GOVERNMENT PRINTING OFFICE

78–427 DTP WASHINGTON : 2002

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2250 Mail: Stop SSOP, Washington, DC 20402–0001

COMMITTEE ON THE BUDGET

JIM NUSSLE, Iowa, *Chairman*

JOHN E. SUNUNU, New Hampshire
Vice Chairman
PETER HOEKSTRA, Michigan
Vice Chairman
CHARLES F. BASS, New Hampshire
GIL GUTKNECHT, Minnesota
VAN HILLEARY, Tennessee
MAC THORNBERRY, Texas
JIM RYUN, Kansas
MAC COLLINS, Georgia
ERNIE FLETCHER, Kentucky
GARY G. MILLER, California
PAT TOOMEY, Pennsylvania
WES WATKINS, Oklahoma
DOC HASTINGS, Washington
JOHN T. DOOLITTLE, California
ROB PORTMAN, Ohio
RAY LAHOOD, Illinois
KAY GRANGER, Texas
EDWARD SCHROCK, Virginia
JOHN CULBERSON, Texas
HENRY E. BROWN, Jr., South Carolina
ANDER CRENSHAW, Florida
ADAM PUTNAM, Florida
MARK KIRK, Illinois

JOHN M. SPRATT, Jr., South Carolina,
Ranking Minority Member
JIM MCDERMOTT, Washington
BENNIE G. THOMPSON, Mississippi
KEN BENTSEN, Texas
JIM DAVIS, Florida
EVA M. CLAYTON, North Carolina
DAVID E. PRICE, North Carolina
GERALD D. KLECZKA, Wisconsin
BOB CLEMENT, Tennessee
JAMES P. MORAN, Virginia
DARLENE HOOLEY, Oregon
TAMMY BALDWIN, Wisconsin
CAROLYN MCCARTHY, New York
DENNIS MOORE, Kansas
MICHAEL E. CAPUANO, Massachusetts
MICHAEL M. HONDA, California
JOSEPH M. HOEFFEL III, Pennsylvania
RUSH D. HOLT, New Jersey
JIM MATHESON, Utah

PROFESSIONAL STAFF

RICH MEADE, *Chief of Staff*
THOMAS S. KAHN, *Minority Staff Director and Chief Counsel*

CONTENTS

	Page
Hearing held in Washington, DC, February 28, 2002	1
Statement of:	
Hon. Tommy G. Thompson, Secretary, Department of Health and Human Services	5
Tara O'Toole, M.D., M.P.H., Director, Johns Hopkins Center for Civilian Biodefense Strategies	45
Gail Wilensky, Ph.D., John M. Olin Senior Fellow, Project HOPE	52
Steven M. Lieberman, Executive Associate Director, Congressional Budget Office	58
Prepared statement of:	
Hon. Adam H. Putnam, a Representative in Congress from the State of Florida	4
Secretary Thompson	9
Dr. O'Toole	47
Dr. Wilensky	54
Dan L. Crippen, Director, Congressional Budget Office	61

DEPARTMENT OF HEALTH AND HUMAN SERVICES BUDGET PRIORITIES FOR FISCAL YEAR 2003

THURSDAY, FEBRUARY 28, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, DC.

The committee met, pursuant to call, at 10:01 a.m. in room 210, Cannon House Office Building, Hon. Jim Nussle (chairman of the committee) presiding.

Members present: Representatives Nussle, Hoekstra, Bass, Gutknecht, Ryun, Collins, Fletcher, Watkins, Hastings, Granger, Schrock, Culberson, Brown, Crenshaw, Putnam, Kirk, Spratt, McDermott, Bentsen, Davis, Moran, Baldwin, McCarthy, Moore, Honda, and Holt.

Chairman NUSSLE. Call this hearing to order.

This is the full committee hearing of the Budget Committee of the House of Representatives, Department of Health and Human Services budget priorities for fiscal year 2003. We have two panels today. Our first panel is the Honorable Secretary of Health and Human Services, Tommy Thompson. On panel two, we have Dr. Gail Wilensky, Dr. Tara O'Toole and Dan Crippen from the Congressional Budget Office.

We were just kibitzing a little before the hearing that Health and Human Services and our first witness, the Secretary, had quite a portfolio of activity when he took over last year. Up to September 10, he probably thought that was a big job in and of itself. Certainly, as we all know, a number of agencies of our government, especially Health and Human Services on September 12 picked up a number of new and growing responsibilities. As we talk about the budget and meet today, we meet within that context.

The purpose of this hearing is certainly as the lead agency for addressing bioterrorism, the Department of Health and Human Services plays a crucial role in enhancing homeland security. How the President's budget addresses this issue obviously will be a major focus of this hearing.

In addition, members of this committee I know will want to use this opportunity to examine a number of issues, everything from research to welfare reform. There is probably nobody in the government at any level that has a more stellar track record of success than Secretary Thompson when it comes to welfare reform. Certainly we meet in the context of the President's new initiative in that regard.

Also at issue is access to health care at all levels, as well as Medicare reform which I will report to my colleagues is one of the disappointments I have both within the budget and the foreseeable future. I think it is one of the biggest challenges facing my State of Iowa, now ranked last in reimbursements under Medicare, but not too far behind Wisconsin when it comes to reimbursements. As we discussed last year, this is a challenge that I hoped and still have hope Secretary Thompson and others in the administration will tackle in the very near and hopefully very foreseeable future.

There is no doubt that the world changed on September 11 and that the budget needs to reflect these new priorities. We are pleased you are here today to discuss these new, growing and expanding priorities within the President's budget request and we look forward to your testimony.

With that, I will turn to Mr. Spratt for any comments he wishes to make before we hear from our witnesses.

Mr. SPRATT. Thank you, Mr. Chairman.

Mr. Secretary, as I said earlier, I was reminded last night in looking over the briefing book for this hearing how big your portfolio is. I am sure when you were vetted for this job, you didn't even talk about bioterrorism and homeland security. It is a whole new category of responsibility, but you bring an experienced hand to the helm and we are glad to have you there.

You have a tough budget this year. It looks like you get more money, but in truth, certain things get more and some things get less. We have some new video equipment here and I have a simple bar graph which illustrates what I am talking about because we would like to focus on this today, who are the winners and losers in your budget.

As you can see, you get an increase of $2.4 billion, but when you look at it in further detail, I think the other increases in individual programs are $5 billion, one big one for NIH again. As a consequence, about $1.3 billion has to be cut out of other programs in order to accommodate the bioterrorism and NIH in your budget. From the get-go, you have problems. You do not have enough to go around and everything you supervise obviously deserves more support than it is getting.

There is also a matter of concern to us concerning Medicare, a big part of your portfolio. There is a serious discrepancy between what you estimate the baseline cost of Medicare to be, before any new policy has been applied. You are assuming that the cost growth in Medicare will be about 5.7 percent annual average over the next 10 years. CBO is about 7.5 or 7.6 percent. That is a big difference compared to CBO, but your numbers are optimistic compared to the last 10 years where we have had growth much closer to what CBO is assuming. If you are wrong, there is a difference here of 200 to $300 billion, $304 billion in this bar graph. I understand you closed the gap somewhat between you and CBO, but there is still a big difference.

We are looking at a budget where the surplus has gone from $5.6 trillion down to $1.6 trillion and if the Bush budget is fully implemented, it is $.6 trillion. That $600 billion remaining unified surplus would be cut in half if CBO is right and you are wrong. That

is why we had to be concerned about it. There is not much forgiveness left in the budget.

There is also no provision in your budget for providing payment adjustments even though MedPAC has recommended a series of them. Mr. Thomas wrote you a letter about 3 weeks ago. I would like to repeat the last paragraph because we would like your responses to the extent you are ready to provide them.

Mr. Thomas concludes his letter about the administration's Medicare budget and about the provisions it does not make for provider payment adjustments as recommended by the MedPAC Commission and he ends with these questions which he put to you in the letter dated February 8. "Does the administration believe Congress should address any of the problems identified by the MedPAC list, and he attaches the list, that comes to $174 billion over 10 years, with respect to hospitals, home health agencies, physicians, skilled nursing facilities and dialysis facilities? Please identify which provider problems you believe merit congressional action and which do not. Since the budget calls for budget mutual payment adjustment, if we made any of these allowances or restorations we would have to offset them with some equal cut somewhere else. Please provide a specific list of Medicare savings recommendations which can finance appropriate provider payment charges." I would like to lay those questions on the table and ask you to answer them to the extent you can.

Finally, one of the biggest bones of contention and one of the biggest debates in Congress this year and the coming years until it is accomplished will be Medicare prescription drugs. The administration is proposing a $190 billion plan, of which about $77 billion would be available fairly soon for the low income benefit, and then we would see following it the addition of some other kind of broader based benefit for which you are allocating about $116 billion. There is no detail provided. We would like the detail to the extent you can provide it for what you have in mind.

Secondly, usually when the administration makes this recommendation with regard to prescription drugs, it does so in the context of Medicare reform and always refers to Medicare reform. Are the two coupled? Can we have one without the other in the administration's view? If not, what is Medicare reform? Broadly speaking, what do you have in mind with respect to Medicare reform? Is it going to constitute savings that will offset some of the gross costs so that the $190 billion is a net number, that plus and minuses will add up to $190 billion? We are a little puzzled as to what that proposal is and we would like your clarification of that.

Once again, thank you for coming. We look forward to your testimony.

Chairman NUSSLE. I have one announcement to make just for the members' information. A GAO report just came out that this committee requested. I believe it came out within the last couple of days on Medicare provider communications and the need for improvement. It is a document that this committee requested based on hearings we have held in the past.

One of the statements in the report confirmed what we had been hearing from physicians for quite some time that it is becoming increasingly difficult for physicians and others to participate in the

Medicare Program because they are getting inaccurate, out of date and sometimes difficult to use or just plain incomplete information.

The House passed unanimously a bill that our colleague Mr. McDermott, myself, and others worked on for Medicare regulatory relief and reform that we passed unanimously in a bipartisan way. We hope the Senate will act on that but it is in some respect reacting to this report. That may be another thing we could address today as well.

With that, without objection, members will have 7 days to submit written statements for the record. Your statement in full will be in the record and you may summarize as you see fit. Welcome to the committee.

[Prepared statement of Mr. Putnam follows:]

PREPARED STATEMENT OF HON. ADAM H. PUTNAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Thank you Mr. Chairman for giving me this opportunity and thank you Secretary Thompson for appearing here today before the House Budget Committee. As we continue to wage a global war on terrorism, it is impossible to overlook the role your department has played and will continue to play in the creation of a homeland security infrastructure. Over the past months it has become apparent that the Department of Health and Human Services (HHS) is vital to ensure the safety and well being of all Americans.

State and Local governments bear much of the initial burden and responsibility for providing an effective response by medical and public health professionals to a terrorist attack on the civilian population. If the disease outbreak reaches any significant magnitude, however, local resources will be overwhelmed and the Federal Government will be required to provide protective and responsive measures for the affected populations. I am encouraged to know that HHS is working on a number of fronts to assist our partners at the State and local level, including local hospitals and medical practitioners, to deal with the effects of biological, chemical, and other terrorist attacks.

In October 2001 Secretary Thompson testified before the House Government Reform Subcommittee on National Security, Veterans Affairs and International Relations. At that hearing, Civilian Preparedness for Biological Warfare and Terrorism: HHS Readiness and Role in Vaccine Research and Development, the Secretary described the Office of Emergency Preparedness. Through the OEP, HHS has created several programs that will work to protect the health of Americans in this time of ever-present threats. I am interested to hear what Secretary Thompson's goals are for these programs for fiscal year 2003 and how the Budget Committee can help him realize these goals in an effort to continue the excellent work of HHS.

At that earlier hearing on Biological Warfare Defense, we raised the need for greater communication and coordination between HHS' Food and Drug Administration and the U.S. Department of Agriculture's (USDA) Food Safety Inspection Service, which hold joint jurisdiction in the protection of our food safety. I want to strongly encourage collaborative actions between the two agencies, particularly in the coordination of inspection responsibilities and the sharing of information.

I understand that efforts have begun to streamline and consolidate inspection capabilities between FDA and FSIS. Currently, one agency's inspectors may be present at a site and the other agency may lack the resources to provide inspection services. Through cross-deputation of agency inspectors, we may improve our inspection capabilities and optimize staff resources. Similarly, disparities and overlap between agency responsibilities to inspect food products should also be reviewed. I wish to encourage concerted and continued efforts between Federal and State agencies with the goal of providing more comprehensive and efficient safeguarding of our Nation's food supply.

Thank you and I look forward to working with you toward this end.

QUESTIONS

1. How will fiscal year 2003 funding levels assist you and HHS in upgrading the surveillance, risk assessment, and response capacity of the public health system?

2. What are HHS's priorities and what specific investments in infrastructure to improve responses to specific priority needs are currently being reviewed?

3. Please elaborate on the goals and funding needs you have for the programs designed to assist in prevention and treatment should our Nation come under a biological attack. Specifically, explain programs such as Metropolitan Medical Response Systems (MMRS), National Disaster Medical System (NDMS), pharmaceutical stockpiles, and vaccine development.

4. I represent a somewhat rural district in the heart of Central Florida. My question then is what method does HHS utilize to determine its resource allocation levels to particular State and local health departments and hospitals for better surveillance, prevention, and control of microbial resistance? How can I be assured that the local health departments and hospitals are receiving appropriate attention even though my district is not as populated as surrounding areas?

5. In HHS's strategic plan you outline various ways to improve the safety of food, drugs, medical devices, and biological products. What specifically is HHS doing to expand and provide technical assistance to the food borne diseases surveillance network (FoodNet). How is it increasing its capacity to identify sources of food borne pathogens?

6. What is HHS doing to streamline and coordinate overlapping inspection capabilities with the FDA?

7. What is the statutory responsibility of HHS to inspect food operations overseas? I understand that that there are discrepancies between USDA and FDA. Please explain.

8. Could you please explain and elaborate on the proposed establishment of a national partnership with the Department of Defense, the Veterans Administration, State health agencies, hospitals, and health care organizations, to develop and disseminate information on the best ways of preventing medical errors. What specific improvements do you see as a result of this program?

9. In fiscal year 2000 strategic plan for HHS one of the main objectives was to encourage the collaboration and coordination with other Federal agencies on common issues and challenges, including: coordination with the Social Security Administration on the Medicare and Medicaid programs. How would you say that effort is progressing today? What specific measures have or do you intend to implement?

10. In fiscal year 2000 there were roughly 900 annual performance goals and many more measures and targets under those goals that were identified as a means of directing annual efforts and determining the progress toward strategic goals. These annual performance goals and measures assess the processes, outputs, or outcomes and results of the programs. Please comment on the current status of fiscal year 2003 performance goals.

11. Since this is only the fifth year of GPRA performance reporting, indicators of program success are still evolving and issues of availability and reliability of performance data are still being addressed by many programs. What real changes have occurred and can you identify any specific instances in which GPRA was the precipitating factor?

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

Secretary THOMPSON. Thank you, Chairman Nussle and good morning to all the members.

Let me first thank you for the leadership of this committee and your long-time advocacy of both fiscal responsibility and prudent public investments.

Congressman Spratt, thank you for all you have done to ensure the fiscal viability of our Nation's Federal budget.

I am very honored today to appear before all of you on this committee to discuss the President's fiscal year 2003 budget for the Department of Health and Human Services. The President's budget is responsible, it is creative and it is effective. I look forward to outlining it for you and some of the key priorities that he has set for America's health care agenda.

As you all know, since the September 11 attack, we have dedicated many of our efforts to ensuring that the Nation is safe. While we responded quickly to the September 11 attack on New York City and the Pentagon, employing medical assistance and support

within hours of the attack, the task of providing health-related assistance reminded us again that there is always room for improvement. It is to that end that our budget furthers the work of preparing America for bioterrorism by calling for $4.3 billion, an increase of 45 percent over the current fiscal year. This will support a variety of critical activities to prevent, to identify and respond to incidents of bioterrorism.

Of this $4.3 billion, $1.1 billion is going directly to the States to help them strengthen their ability to respond to bioterrorism and other public health emergencies in creating a strong, vibrant, creative public health system. It will enable States to begin planning and preparing their public health systems to respond even more effectively to terrorist attacks. We are building up our national pharmaceutical stockpile, increasing assistance to State and local governments, and doing more to protect America's food supply.

Our budget promotes vital scientific research, dramatically increases funding for the National Institutes of Health, and supports childhood development while delivering a responsible approach for managing HHS resources. It is a budget that touches the life of every American in a positive way.

The total HHS request, as indicated by Mr. Spratt, for fiscal year 2003 is $489 billion in outlays. This is an increase of almost $30 billion or 6.3 percent over the comparable fiscal year 2002 budget. The discretionary component of the HHS budget totals $64 billion and an increase of $2.4 billion or 3.9 percent.

Let me spend a few moments on an issue that has been a passion of mine for many years, welfare reform. On Tuesday, I was with President Bush when he unveiled our new welfare plan. I know we all share the President's vision of helping even more Americans regain hope and dignity through employment and training. The recent past gives us great reason for realistic optimism. Since 1996, welfare reform has exceeded expectations, resulting in millions of Americans being moved from dependence on AFDC to the independence of work. Nearly 7-million fewer Americans are on welfare today than in 1996 and 2.8 million fewer children are in poverty because of welfare reform. The President's budget boldly takes the new step which requires us to work closely with States to help those families that have left welfare to climb up the career ladder and become more secure in the work force. The foundation of welfare reform success remains work, for work is the only way to climb out of poverty and become independent.

The President's budget allocates $16.5 billion for block grant funding, provides supplemental grants to address historical disparities in welfare spending among States, and strengthens work participation requirements. The budget provides another $350 million in Medicaid benefits for those in the transition from welfare to work to make sure they continue with their health coverage. We are calling for a continued commitment to child care, including $2.7 billion for entitlement child care funding and $2.1 billion for discretionary funding.

We are going to require States, however, to engage everyone in the TANF Program and work on work preparation activities. States will have to develop and implement self sufficiency plans for every family and regularly review the progress each family is making.

That is not only reasonable, but also essential to the continued movement of people from welfare to permanent gainful employment. While the $16.5 billion represents level funding for TANF, it provides the funds necessary that States can spend on helping workers remain in the work force. That is where the State flexibility comes in.

Just as we reach out to those still relying on welfare, we also cannot ignore the roughly 40 million Americans who lack health insurance. That is simply too many in a nation as compassionate and well off as ours.

During the first year of the Bush administration, we have made great strides in extending access to health care to Americans. As part of our efforts, we have had extensive meetings with the Nation's governors to find out how we can best help them address the needs of their States. Working in tandem with them and Members in Congress, here is what we are doing.

Since January 2001, we have approved State plan amendments and Medicaid and SCHIP waivers that have expanded the opportunity for health coverage to 1.8 million Americans and have improved the existing benefits for 4.5 million individuals. In addition, we are strengthening the Nation's community health centers which provide family oriented preventive and primary health care to over 11 million patients annually, regardless of their ability to pay.

Currently there are more than 3,300 community health center sites nationwide. The 2003 budget seeks $1.5 billion to support the President's plan to impact 1,200 communities with new or expanded health centers by 2006. This is going to be a $114-million increase over fiscal year 2002 and will support 170 new and expanded health centers. Forty-seven percent of those will be in rural areas. Also, the President has proposed providing $89 billion in new health credits to low income individuals to acquire health insurance.

Modernizing Medicare is another key component of our across-the-board effort to broaden and strengthen our country's health care system. Since becoming Secretary, I have begun to modernize the very structure of the centers for Medicare and Medicaid services. Mr. Chairman, I know you are deeply concerned about the effectiveness of CMS and I share a commitment to making sure that CMS is responsive to beneficiaries.

We instituted a proposal when I started at HHS. It took 80 days when I came to get a response to Congress. The first half of last year, we got it down to 32 days; the second half down to 20 days and it is my goal, and I can assure you next year when I come before you, we will be responding to Members of Congress within 15 business days.

In addition, last year, I committed to reducing Medicare's regulatory burden and bringing openness and responsiveness to that program. We have acted on that and CMS has now initiated open door forums so that all providers can discuss their concerns and get a direct response. I have also asked Administrator Scully to think innovatively about how we can improve the way CMS does business and he is working diligently to meet this challenge.

As our work in the area continues, I look forward to working with you and other members of this committee to make CMS more

user friendly for everyone. These reforms are essential to continued success of the Medicare Program which is why the 2003 budget is such a significant step forward. It dedicates $190 billion over 10 years for immediate targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection and better private options for all beneficiaries.

I know that some Members of Congress are concerned that $190 billion over 10 years is not enough. However, while we may not agree on the overall cost, we are committed to working with this committee and other Members of Congress to ensure that all Medicare recipients have access to a prescription drug benefit as part of Medicare. I am confident that as we come together in good faith, we will reach a fiscally responsible and effective conclusion about where the funding should be.

This budget proposal also proposes a subsidized drug benefit as part of a modernized Medicare but also providing better coverage for preventive care and serious illness. We also proposed that preventive benefits have zero co-insurance and be excluded from the deductible.

In addition, the budget proposes several new initiatives to improve Medicare's benefits and address costs, and offers additional Federal assistance for comprehensive drug coverage to low income Medicare beneficiaries up to 150 percent of poverty, about $17,000 for a family of two. This policy helps establish the framework necessary for a Medicare prescription drug benefit.

Finally, Mr. Chairman, a word about how we can help rural areas. I am from a rural area as you are. I know too well the problems that rural areas and many communities like it face when it comes to addressing health care. The health needs of rural areas are as great as those in the big cities and suburbs and I want to assure you we are working hard to meet them.

The President's budget proposed increases for community health centers, which I noted earlier, is an example of that commitment. Forty-seven percent of those centers serve patients in rural communities. They reach 6 million patients across the country.

I have also announced an HHS Rural Task Force to examine the Department's overall resources and services for rural communities. We will be rolling that out within the next two weeks. I have asked them to report to me how we can better serve rural areas.

Mr. Chairman, the budget I bring before you today contains many different elements of a single proposal, namely to help every American of every age and station, in every State and territory, and on every reservation so they can receive quality, affordable health care. All of our proposals are put forward with the simple goal of ensuring a safe and healthy America. I know this is a goal that we all share and with your support, we are committed to achieving it.

I thank you again, Mr. Chairman, and I look forward to your questions.

[The prepared statement of Secretary Thompson follows:]

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

Good morning Chairman Nussle, Congressman Spratt and members of the committee. I am honored to appear before you today to discuss the President's fiscal year 2003 budget for the Department of Health and Human Services. I am confident that a review of the full details of our budget will demonstrate that we are proposing a balanced and responsible approach to ensuring a safe and healthy America.

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

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

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

PROTECTING THE NATION AGAINST BIOTERRORISM

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

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

Funding for the Laboratory Response Network enhances a system of over 80 public health labs specifically developed for identifying pathogens that could be used for bioterrorism. Funding will also support the Health Alert Network, CDC's electronic communications system that will link local public health departments in covering at least 90 percent of our Nations' population. Funding will be used to support epidemiological response and outbreak control, which includes funding for the training of public health and hospital staff. This increased focus on local and State preparedness serves to provide funding where it best serves the interests of the Nation.

An important part on the war against terrorism is the need to develop vaccines and maintain a National Pharmaceutical Stockpile. The National Pharmaceutical Stockpile is purchasing enough antibiotics to be able to treat up to 20 million individuals in a year for exposure to anthrax and other agents. The Department is purchasing sufficient smallpox vaccines for all Americans. The fiscal year 2003 budget proposes $650 million for the National Pharmaceutical Stockpile and costs related to stockpiling of smallpox vaccines, and next-generation anthrax vaccines currently under development.

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

Today, the United States has one of the world's safest food supplies. However, since the September 11 attacks, the American people have a heightened awareness about protecting the Nation's food imports and food supply at home. The fiscal year 2003 budget supports a substantial increase in the number of safety inspections for FDA-regulated products that are imported into the country. Physical examinations of food imports will double in fiscal year 2002 over the previous year, and double again in fiscal year 2003. We anticipate further progress as new staff become fully productive.

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

INVESTING IN BIOMEDICAL RESEARCH

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

NIH is the largest and most distinguished biomedical research organization in the world. The research that is conducted and supported by the NIH offers the promise of breakthroughs in preventing and treating a number of diseases and contributes to fighting the war against bioterrorism. The fiscal year 2003 budget includes the final installment of $3.7 billion needed to achieve the doubling of the NIH budget. The budget includes $1.7 billion for bioterrorism research, including genomic sequencing of dangerous pathogens, development of zebra chip technology, development and procurement of an improved anthrax vaccine, and laboratory and research facilities construction and upgrades related to bioterrorism. With the commitment to bioterrorism research comes our expectation of substantial positive spin-offs for other diseases. Advancing knowledge in the arena of diagnostics, therapeutics and vaccines in general should have enormous impact on the ability to diagnose, treat, and prevent major killers-diseases such as malaria, TB, HIV/AIDS, West Nile Fever, and influenza.

The fiscal year 2003 budget also provides $5.5 billion for research on cancer throughout all of NIH. Currently, one of every two men and one of every three women in the United States will develop some type of cancer over the course of their lives. New research indicates that cancer is actually more than 200 diseases, all of which require different treatment protocols. Promising cancer research is leading to major breakthroughs in treating and curing various forms of cancer. Our budget continues to expand support for these research endeavors.

BUILDING UPON THE SUCCESSES OF WELFARE REFORM

President Bush has said that American families are the bedrock of American society and the primary source of strength and health for both individuals and communities. Our budget includes a number of new initiatives that support this principle by targeting resources to strengthen our Nation's families. We look forward to working with Congress in considering the next phase of welfare reform and other elements of the President's proposals to help America's low-income families succeed.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

As a former Governor, I can tell you that the Temporary Assistance for Needy Families program [TANF], has been a truly remarkable example of a successful Fed-

eral-State partnership. States were given tremendous flexibility to reform their welfare programs and as a result, millions of families have been able to end their dependency on welfare and achieve self-sufficiency.

Since 1996, welfare dependency has plummeted. As of September of 2001, the number of families receiving assistance—which represents the welfare caseload—was 2,103,000 and the number of individuals receiving assistance was 5,343,000. This means the welfare caseload and the number of individuals receiving cash assistance declined 52 percent and 56 percent, respectively, since the enactment of TANF. Between January and September of last year national caseloads actually declined about 2 percent, and while the July to September statistics indicate a slight increase, the figures are still well below the previous year's caseload levels. The general trend suggests the national caseloads are not rising but, instead, have stabilized.

In New York City, where we are understandably most concerned about job opportunities, the city has achieved more than 53,000 job placements for welfare recipients from September through December 2001. While the number of TANF recipients increased briefly directly because of the tragedy on September 11, by December there were about 15,000 fewer TANF recipients on the rolls than there were in August. Indeed, in December the city had its lowest number of persons on welfare since 1965.

Some other positive outcomes we have seen since the law's passage include:

- Employment among single mothers has grown to unprecedented levels.
- Child poverty rates are at their lowest level since 1978. Overall child poverty rates declined from 20.5 percent in 1996 to 16.2 percent in 2000. The poverty rate among African American children declined from 39.9 percent to 30.9 percent, the lowest level on record. The poverty rate among Hispanic children declined from 40.3 percent to 28.0 percent, the largest 4-year drop on record.
- The rate of births to unwed mothers has not increased.

But even with this notable progress, much remains to be done, and States still face many challenges. Last year, I held eight listening sessions throughout the country to discuss the state of their TANF systems and understand the new challenges they are facing. The States overwhelmingly support this program. While keeping the basic structure and purpose of the program, States, administrators, recipients, employers, and advocates have provided valuable insight into where we could make the program even more responsive to the needs of families.

Our reauthorization proposal embraces the needs of families by maintaining the program's overall funding and basic structure, while focusing increased efforts on building stronger families through work and job advancement and adding child well-being as an overarching goal of TANF.

Our budget proposes $16.5 billion each year for block grants to States and tribes; $319 million a year to restore supplemental grants; $2 billion over 5 years for a more accessible Contingency Fund; and a $100 million a year initiative for research, demonstration and technical assistance primarily to promote child well-being through strengthening family formation and healthy marriages. In addition, our proposal will call for modification of the bonus for high performance to reward significant achievement in promoting employment of program participants.

We maintain State flexibility, but include important changes to improve the effectiveness of the program. We will also expect States to engage all families they serve and help them make progress toward their highest degree of self-sufficiency, even those cases that may appear hard to employ. We will eliminate the separate two-parent work participation rates and give States more flexibility in designing productive self-sufficiency activities while ensuring that the participation rate requirements are meaningful. We will also ask States to set performance goals for their TANF programs and report on their progress toward meeting these goals.

I look forward to working with Congress on reauthorization of this hallmark program. I am confident that together we will witness even greater achievements under the TANF program.

OTHER PROGRAMS SUPPORTING TANF GOALS

The President's budget also includes funding for several other programs at the State and community level that work to support the goals of TANF. The Job Opportunities for Low-Income Individuals program (JOLI) provides grants to non-profit organizations to create new employment and business opportunities for TANF recipients and other low-income individuals. Our budget provides $5.5 million to continue this valuable program. The Individual Development Account (IDA) demonstration program similarly seeks to increase the economic self-sufficiency of low-income families by testing policies that promote savings for post-secondary education, home

ownership, and micro-enterprise development. The President's budget calls for $25 million to support IDAs. More broadly, the Social Services Block Grant (SSBG) provides a flexible source of funding for States to help families achieve or maintain self-sufficiency and provide an array of social services to vulnerable families. The President's budget request for SSBG is $1.7 billion.

The President's budget extends the Transitional Medical Assistance (TMA) program which provides valuable health protection for former welfare recipients after they enter the workforce. This important program allows families to remain eligible for Medicaid for up to 12 months after they are no longer eligible for welfare because of earnings from their new job. TMA is an important stepping stone in helping workers and their families successfully transfer from welfare to work without fear of losing vital health coverage.

CHILD CARE

Child Care has played an important role in the success of welfare reform by providing parents the support they need to work. The President's budget recognizes this critical link and maintains a high level of commitment to childcare. Continuing the substantial increase in funding that Congress has provided over the last several years, the President's budget includes a total of $4.8 billion in childcare funding in conjunction with our request to reauthorize the mandatory and discretionary funding provided under the Child Care and Development Block Grant and the Child Care Entitlement. States will also continue to have significant flexibility under the TANF program and under the Social Services Block Grant program to address the needs of their low-income working families. These additional funding opportunities have substantially increased the amount of resources dedicated to child care needs. For example, in fiscal year 2000, States transferred $2.3 billion in TANF funds to the Child Care and Development Block Grant.

CHILD SUPPORT ENFORCEMENT

The Child Support Enforcement program offers another vital connection to families' ability to achieve self-sufficiency and financial stability. The President's budget proposes to increase child support collections and direct more of the support collected to families transitioning from welfare. Under our proposal, the Federal Government would share in the cost of expanded State efforts to pass through child support collections to families receiving TANF. Pass through payments enhance a family's potential for achieving self-sufficiency while also creating incentives for non-custodial parents to pay support and custodial parents to cooperate in securing support. Similarly, States would be given the option to adopt simplified distribution rules that ease State administration but, more importantly, benefit families that have transitioned from welfare by directing support otherwise retained by the State and Federal Governments to these families.

Overall collections would be increased by expanding our successful program for denying passports to parents owing $2,500 in past-due support, requiring States to update support awards in TANF cases every 3 years, and authorizing States to offset certain Social Security Administration payments when they determine such action would be appropriate to collect unpaid support. Our child support legislative package would also impose a minimal annual processing fee in any case where the State has been successful in collecting support on behalf of a family that has never received assistance.

STRENGTHENING FAMILIES

The fiscal year 2003 budget contains funds for four competitive grant programs, targeted at community and faith based organizations, to assist in delivering innovative services, to strengthen families and help change lives. The Compassion Capital Fund, at $100 million, will expand the capacity of groups and organizations willing to step up and help provide these critical social services. Twenty million dollars is included to promote responsible fatherhood by providing competitive grants to organizations that work to strengthen the role that fathers play in their children's and family's lives. The budget also supports $25 million in new authority for the mentoring children of prisoners initiative first proposed last year. Finally, young pregnant mothers and their children will be provided safe environments through the $10 million included for Maternity Group Homes.

PROMOTING SAFE AND STABLE FAMILIES

The President's budget would increase the funding level for this program to $505 million, fully supporting the increased authorization included in the new law. These

funds will be used to help promote and support adoption so that children can become part of a safe and stable family, as well as for increased preventive efforts to help families in crisis.

This landmark legislation also authorized a new program to provide vouchers to youth who are aging out of foster care so that they can obtain the education and training they need to lead productive lives. The President's budget includes $60 million for these vouchers, bringing the total request for the Foster Care Independence Program to $200 million.

CHILD WELFARE/FOSTER CARE/ADOPTION

Our budget framework includes resources for a number of additional programs targeted to protecting our most vulnerable and at-risk children. Foster Care, Adoption Assistance, Adoption Incentives and Child Welfare Services are designed to enhance the capacity of families to raise children in a nurturing, safe environment. The President's budget provides resources to help States provide safe and appropriate care for children who need placement outside their homes, and to provide funds to States to assist in providing financial and medical assistance for adopted children with special needs who cannot be reunited with their families, and to reward States for increasing their number of adoptions. At the same time, the budget also supports Child Welfare Services programs with the goal of keeping families together when possible and in the best interest of the child.

The budget provides nearly $4.9 billion for Foster Care, $1.6 billion for Adoption Assistance, and $43 million in Adoption Incentive funds. In addition, the President's budget seeks almost $300 million in funding for child welfare services and training. Together, these funds will support improvement in the healthy development, safety, and well being of the children and youth in our Nation.

ABSTINENCE EDUCATION

The President's budget proposes to reauthorize $50 million in mandatory funding for abstinence education grants to States. These resources complement the proposed $73 million in abstinence education grants to community-based organizations and Adolescent Family Life's CARE grants ($12 million). Both grant programs will continue to support the message, through mentoring, counseling and adult supervision, that abstinence from sexual activity is the only sure way for teens to avoid out-of-wedlock pregnancies and sexually transmitted diseases.

REPATRIATION

Finally, our commitment to supporting America's families does not stop at our borders. The President's budget seeks $1 million in funding for the Repatriation program to assist U.S. citizens and their dependents returning from foreign countries under extreme circumstances.

INCREASING ACCESS TO HEALTHCARE

The issues that have confronted the Nation in the past 6 months will have far reaching effects. Of all the issues confronting this Department, none has a more direct effect on the well-being of our citizens than the quality and accessibility of health care. Our budget proposes to improve the health of the American people by taking important steps to increase and expand the number of Community Health Centers, strengthen Medicaid, and ensure patient safety.

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

The Medicaid program and the State Children's Health Insurance Program (SCHIP) provide health care benefits to low-income Americans, primarily children, pregnant women, the elderly, and those with disabilities. The fiscal year 2003 budget we propose strengthens the Medicaid and SCHIP programs by implementing essential reforms, such as the extension of expiring SCHIP funds.

As a first step, we propose to develop legislative proposals that build on the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, which would give States the flexibility they need to design innovative ways of in-

creasing access to health insurance coverage for the uninsured. In addition to HIFA, the administration's plan would allow those who receive the President's health care tax credit to increase their purchasing power by purchasing insurance from plans that already participate in their State's Medicaid, Children's Health Insurance, or State employees' programs. This could help keep costs down and provide a more comprehensive benefit than plans in the individual market.

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

STRENGTHENING MEDICARE

The fiscal year 2003 budget dedicates $190 billion over 10 years for immediate targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. Last year, President Bush proposed a framework for modernizing and improving the Medicare program that built on many of the ideas that had been developed in this committee and by other Members of Congress. That framework includes the principles that:

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

The improvements the President and I have proposed include not only a subsidized drug benefit as part of modernized Medicare, but also better coverage for preventive care and serious illness. Thus, we propose that preventive benefits have zero co-insurance and be excluded from the Part B deductible. We must make these improvements to more effectively address the health needs of seniors today and for the future.

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

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

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

gress. That is, the policy provides new Federal support for comprehensive prescription drug coverage for low-income seniors up to 150 percent of poverty. And in all the proposals, the Federal Government would work with the States to provide this coverage, just as we are proposing with this policy.

Recently, I announced a model drug waiver program, Pharmacy Plus, to allow States to reduce drug expenditures and expand drug only coverage to seniors and certain individuals with disabilities with family incomes up to 200 percent of the Federal poverty level. This program is being done administratively. The recently approved Illinois initiative illustrates how States can expand coverage to Medicare beneficiaries in partnership with the Federal Government. The Illinois program will give an estimated 368,000 low-income seniors drug coverage. The model application I have announced is easy to understand and use, and the Centers for Medicare and Medicaid Services is working with numerous States, at least 12, that have already expressed interest in this program. Making it easier for States to take similar steps to help their citizens who need help the most is the goal I believe we all share.

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

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

This budget proposes a $1.50 charge for submitting paper or duplicate claims as an incentive for providers to submit electronic claims one time only. These proposals will help reduce claims processing costs and ultimately speed up payment of claims. I recognize that a few health care providers in disadvantaged circumstances may have to submit a paper claim. This proposal will allow me to waive this requirement for providers in rural areas or those providers whose special circumstances make it difficult to comply with submission requirements. Together, these fees generate $130 million in fiscal year 2003. The paper claims fee is expected to produce $70 million in fiscal year 2003. In future years, we expect the amount of the fee collected to decrease as more providers submit electronic claims. The duplicate and unprocessable claims fee is expected to produce $60 million in fiscal year 2003. The effective date for each proposal is March 1, 2003 to allow time for CMS to modify systems to incorporate this change. Each proposal amount represents 7 months of fee collections.

SUPPORTING HEALTHY COMMUNITIES

The fiscal year 2003 budget includes $20 million for a Healthy Communities Innovation Initiative; a new interdisciplinary services effort that will concentrate Department-wide expertise on the prevention of diabetes and asthma, as well as obesity. The purpose of the initiative is to reduce the incidence of these diseases and improve services in five communities through a tightly coordinated public/private partnership between medical, social, educational, business, civic and religious organizations. These chronic diseases were chosen because of their rapidly increasing prevalence within the United States. In addition there is $5 million for related activities in CDC.

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

IMPROVING MANAGEMENT AND PERFORMANCE OF HHS PROGRAMS

I am committed to being proactive in preparing the Nation for potential threats of bioterrorism and supporting research that will enable Americans to live healthier

and safer lives. And, I am excited about beginning the next phase of Welfare reform and strengthening our Medicare and Medicaid programs. Ensuring that HHS resources are managed properly and effectively is also a challenge I take very seriously.

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

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

HHS continues to be at the forefront of the government-wide effort to integrate budget and performance. We were one of the first Departments to add tables to its GPRA Annual Performance Reports that provide summary tables that associate resource dollars and performance measures HHS-wide. Although we work in a challenging environment where health outcomes may not be apparent for several years, and the Federal dollar may be just one input to complex programs, HHS is committed to demonstrating to citizens the value they receive for the tax dollars they pay.

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

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

GOVERNMENT PERFORMANCE AND RESULTS ACT

HHS is committed to continual improvement in the performance and management of its programs and the administration's efforts to provide results-oriented, citizen-centered government. The budget request for fiscal year 2003 is accompanied by annual performance plans and reports required by the Government Performance and Results Act (GPRA). The performance measures cover the wide range of program activities essential to carrying out the HHS mission. Some notable fiscal year 2001 achievements include:

- Reducing Erroneous Medicare Payments: CMS has continued to reduce the payment error rate from 14 percent in fiscal year 1996 to 8 percent in fiscal year 1999, 6.8 percent in fiscal year 2000, and 6.3 percent in fiscal year 2001. CMS, with the assistance of the Office of the Inspector General, is committed to further reducing the error rate to 5 percent by fiscal year 2002.
- Moving Families Toward Self-sufficiency: ACF reported that 42.9 percent of adult recipients of TANF were employed by fiscal year 1999. This is a primary indicator of success in moving families toward self-sufficiency. It improves on the fiscal year 1998 baseline of 38.7 percent and exceeds the target of 42 percent.
- Families Benefiting from Child Support Enforcement: The Child Support Enforcement program broke new records nationwide in fiscal year 2001 by collecting

$18.9 billion, one billion over fiscal year 2000 levels. In one such initiative in fiscal year 2000, the government collected a record $1.4 billion in overdue child support from Federal income tax refunds, and more than 1.42 million families benefited from these collections.

These are just a few of the dozens of impressive success stories found in the 13 performance plans and reports. GPRA has been and will continue to be an important part of our effort to improve the management and performance of our programs.

WORKING TOGETHER TO ENSURE A SAFE AND HEALTHY AMERICA

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

Chairman NUSSLE. Thank you, Mr. Secretary.

First, let me begin with the compliments because clearly there are many areas within the budget and many areas within your jurisdiction over the last year in which there has been much progress. Certainly the response to September 11, as well as the continued changes in management within a number of your agencies has been well documented and very well appreciated by this body.

We could go on for quite a while just talking about all of those areas. Unfortunately, we don't have as much time to talk about the compliments as we do the challenges, so I would like to cut right to the chase.

Being from the Midwest, I think you know what it means to be direct. I am not sure what your Rural Commission will find, but I will give you a hint that I think you already know and that is money. Our taxpayers in Iowa and Wisconsin pay the same amount as every other taxpayer when it comes to Medicare and we don't get a fair shake, in our opinion, when it comes to the reimbursements.

Certainly at the town meetings I held over the last week, my seniors are interested in a prescription drug benefit. What they don't know, but what we know, is that if our reimbursements don't change and if this system does not change, our Medicare-dependent areas will continue to fail to meet the challenge. We will have a drug benefit but the hospital will close and when the hospital closes, the doctors and nurses will leave, and the other health care practitioners, the skilled nursing homes will have a tough time staying open and may in fact not be there.

Of course the pharmacist on Main Street isn't going to stick around because if there is no other health care, there is no reason for her or him to be there. So now as a result, any emergency procedure, whether you are on Medicare or not, is now 100 miles away instead of maybe 30 or 50 miles away.

As a result of not having a hospital and no health care, there are no new families who are going to move to town, so good luck attracting any new businesses to town and the cycle continues to spiral out of control. As you have seen in your years in Wisconsin and as we continue to see in a number of areas, the challenge becomes even greater for a number of other areas within our priorities. The bottom line is Medicare modernization, in my opinion, is the key

to this. The bumper sticker may read prescription drugs but undergirding this entire proposal's success or failure will be our ability to modernize the entire system.

It strikes me from the President's budget that putting in the exact same amount for a prescription drug benefit as the year before fails to address the need in a complete way, recognizing of course that there are tradeoffs within Medicare and that savings can be found, I would agree with you that the costs are still hard to define. Maybe $190 billion is a reasonable amount, but without the proposal in front of us to see where those tradeoffs will come, without seeing where the precise savings will come, it makes it much harder to suggest that is real. It causes us to believe in the budget we will have to write here in the House, that number of $190 billion will have to grow in order to be realistic.

Having said that, let me ask a couple of questions. One, when do you foresee, because I understand you may not be prepared today to talk about what Medicare modernization will mean for this administration in totality. In part, that is what Mr. Spratt is getting to in the letter Chairman Thomas has written. When will we see a proposal with regard to Medicare modernization, more than just what has been put forth with regard to a prescription drug benefit, and how long do you anticipate States like Wisconsin, Iowa, Minnesota and others will languish in the bottom of the barrel when it comes to Medicare reimbursements without a level playing field?

I know that is a lot to ask, but in my 5 minutes I wanted to try and lay that all out on the table. I appreciate certainly your sensitivity to it and I don't want to leave without appreciating the fact that I know you are moving forward on it but time is of the essence. We are interested in the timing on this as well as a little bit of a glimpse of what we might be able to expect here in the near future.

Secretary THOMPSON. You have raised many questions, so I am not going to give you lengthy answers. I will go through them and be as direct as I possibly can so I can respond as quickly as possible.

We are making a lot of progress in regard to improving the responsiveness at CMS and we are going to continue to do so. I would appreciate and thank you so very much for sponsoring the Regulatory Improvement Act. Hopefully, the Senate will pass the bill also.

We have 49 fiscal intermediaries and carriers. We can get by with 20. We could put in the performance kind of agreements with them and we could improve that tremendously.

Second, with regard to rural reimbursements, rural updates, you are absolutely correct. This is something I have fought when I was a Governor and you were a Congressman. I think it is important for us to address it. The situation in rural areas is there is less utilization and the wage index works against us. These are the two big factors. The wage index affects the rates and the formula by about 71 percent. We need to change that if we are going to improve. That means there will have to be some additional money, some savings within Medicare.

In regard to Medicare, we just rolled out welfare reform authorization this week and the next step is to work on Medicare and get that up here as soon as possible. I cannot give you an exact date. I can tell you that we are working on it and we are working on the principles the President set down a year ago on Medicare. We need to improve them, to build upon them and hopefully we will have a package in front of you sometime relatively soon, hopefully this spring.

Chairman NUSSLE. Would you also comment on the differences between the OMB and CBO baseline as you perceived them within the Medicare Program and why we have the discrepancy that we do. I think Mr. Spratt said 304 on that chart—according to that chart, $304 billion difference. If you could touch on that, I would appreciate that as well.

Secretary THOMPSON. I certainly can. There is no question that there are reasons for it. Basically, there are several reasons. First, CBO I believe will testify later this morning. They will be coming closer to the figures we put out. That will be announced later on this morning. We think once it has been developed, there will be even closer figures coming together between CMS and CBO.

The main difference is the Medicare baseline in our budget was produced by our independent Office of the Actuaries, used by Democrats and Republicans alike for the last 30 years. They usually are very much on target. Our actuaries did a full baseline reduction, produced the estimates in the budget. There are certain differences, of course. When we put in recommendations like prospective payments, we take into our formula the savings. CBO does not recognize those formulas until they are put in rules, so that is a big difference.

The outpatient expenditures have not been rising as rapidly as estimated by CBO and by CMS in the past. In fact, they were almost level last year. They are going to go up but not as rapidly as before. That is also a difference. Those are two big differences.

Technical assumptions and economic assumptions are different between CBO and CMS and those are things that probably reflect the difference. Those are still being worked on between CBO and CMS and hopefully we will be able to get closer in the future.

Chairman NUSSLE. Mr. Spratt.

Mr. SPRATT. Thank you, Mr. Secretary, for your testimony.

This is Dan Crippen's testimony which he will deliver shortly after you. It is dated February 28 and I think it reflects the narrowing of the gap you mentioned. The administration projects that net mandatory spending for Medicare will grow at an average rate of 5.4 percent. I think you indicated earlier it should be 5.7 percent through 2012.

It also projects that growth will tend to be lower than the 10 year average rate through 2006, only 4 percent and higher after 2006, 6.4 percent. That is one reason it is somewhat suspect because if you spend any time crunching the numbers in this 10 year time frame and trying to put together a budget, you find it is a lot easier to get the numbers in the latter part of the 10 year time frame than it is in the near term.

The administration also estimates that net mandatory spending for Medicare will total $3 trillion over the period 2003 through

2012 which is about $225 billion or 7 percent lower than CBO's projection for the same period. It seems to still be a big discrepancy between the two of you, a significant number.

If they are right and you are wrong and looking backward 10 years, the number is very close to 67 percent, what they are projecting forward, we have a major problem on our hands, a real shortfall.

Secretary THOMPSON. May I respond?

Mr. SPRATT. Yes, sir, I would like your response.

Secretary THOMPSON. There is no question there is a difference, no question CBO is moving closer to that. We have our actuaries here, Rick Foster who has been the head of the actuaries out of CMS, been used by Democrats and Republicans alike in both administrations. They have been always relatively on target. I have a great deal of confidence in their professionalism.

The second big difference is that we assumed in the current laws the 15 percent home health cut that starts in 2003, the SNF add-on payments ending, the reduction in the physician baseline and the reduction of the outpatient baseline. All would impact on the growth rate which would I think argue for a closer assumption of the 5.4, the 5.7 to the 6.0, much more so than CBO. I don't think CBO recognized them, I don't think CBO recognized the prospective payment changes that we did at CMS. There are different assumptions and I believe the testimony of CBO will indicate there have been some technical changes and they are relatively close.

Mr. SPRATT. You mentioned the 15 percent across-the-board cut in home health care which has been hanging there like a sword over the home health care industry for the last several years. We pulled our punches every year because after the initial home health care cuts in the Balanced Budget Agreement of 1997, a number of home health care agencies went out of business, went bankrupt and we saw the consequences of it, each of us, in our own districts and we said enough is enough. You are still assuming that the 15 percent would be administered?

Secretary THOMPSON. We are assuming what the law is and the law is that it was going to be phased out.

Mr. SPRATT. But you are not recommending that we give another reprieve to home health?

Secretary THOMPSON. What I am recommending is that we sit down and look at all the provider payments. We are working with the Ways and Means Committee; we want to work with the Budget Committee. We want to take a look at this because we know the pressure you are under, pressure that all the Members of Congress are under for physician payments. The 15 percent, if you extrapolate it, is closer to 7 percent after you take into consideration the inflation factor.

We are looking at all these things and hopefully we will come up with a provision that is going to be budget-neutral that you and the chairman can look at, the Ways and Means Committee could look at and see whether or not Congress would approve it.

Mr. SPRATT. Let me ask you about each one of these major items on Chairman Thomas' list. First of all, MedPAC made a recommendation that the physician provider payment rates be adjusted because the sustainable growth factor they believe is flawed.

That is the lion's share of the $174 billion in provider restorations or corrections Mr. Thomas recommends, $128 billion. Where does the administration stand on that recommendation?

Secretary THOMPSON. We are working with the Ways and Means Committee and we are working with any Member of Congress that wants to work with us. We are coming up with suggested savings that hopefully will make the changes budget-neutral and hopefully coming together with a package that could be approved by this Congress on a bipartisan basis.

We spent 3 hours yesterday with OMB on this particular subject, we are going to be meeting all day Monday on it and will hopefully be making some recommendations to Chairman Thomas sometime within the next 10 days.

Mr. SPRATT. Will that package include the offsets to make this budget-neutral or will you recommend that some portion of what is left of the surplus be assigned to pay for this?

Secretary THOMPSON. We are trying to make it budget-neutral. It is not easy as you can well imagine but we are trying to making it budget-neutral as suggested by Members of Congress.

Mr. SPRATT. Within Medicare or would you look outside of Medicare for offsets?

Secretary THOMPSON. We are looking within Medicare to make the savings, sir.

Mr. SPRATT. Turning now to the hospitals, a small amount of money relative to physicians payments but I believe it would affect rural hospitals, the MedPAC recommendations with respect to the difference in in-patient national rates between hospitals and MSAs less than $1 million and hospitals in all other areas. It would at least affect those in small towns and smaller areas. That is $15 billion. Is that feasible from your standpoint?

Secretary THOMPSON. If I want to talk from my heart, absolutely, but looking at the budget situation, we are trying to take a look at all the provider payments, trying to look at the reimbursement formulas but it is going to be difficult to include that.

Mr. SPRATT. How about the DSH payment, increasing the cap up to 10 percent instead of 5.25 percent?

Secretary THOMPSON. I doubt very much that DSH payments are going to be included.

Mr. SPRATT. And skilled nursing facilities?

Secretary THOMPSON. We are looking at that as part of the package.

Mr. SPRATT. Don't you think maybe we should withhold our mark of the budget? This is a big item, $127 billion, until we see that package and see whether or not it needs to be accommodated within the budget?

Secretary THOMPSON. That is strictly in your purview. I don't want to ever recommend any advice to you as to what you should do on the budget.

Mr. SPRATT. Let me ask you about the Medicare prescription drug proposal you are formulating. As I understand it, in the near term, you are recommending that we enhance the programs we have for low income beneficiaries which are mainly now under Medicaid rather than Medicare and give the States the where-

withal to expand those programs I suppose to maybe 160, 170, maybe 200 percent of poverty, is that what you have in mind?

Secretary THOMPSON. There are two provisions. One is $77 billion which hopefully would only be utilized by the States up to 2006 when hopefully we will have a Medicare provision within a restructured Medicare. That would require only $7.8 billion of the $77 billion. Basically, that would allow your State, the Governor and the legislature to be able to design a prescription drug benefit however they want to do it. They would have to cover individuals up to 100 percent of poverty and would get the Federal Medicaid match up to 100 percent. Then, for coverage of individuals from 100 percent to 150 percent, they would get a 90 percent return for a 10 percent investment. When I discussed that with the Governors this week on a bipartisan basis, they were very enthusiastic.

The second one is to use the waiver program and allow what we call pharmacy plus, allowing States to develop their own program as long as it is budget-neutral up to 200 percent of poverty. The State of Illinois has just passed it and they have allowed it. They have capped it so they will be responsible for anything over and above that figure as a State and with their funds. They are going to be able to ensure 368,000 low income seniors in the State of Illinois will be able to get covered prescription drugs.

Mr. SPRATT. You said as long as it is budget-neutral. What do you mean by that?

Secretary THOMPSON. We have a provision in giving waivers that States have to be able to show it is not going to increase the outlay of any Federal dollars. That is the budget neutrality.

Mr. SPRATT. Budget neutral up to 200 percent?

Secretary THOMPSON. That is correct, but also, they are allowed to be able to establish budget neutrality over the 5 years. That is what the State of Illinois is doing.

Mr. SPRATT. Usually in your budget proposal and elsewhere when you make this proposal of $190 billion, it is coupled with Medicare reform as if the two were linked and reciprocal, we won't do one without the other. Is that the administration's position, we have to have Medicare reform in order to have drug benefits?

Secretary THOMPSON. Absolutely, Congressman. We do not believe if we just pass prescription drugs that we will ever reform Medicare. The administration believes very strongly that we have to strengthen, reform and improve Medicare, make some savings, allow for catastrophic loss coverage and cover prescription drugs. We are hopefully going to have a proposal for you sometime this spring.

Mr. SPRATT. Can you give us an idea what reform means, what specifically you have in mind for reforming Medicare that would save that much money?

Secretary THOMPSON. We are looking at a lot of things at this point in time.

Mr. SPRATT. Thank you very much.

Chairman NUSSLE. Mr. Gutknecht.

Mr. GUTKNECHT. I want to thank you, Governor, for coming today. Let me say for the record, I happen to agree there are significant savings and it really is time we really do look at real reform at the Medicare system.

I also want to congratulate you on a number of things because normally being the Secretary of Health and Human Services is a very tough job but after September 11 and with the anthrax and everything else, it became almost an impossible job. I, for one, admire the work you have done.

I hate to sound like "Johnny One Note" but again, going back to the anthrax story, you did a brilliant job of negotiating with the Germans as it relates to the price of Cipro. We ended up with a very good deal. I don't think most Americans realize that you did a yeoman's job of making certain we got a fair price for Cipro.

I want to come back to the basic issue of prescription drugs because when we talk about a prescription drug benefit, it seems to me that we continue to just chase our tails—frankly, I want pharmaceutical companies to make money. I am a capitalist and I understand they need a profit incentive and I also understand if they are going to do the kind of research that we expect on the next breakthrough drugs, they have to have a profit margin but the more I learn about the system, the more I think that we as Americans have got to become much, much better negotiators and at some point, we have to allow market forces to work.

I look at drugs like Coumadin, for example. My 82-year-old father takes Coumadin. I have learned from independent sources that the price here in the United States, the average price, is about $35 a month. The average price in Europe for exactly the same drug, adjusted for currency differences, is about $5. I think we should pay our fair share of those research costs, but on drug after drug after drug and particularly those drugs which seniors take on a repeat basis, what bothers me the most is when you look at what is happening between what we pay in the United States versus what they pay in Europe, the differences are 30 to 300 percent right down the line.

At some point, together with your office, we have to make it clear to our own FDA that they work for us and not the other way around. They have been so busy trying to protect us from ourselves that we have criminalized a lot of seniors who are simply trying to afford the prescription drugs which their doctors say they need.

I would be happy to work with you, to work with Greg or anybody from your staff to get the information so that we begin to make it clear to these large pharmaceutical companies, which I want to make clear to everyone, many of them now are no longer American companies. These are companies that are based in Germany, Switzerland or other parts of Europe. They have one price structure for the European Union and a much, much different price structure for the United States of America.

I don't think we can seriously talk about a prescription drug benefit for seniors as long as we have a situation where my estimates are that this year seniors and the Federal Government will buy somewhere in the area of $100 billion worth of prescription drugs. Based on some outside experts we have talked to, if we just open the markets, prescription drug prices in the United States will come down at least 30 percent. That is $30 billion that would go a long ways to help provide a benefit to those seniors falling through the cracks.

We want to work with you but I think with all due respect, Mr. Secretary, you have to make it clear to the FDA that they work for us and not the other way around.

Secretary THOMPSON. Thank you, Congressman. We are neighbors and I have known you a long time. You are a friend of mine and all you ever have to do is call me and talk to me, which you do on occasion. I respond right away as I do with any Congressman that calls me.

We want to work with you. FDA has put a new leader out there, a gentleman by the name of Les Crawford, with those instructions directly. I think you are going to be very impressed by the leadership of Dr. Crawford. He is a wonderful individual. I hope you get a chance to meet him soon—I hope you get a chance to bring him up and talk to him. There are going to be changes made and improvements made. All I can tell you is we are changing a lot of things at the Department to make it a lot more responsive in many areas, not only to Congress but to the public at large.

Mr. GUTKNECHT. Thank you.

Chairman NUSSLE. Let me announce to the members we have one vote evidently on the floor. We will continue this hearing and Mr. Collins has gone to vote and will continue to chair the hearing as we continue so that members can make a decision how they would like to proceed, but we will continue the hearing during this vote.

Mr. Bentsen is next to inquire.

Mr. BENTSEN. Mr. Secretary, good to see you. I have a couple of questions for you, but I want to make a comment.

In part of your budget, I appreciate the increase in the community health services funding and in bioterrorism. I am disappointed that you have sent us another budget that would cut the pediatric GME program. We are going to restore that money like we did last year. As is true in your State, these pediatric hospitals train about 30 percent of the pediatricians across the country and that program has proven to work quite well, but I am disappointed you all did that. I figure that was probably done at the White House and not in your department.

I want to talk to you about the Medicare Program, what you said in your testimony and what you have here. One question is: are you saying in response to Mr. Spratt that you all believe that Medicare reform, whatever that may be, net of any prescription drug program, would provide net savings to the Medicare Program because everything else we have seen from this administration, the prior administration, from both parties is Medicare reform costs money. I would like you to clarify that.

I also want to talk to you about your drug program. There are about five things I see a problem with. Many have said that the $190 billion is insufficient from both sides of the aisle, from the CBO and from others. The plan you put forth, at least in the outset over the next six years, this is a problem we have seen for many years, would only cover about 10 percent of senior citizens, 10 percent of Medicare beneficiaries.

I think a huge flaw is relying on the States. You mentioned the State of Illinois and they have done pretty good work on this, but we know that when you look at programs like SLMBE and

QUMBE, that the States have not done a very good job. Maybe 40 or 50 percent of the eligible participants are actually enrolled. When you look at the CHIP Program, and other portions of the Medicaid Program in my home State of Texas, the State has not done a particularly good job of enrolling children in the Medicaid Program. We are one of 14 States that has not waded into the Breast and Cervical Cancer Treatment Act because the State doesn't want to pull down the money and put their share up. We are talking about taking a program, Medicare, a whole Federal program, and dividing it with the States in the prescription drug component and asking them to pick up the slack when the evidence has not been particularly good that they will do that.

As you know, this last week your former colleagues, the Governors who were meeting, were complaining they can't fund their Medicaid budgets as it is with what Washington tells them they would like to do, and here the administration's plan on prescription drugs would rest a great deal on the States stepping up to the plate.

You also talk about expanding Medicare choice and the fact that Medicare choice provides prescription drugs. In my experience in Washington, we have consistently had to raise the stipend to manage care companies to stay in the program and every indication is not only are people dropping out of the program but they are also dropping the benefits. We are starting to pay the managed care companies almost the same amount the government runs the fee for service portion of Medicare itself. From my economics training, once those curves cross, that is a very inefficient program.

Finally, I have to tell you on the discount card, that I have talked to more than a number of small pharmacists in my district and across my State who tell me that plan will only force them to carry the freight on trying to fund the administration's prescription drug program. I think that is very problematic. These are folks who already are getting a minimal, marginal or nominal amount from the insurance companies as it is for the prescriptions they fill.

I think those are some major flaws in your plan and I would like to know what your response would be to that. I think the biggest flaw, unfortunately, and I don't want to be critical of the States, is they have not always followed through and we are asking them to take a portion of a Federal program and fix that.

Secretary THOMPSON. You have addressed lots of subjects, Congressman. Let me try and go through them.

GME, the program started in fiscal year 2000 at $40 billion and in fiscal year 2003, we think $200 billion is a very proper figure. Based upon that fact, it extrapolates up to $51,300 per resident doctor.

Mr. BENTSEN. If I might, quickly. As you know, we funded at a higher level last year, so this would effectively be a cut.

Secretary THOMPSON. You subsidized it at $71,000 last year and we figure $51,000 per resident is adequate.

Mr. BENTSEN. Also, we have never subsidized this before, whereas the Medicare Program has subsidized other types of positions, pediatricians who are primarily trained in hospitals.

Secretary THOMPSON. We think $51,000 is a more accurate figure considering the budgetary problems right now than $71,000, but that is a decision you are going to have to make.

In regards to Medicare, we believe there are savings to have, savings that are hopefully going to be streamlining the rules and regulations as well as the law. We are hoping to be able to save lots of dollars in that. We are putting in an additional $190 billion for that. We know that you do not believe that is enough. We think it certainly can get us into good bipartisan negotiations for improving Medicare.

We are very fearful that once again we will talk about it as we did last year and not get something done. We are hopeful this year we can get a streamlined, strengthened Medicare program with prescription drugs and we think $190 billion over 10 years which starts in fiscal year 2006 is a good way.

In regard to what the States are doing, we think this immediate transitional program, of which we would pay 90–10 for those States covering individuals over 100 percent of poverty, giving them a Federal match allowing the States to design their own prescription drug program is a wonderful way to go. We had a lot of enthusiastic support from Governors on both sides of the aisle this week when I discussed it with them.

In regard to breast and cervical examination, I am hopeful that Texas will be one of the next States that comes in and puts the dollars in there. It is badly needed, it is a very good program, as you know, and we think it is the right thing to do.

In regard to other State functions, we think the welfare, the TANF Program, the States have measured up and have done an excellent job. We think if we allow the $77 million for the transitional drug benefit, they can do an excellent job as well and design a program that will be very beneficial to your seniors in Texas while we are working on the permanent fix through Medicare.

Mr. BENTSEN. With the chairman's indulgence, I guess I would say it sounds to me like once again we are telling senior citizens, the vast majority, 90 percent, of the Medicare beneficiaries, that nothing will happen until 2006 because we want to redesign the Medicare Program because your plan only appears to cover 3 million, according to your budget document, senior citizens out of the 32 to 35 million in this country under the Medicare Program.

Secretary THOMPSON. The transitional one will cover 6 million right away and we believe the card and the other one will add an additional 3 million or 9 million. That is a very good start forward. Hopefully Congress will pass that on a bipartisan basis. We think a $77 billion transitional program that could go into effect as early as next year is a wonderful investment.

Mr. BENTSEN. There is no guarantee under your plan like there is under Medicare where it is a Federal plan that the States will pick up the plan and run with that. The experience has been, as in the case in Texas, and I wish it were otherwise, that even at a 90–10 match, the States are under no obligation to take it. The other problem you have is States that run in a biennium like my State of Texas. We pass it this year, they are not coming back until next year, so we are looking a year or further off.

I am not trying to be critical but I think that is a programmatic flaw in what the administration has proposed.

Secretary THOMPSON. I don't want to argue with you because I respect you.

Mr. BENTSEN. And I respect you as well.

Secretary THOMPSON. But the truth of the matter is that what you are arguing with me is, don't do anything. I say $77 billion for States to try it. I am a former Governor; I was the longest serving Governor until I resigned. I can assure you when States and Governors see 90 cents for every 10 cents they invest, they jump at it. They are going to come up with an innovative program. I have much more confidence in my fellow Governors that they are going to look at this program. I had the opportunity to talk to them this week and they said, "you mean if we put up our Federal match to get to 100 percent, you will come in with 90 cents on the dollar so we can structure our own prescription program?" I said, "yes, that is the program." They said, "how do we get Congress to move?" That came from Governor Gray Davis, I believe.

Mr. BENTSEN. But Governor Perry of Texas vetoed the Women's Health Initiative plan that had a 90–10 match on it and the State of Texas right now has a significant gap in its Medicaid budget. The point is, it doesn't always work out that way.

I appreciate what you are trying to do. I guess the alternative would be what we proposed to do in the last Congress, put forth a program for prescription drugs under Medicare today and not go back and rely on the States for what is otherwise a wholly Federal program and not a Federal/State program. I think that is the alternative but I appreciate your comments.

Secretary THOMPSON. I just want to move, get it done.

Mr. BENTSEN. As do I.

Secretary THOMPSON. I think while we debate the restructuring of Medicare with prescription drugs, let us pass this one, let us see if it works.

Mr. BENTSEN. The only concern I have is that in doing so, we may never get to a universal program because some who proposed the plan you are putting forth say we want to help those who need it the most rather than helping those who need it as a total. There are a lot of folks in my State and your State as well, who aren't wealthy people that make more than 150 or 200 percent of the poverty level who are having to decide how much of the drugs to take their doctor prescribes to them, or what else they can buy with their fixed income on a monthly basis. Therein lies the problem. Therein is why I think we ought to be moving forward. We tried in the last Congress and we should be doing it in this Congress on prescription drugs.

Secretary THOMPSON. I couldn't agree with you more that we should move ahead and get something permanently done but I don't know if that is going to happen. I hope that it does. I am an optimist and believe we can get something done but in the meantime if we would have passed this last year, we could have had a lot of States designing their own prescription drugs, giving help to a lot of low income seniors all over America. That is my motive. I want to get as many seniors covered as soon as possible. I hope

we can get something done this year, both on restructuring Medicare and as well, the transitional program for the States.

Mr. BENTSEN. Thank you.

Mr. COLLINS [presiding]. Thank you, Mr. Secretary. I think you just had a good example of the difference here in where you are coming from and where a lot of Members of Congress are coming from. Many want a universal program,"one size fits all," rather than a good, sound program that can be paid for. We have to bear in mind that the American worker pays for all the programs up here.

I am always pleased to see the Ranking Member, Mr. Spratt, as he opens his portion of the hearings because he always has good charts, good information. He does his homework, very thorough. When you look at the charts he puts up and look at the increases and reductions he showed, the difference between OMB and CBO, and your explanation of each of his questions, which were very good questions. I appreciate his questions and I am sincere with that, I appreciated your answers. It reminds me of what I was told back in January 2001 prior to the inauguration when President-elect Bush was choosing people for his Cabinet. You were one of them and that comment was, it is great to see the adults back in charge.

What we have here, what you have evidenced, based on the very good questions of Mr. Spratt, you have brought management to Health and Human Services, management that was badly needed.

As we observe the questions about what is coming with Medicare reform, I think you handled it very well because Medicare reform is very important to be able to meet all the programs that are needed under the Medicare system. If you don't do them all together, you won't get it done in this town. We have seen that in the past.

I like the provisions you are bringing forth on welfare reform. You were very helpful to us in 1995 and 1996 when we worked through three welfare reform bills. I was on the Human Resources Subcommittee for Ways and Means at that time, had a lot of input on the child support enforcement provisions of it and I am glad to see you are recommending that the States pretty well take full control of that program.

I have always emphasized that the States should have full control of it. The Federal Government does do some financing in it but those funds collected should go to those who are due the funds and those are the children of the custodial parent.

A lot has been said about rural hospitals. The community health centers I think will help rural hospitals. You are keeping those who need health care within those communities. Many of them are rural communities, many of them have rural hospitals who not only will face problems in the future but have faced problems in the past. I was a county commissioner in a small county in Georgia with Hill Burton Hospital 25 years ago and I know how we struggled with that hospital then. I think the community health centers will help in that area.

The chairman mentioned in his opening comments that it is money, money, money. That is usually the answer to all solutions inside the beltway of Washington, DC I refer to it as cash-flow.

Yes, we have had a reduction in the cash flow of the Federal Treasury, a reduction based on the economy, the fact that we have had a decline in the economy beginning early in 2001, escalated by the events of September. That is the reason we have followed the President's advice and his proposals have three times passed a stimulus package in the House of Representatives to send over to the Senate.

I recall in the 1960's, the 1980's and now what happened when tax reduction was put forth. Under President John F. Kennedy, massive tax relief package in the 1960's brought in tons of money to the U.S. Treasury, positive cash flow. What did we do with that cash flow, sir? Create a lot of programs that you are responsible for today—the Medicare, the Medicaid.

In the 1980's, under President Reagan, the reduction in the tax burden on the American worker, tremendous increases in cash flow in the Federal Treasury. What was done with that? What was done with those dollars? We built a defense department second to none, ended the cold war, dissolved the Soviet Union. A lot of good things happened with those dollars.

We need a strong economy now and that is the reason it is so important that the Senate follow through with the stimulus packages we put forth because we need the dollars today and the cash flow of the Treasury. Those dollars come from the cash flow of individuals across this country. They don't come from inside Washington. Those dollars are needed to do two things this decade that you have a large part to manage, Medicare and Social Security. Both have to be addressed as soon as possible particularly in this decade. We will need dollars. There is no way you will handle both programs with the trust funds and we know that. We might as well 'fess up to it. It is going to take some general funds to take care of both or you are going to have such a tax burden on the next generation behind me that you won't be able to pay for it. We need that tax relief.

To have someone who is of high authority in either body to call the measures that we put forth, the tax measures we put forth in three different stimulus packages as fool hearted is foolish itself. It should never have been said.

Mr. Secretary, I think you are doing a good job. There is one area I want to caution you about. I mentioned this in the Ways and Means Committee the other day when we had Treasury before us talking about some tax proposals and one is in your proposal today. That is the tax credit for health insurance.

It has an income cap on it, an income cap that cuts off those who actually pay the bill. That is above the $60,000 annual income. We need to be careful with those types of provisions. We have enough provisions in the tax codes today to transfer payments from one taxpayer to another. We need to be very careful about adding more to it.

Thank you for your work, your dedication. You have been a Governor, a very good Governor. You understand what goes on at the local level. You remind me of the phrase that Ronald Reagan put forth. I have it on a plaque in my office. "It doesn't matter who gets the credit, just get the job done." I don't care if the Governors take

credit for prescription drugs for seniors, get the job done. That is your attitude and I appreciate it.

Thank you for your being here.

Mr. McDermott.

Secretary THOMPSON. Thank you for your comments.

Mr. MCDERMOTT. I had to choose between going to the Ways and Means Committee and listening to MedPAC talk or come up here and listen to you and I thought well, I am going to go see the Secretary because I admire you. I think coming from a Governor's job to sit up here and be lectured by us is probably not exactly what you would like to do, so I admire your willingness to serve. I never have understood why you took that job.

Secretary THOMPSON. Sometimes I wonder myself.

Mr. MCDERMOTT. I know. It is because I respect you that I have a little difficulty putting this up here, but you say you are for rural health but when we look at your budget, you cut Rural Health Administration. For me to put that all together because $54 million cut out of there doesn't make sense. Maybe you will have an explanation but I have a bigger question than that.

Your budget document says Medicare's extremely complex provider payment systems based on regulated prices do not always function smoothly or equitably over time. We all agree on that. Then you go on to say you are willing to work with Congress by making budget-neutral adjustments across provider payment updates.

MedPAC is downstairs telling us that they vote for a full inflation increase for outpatient services in 2003 and for inpatient payments in rural hospitals, they also want them to have full inflation increases.

In the zero sum game of budget-neutral stuff, that is not possible. I guess you want us to gore somebody else's ox. I don't know whose ox you are thinking about. If we are going to actually give these inflation increases to rural hospitals and keep them open and all the rest, and do something about the physician business, where are these savings coming from? Is it coming out of nursing homes? How is this going to happen? You can't have it both ways and you know that.

Secretary THOMPSON. First off, let me tell you that on the reduction at the Rural Administration, that hurt me. That was one of the last things I lost in my tussle with OMB, so I don't have much defense for it.

Mr. MCDERMOTT. Thank you. I like that honesty. We will take care of it. I am sorry there are no other members here. I come from an urban district, so it doesn't mean anything to me. There are a lot of people here who have rural districts who don't realize you are fighting for them and I like that.

Secretary THOMPSON. You must be Irish, Congressman.

Secondly, in regard to the provider payments, most of these things are things you passed, Congress passed in 1998 and 1999 asking us to do this. We carried out the law and that is why the physician payment, that is why the reduction in SNF, the reductions are actually laws that have been passed by this Congress.

My answer to you is that the only way we are going to fix them is to sit down on a bipartisan basis, put all the provider payments

on the table and not look to gore one over the other, but see whether or not we can make some savings and put them all out there and see if we can come up with a plan on physicians, on SNFs, on home health and on the outpatient. We are working on that. In fact, as we speak, there is a meeting going on over in the Humphrey Building doing just that. We have another meeting on Monday which I will chair. Hopefully we will spend all day Monday looking at where we might be able to come up with some savings because Congress has also asked us to come up with a budget-neutral answer to this and that is what Congressman Thomas has suggested. We are trying to do that, trying to comply with what you are saying.

Mr. MCDERMOTT. You have told us that Pogo was right, the enemy is us. I get that and I am glad you would say it to the committee. I have one other question I want to put on the table.

We are going to have a budget out of this committee in two weeks, ready or not, here it comes. I don't think anybody knows what in the world they are doing but you believe more people are going to go off welfare, don't you?

Secretary THOMPSON. Yes, I do.

Mr. MCDERMOTT. Right now, the Child Development Block Grant only covers 2 million out of 15 million kids eligible in this country and you flatlined that. You gave them no more money and the TANF grant, which has also been used for child care, is also flatlined.

I understand we don't want to leave any child behind, but if you are going to push people to go to work and have no way to pay for decent child care, it doesn't work. I can't understand how you can flatline both the Child Development Block Grant and the TANF grant and expect that more people are going to leave when already less than 20 percent of the children eligible get any money in it. If you can give me some explanation, I would be pleased to hear it.

Secretary THOMPSON. First off, we are flatlining the child grant. It is about $5 billion, $2.8 billion in the mandatory and $2.1 billion in the discretionary. We are also putting $16.5 billion in TANF, of which 30 percent of the TANF dollars can go into child care. We are also allowing additional money to be taken out of the Social Service Block Grant to be used for child care. When you add all those figures together, it is about $9 billion. We think that is a giant step forward.

Because the caseload has been reduced by about 50 percent across America and TANF has been at the same level, $16.5 billion, we think the States should have enough flexibility in there to put the additional money into child care. That is our assumption.

Mr. MCDERMOTT. I hope you will not grant a waiver to the State of Washington for their Medicare Program. They want to set up waiting lists and all kinds of awful things because there is $1.5 billion they have to cut out of the budget, big chunk comes out of Medicaid and these programs and we have the highest unemployment in the country.

Maybe everyone else believes the economy is taking off and this problem is going to go away, but I think you are going to get more people back on welfare in the next few months because of the fact

that all those people we pushed out on $6 a hour jobs have been cut. They are not making beds at Holiday Inn anymore. It is this crunch I see the States in, you having been a Governor know better than anybody else.

Secretary THOMPSON. Your Governor was in to see me for a hour this week, Governor Gary Lock, and he told me he had full support for his waiver except for you.

Mr. COLLINS. With that, the gentleman's time has expired.

Mr. Fletcher.

Mr. FLETCHER. Mr. Secretary, thank you for coming back here. We want to laud you for the wonderful job you have done in a very difficult situation we faced over these last months as a Nation and laud you for the efforts as we look at addressing some of the concerns. Welfare was mentioned and as a Governor, you kind of led the Nation in that reform. I am glad you didn't listen to some of the far left radical ideas that we may hear around here. Otherwise we would have still have a number of people locked in a cycle of poverty with no hope of ever rising to their potential. Thank you for doing that. Certainly we are glad you are at the helm of further reforming welfare to give more people in poverty hope of lifting themselves out of that. Thank you.

Let me ask you about the uncertainty of the baseline that we heard a lot of discussion about here, if that demonstrates the need for any fundamental Medicare reform now in the sense that it is very difficult to predict, as we have heard with the different estimates we get on the best baseline.

Secretary THOMPSON. You are absolutely correct, as you usually are. I applaud you for your question and for your dedication in this arena.

The truth of the matter is that there are certain economic assumptions that are made by CMS and by CBO and they are not always the same and you are going to have a difference. The second thing is outpatient expenditures have gone down. It was projected to go up at this level, it has been level pretty much for the last two fiscal years, so you are starting at a lower baseline for the outpatient expenditures. It is going to start going up but it is not going to go up as rapidly as it was. That is an assumption that continues through our actuaries at CMS.

The third thing is that we took into consideration what the law tells us to do, that is that there is going to be a provider payment on SNFs and on physicians. When you put all the variables in there you come out with an answer. That answer is that there is going to be a reduction there. As a result of that, the baseline is not going to go up as rapidly as CBO predicts. So there are changes and there are some differences that need to be reconciled.

The best way to reconcile, as you have indicated, is to come up with a streamlined and strengthened Medicare reform package with prescription drugs. This law was enacted in the 1960's and we all know there are many changes that have taken place in health care led by your profession. There are many changes that need to be done, namely prescription drugs have to be included as well as catastrophic loss has to be included.

There are ways I believe that we can streamline it and make some savings that will be good for the system and make it better for future populations.

Mr. FLETCHER. There are a couple of areas I know you are interested in and the administration is interested in as well, and that is the uninsured, your efforts to reduce that to provide more availability and access to quality health care. Let me ask you a question about the tax credits. We have several options, one of expanding the availability of getting into CHIPS. I am speaking of folks that may have this tax credit, but because the individual market is not as strong and healthy as it should be, we need to make sure, especially for lower income people, high risk, that they have an opportunity to get into some sort of plan that is affordable, CHIPS, Medicaid.

I wondered if there is any possibility of coming up with a grant for our high risk pools back in the States? We have looked at whether it is 75 or $100 million, something that is not tremendously large but would help those risk pools especially with tax credits. These people would have an opportunity to buy in at an affordable rate.

Secretary THOMPSON. That is part of the budget. We are allowing States to pool in this provision and we are allowing individuals to be able to go into a regional IRS office, get a number right away, take that to the insurance agent and be able to use that number as money up front so they can start making the monthly payments on their health insurance policy which is an improvement.

Second, we are giving States the authority to set up pooling arrangements within the State, so you can put all the uninsured into a pool. A lot of the uninsured are young, healthy individuals so the pooling rate should be fairly good, I would think. Maybe you could put some high risk in there as well and make an overall pool that would be able to allow for the $3,000 to be able to purchase a very good health insurance benefit for a family or $1,000 for an individual.

Mr. FLETCHER. I appreciate that. I think we do need to look at several avenues there. We did some pooling in Kentucky and some other things.

Secretary THOMPSON. We did in Wisconsin too and they worked out very well.

Mr. FLETCHER. As long as we make sure that you can have a good competitive market which keeps the rates down for the young, healthy folks, they get in. Take care of the high risk folks and if there is some way of making sure they can get in an affordable rate, especially low income, then you allow the market to work very well and increase the access to health care, as you know.

Secretary THOMPSON. In Wisconsin we required the insurance companies to subsidize. They were not too excited about that but it was a way for us to do it.

Mr. FLETCHER. I will be working to see if we can't get a small amount here to look at helping with some of the block grants in that program.

I think my time is up. Thank you, Mr. Secretary.

Mr. COLLINS. I am going to request that the gentleman take the Chair. Mr. Secretary, once again, thank you. I do want to read a

couple of excerpts from a paper that was drafted by the Honorable Jim DeMint from South Carolina. These are words of caution. "By the next election, the majority of Americans will be dependent on the Federal Government for their health care, education, income or retirement and at the same time, the number of taxpayers paying for these benefits is rapidly shrinking. Today the majority of Americans can vote themselves more generous government benefits at little or no cost to themselves." Travel with caution, Mr. Secretary.

Secretary THOMPSON. Thank you, Congressman. I appreciate your admonition and your common sense.

Mr. FLETCHER [presiding]. Let me recognize Mr. Moore now.

Mr. MOORE. Thank you very much, Mr. Chairman. And thank you, Mr. Secretary for being here. I think you have probably one of the toughest jobs in Washington. So I appreciate the fact that you are willing to be here and talk to us about some of the concerns that we have.

Mr. Secretary, I received a letter recently from a constituent, a woman. It is very brief and I want to read it to you and maybe you can help me answer her. She says she is trying to locate a new doctor. "I had to call four doctors before I finally found one who would take me. As soon as I told them Medicare was my primary provider even though I have a backup, they told me they were not taking any more Medicare patients. It does not do any good to have Medicare if you can't get a doctor. I don't know the answer but the problem needs to be addressed. Thank you." I wonder if you can help me answer her.

Mr. THOMPSON. I wish I knew more about the situation. But all I can tell you is that we are attempting to get more doctors into the system. We are putting the pressure on the providers to take Medicare patients. We are also providing for additional money in here to get more doctors into underserved areas. I do not know if it is an underserved area.

Mr. MOORE. No, it is not.

Mr. THOMPSON. But it is a problem. Of course, one of the problems is the reimbursement and we have to take a look at that. That is why, according to Congressman Spratt and Congressman McDermott as well as Congressman Thomas, we are looking at ways in which we can figure out a way on a budget-neutral basis hopefully to do something for provider payments. Hopefully, we will have some suggestions for this committee and the Ways and Means Committee in the next 10 days.

Mr. MOORE. Thank you. I do appreciate your very candid, honest answers to Congressman McDermott, because when you do not have a defense or a justification for something there, and it is clearly not your fault, I really appreciate the fact that you are very candid with us.

Another question. I know, and please forgive me if I cover something that may have been covered before, I have been in and out for a vote.

Mr. THOMPSON. I know.

Mr. MOORE. On February 8, Chairman Thomas and Nancy Johnson wrote you and Mitch Daniels a letter, and I am going to read just one sentence here. "However, MedPAC has identified serious problems such as significant and successive payment cuts to physi-

cians which are unsustainable and require reform." And this is kind of what you addressed. I do not know if you have responded to the chairman's letter yet.

Mr. THOMPSON. We have been working with him, Congressman, and we are going to be responding sometime within the next 10 days. That is pretty much what I indicated before.

Mr. MOORE. OK. Alright.

Mr. THOMPSON. But what you have got to understand, Congressman, is that we are implementing what Congress has passed. This is the law that was passed in 1998 and 1999, the Physicians Provider Payments. So we are implementing that. I know it is causing some concern from Members of Congress. We are trying to come up with a constructive solution for you and for Congressman Thomas and for all Members of Congress. Are we going to be able to satisfy everybody? No. But we are working on it.

Mr. MOORE. I understand that. Thank you.

Mr. Secretary, last year Republicans and Democrats in Congress provided $285 million to fund graduate medical education for pediatric hospitals. This funding, as you know, helps pediatric hospitals offset the extremely high cost of providing advanced training to pediatricians. The budget that has been presented cuts that funding by about 30 percent, from $285 million to $200 million. My concern is, and I guess I would just ask for your comments or your thoughts on this, these cuts I think are going to adversely affect some of our most vulnerable children. Your thoughts, sir?

Mr. THOMPSON. I do not agree with you, Congressman, and I will tell you why. This program was started in fiscal year 2000 with $40 million. It is now at $285 million and we cut it back to $200 million. And the subsidy that a resident gets in a children's hospital goes down from $73,000 to $58,000. We think a pediatric resident who gets $58,000 subsidy from the Federal Government is very lucrative. We can argue about that, but since the program was only started in 2000 and now is up to $285 million, we do not think a cut down to $200 million, down by $85 million, or a reduction from $73,000 per resident to $58,000 is that difficult to handle.

Mr. MOORE. Thank you, Mr. Chairman. Thank you, Mr. Secretary.

Mr. FLETCHER. You are welcome. Let me just add this briefly on the physician reimbursement. Access is a problem. I appreciate your working on that. We had looked at scores, about $127 billion over 10 years. It is a big cost factor. One of the things I had recommended toward the end of the last year was to freeze it and then come back and look at it, which does not score, obviously, over 10 years. It gives us the ability to sit back and really try to look at how we are going to do this. And if Medicare could be reformed and you had it more on a market-based system for pricing rather than mandated, we might have some answers there.

Let me recognize Mr. Watkins now.

Mr. WATKINS. Thank you, Mr. Chairman. I appreciate your being here, Mr. Secretary. As usual, Mr. Secretary, I think you do a great job and you bring a lot of the zeal and passion to a lot of different areas. There are gigantic problems that face this country. But I would like to say ditto to what Chairman Nussle was talking about in the small town rural America and trying to make sure we can

have some kind of health care there. I am delighted that this is one of your passions. I know you have got several, you are spread out quite a bit, but do not let up on that because that erosion is taking place.

Mr. THOMPSON. It is.

Mr. WATKINS. When you cannot find a hospital, or you cannot find a provider for hundreds of miles. There are a lot of things we are trying to do in telemarketing health-wise. The medical delivery, you are trying to get more especially in that. But do not let up on that.

I want to mention home health care. When I was making the race in 1996 throughout our area, I noticed—in my passion to try to help—I recognized in home health care that there were some abuses. So many of them just blooming out there. Like in one of the country areas, only the one store that was down there and they had three home health cares. So knowing there is some abuse to that, I called all my friends that were in home health and I asked them to come meet with me at the Chamber of Commerce meeting room in one of my areas to talk to them exactly about what was happening. The cost of home health care had jumped from $4 billion to $20 billion in like a 6-year period. Just like we were talking about a while ago with the hospitals, boom, everybody started taking advantage of it.

I was pleased that nearly every one of them responded throughout the area to come and sit down. I said we have got to solve a problem. It is going to be a problem in your profession of home health care. I am delighted that most of them agreed that there is a problem there and most of them sat down and started working and they realized there have to be some reductions. And also I think what was taking place here, they made some reductions. May have cut a little deep in some areas. Lots of times it happens. So I worked to try to help later to preserve the 15 percent because we had cut out such a tremendous amount that it had gone further than what we thought. So most of them worked in a very professional way in trying to work through all of that.

So I thank you for taking a good hard look at that situation and realize that the home health care has been very vital, one of the most economical delivery systems, keeping folks in their homes and all. But we cannot cut the muscle out there. There were some abuses, some big time abuses and we all realized we had to get to it.

Also, I would like to submit a letter to you about Oklahoma.

Mr. THOMPSON. I received your letter, Congressman.

Mr. WATKINS. I have even gotten more up-to-date. But if you can help me with an answer on that.

Mr. THOMPSON. OK. Fine.

Mr. WATKINS. We are trying to do some privatization on the health care. But the circular A–87, the interpretation by the previous administration goes right against what this administration is trying to do in helping move some health care to a privatization-type effort, right reverse of what we feel strongly about trying to do. So we have got a little time. If there is some administrative review that could be pulled back to look at that, or if a motion stay or something could be made by the administration, I think it would

be very helpful not only to Oklahoma and several others, but also for the policy, the direction that we are wanting to go overall. Could you reflect on that for me?

Mr. THOMPSON. Congressman Watkins, I have not been able to do a great deal of study personally, but I have assigned it to my General Counsel because I believe it is up in the Federal Court of Appeals. Is that correct?

Mr. WATKINS. That is correct. They are going to be doing something but I think we have time to have administrative——

Mr. THOMPSON. If we have time to do administrative review, I will be more than happy to take a look at it and see if we can work with you to find out some happy medium in which we can solve this problem. I would like to get it solved and I know you want to and you are pushing very hard on it.

Mr. WATKINS. And it is not just the State of Oklahoma. It is other States as well. But it is the policy itself that I think we are wanting to try to move toward, the lower cost. But the thing is in jeopardy because if they do not allow that to happen—I put a little chart here about the model that several States are using, which you will see is the model based on a Medicaid privatization-type effort. That is the model that we are using here. So I have updated this in the last 24 hours to try to give you a——

Mr. THOMPSON. Can you give it to us and we will be happy to——

Mr. WATKINS. I made two copies, one for you and one for your assistant. If you could get back to me in just the next day or two, I would appreciate it very much. The entire State, as you know, by middle of March, if it goes into that time period, it is going to be too late to pull it back and have a review of that interpretation before it goes.

Mr. THOMPSON. I will not be able to get back to you tomorrow because I have to be in Colorado on an aging issue. But I will have somebody get back to you tomorrow, Congressman.

Mr. WATKINS. OK. Let me give you my home phone number. Anytime, day or night.

Mr. THOMPSON. OK. I have never had this happen. [Laughter.]

Mr. WATKINS. That is how important this is. You can call me day or night.

Mr. THOMPSON. OK. And you underline "urgent."

Mr. WATKINS. Yes. OK. Thank you. Thank you, Mr. Chairman.

Mr. FLETCHER. You are welcome. Let me recognize Mr. Moran. And be advised, I believe the Secretary needs to leave at noon. So if we can try to keep within the time limits, thank you.

Mr. MORAN. The clock must be behind the screen there. Are you suggesting we are getting near noon?

Mr. THOMPSON. I hope so. [Laughter.]

Mr. MORAN. Thanks a lot. I do not have any personal kind of stuff. Nice job there, Wes. Boy, I hope those constituents are someplace in the audience there.

Mr. WATKINS. I hope everybody does not start calling my home. [Laughter.]

Mr. MORAN. If I was in your district, I would.

Mr. Secretary, we all understand that Health and Human Services has fallen off to the periphery of the public's and thus the

President's radar screen. Now we are talking about national defense, homeland security, and so on. That has the resonance. And so this is pretty much a stand pat budget. I do not see much initiative here. Yet you took a lot of initiative as Governor, came up with a lot of new ideas, pushed the envelope. I have looked through your stuff, I do not see much envelope-pushing here. So let me just suggest a couple of areas.

Mr. THOMPSON. OK.

Mr. MORAN. In subsequent years I would like to see if we could not do a little more on them. One is in the area of public health. Increasingly, we have concentrations of people who are not accessing the traditional health delivery system, as you know, particularly with immigrant populations. They are not likely to have a traditional health insurance plan or any health insurance. They are not likely to have a medical practitioner. They are not likely to go to a hospital until they get to an acute situation where their kid just is not healing or is not getting better and they wind up going to the emergency room. We all pay for it with public funds. Not only does it cost money, but it is not the way to provide medical care, as you know. In too many situations the disease spreads, the kid gets an injury that is difficult to overcome as they grow up.

One of the ways to most efficiently deal with that is through a stronger public health outreach system, as you know. I am not suggesting anything you are not very much aware of. And yet, our public health systems have really declined over the last several years, epidemiologists particularly. Every single year the number of epidemiologists has been reduced. And just as we know the reason that you have so many physicians that care for the elderly, it is because of Medicare. The medical profession goes where the money is and the money is not in public health.

This might have been an opportunity when we talk about bioterrorism to beef up public health. Much of that money is going to NIH I see. But I do not think it is necessarily going where it might have the largest long-term sustainable effect upon the Nation's public health. So I would like to hear what you are thinking about doing there.

The second area is in education, vocational education. There will only be two and they are both areas you are familiar with so you do not necessarily have to take notes. Vocational education, it has become a dumping ground in the last 25 years. The kids that are the disciplinary problems, that have academic problems, they are dumped into vocational education. And so the middle class does not put their kids there. What happens in our economy is a lot of jobs that pay $50,000, $60,000, $70,000 go begging because our high schools are not preparing kids with those skills.

Mr. THOMPSON. That is right.

Mr. MORAN. And yet there seems to be insufficient incentive at the local educational district level to beef up vocational education, to get some professional teachers in there, to make the connection between the business community and the public school community, bringing businesses in to offer people to teach, using them in the summer so that you have summer intern programs where they can learn those skills and can get the kind of motivation they need to fulfill the curriculum.

Those are two areas that I think you have an interest in. They are two areas that do not cost much money but they make a lot of difference. And I would like to hear your views on both of them and see whether we might see some initiative in subsequent years on those areas.

Mr. THOMPSON. First, I have to respectfully disagree that this is not much innovation because I think there has been tremendous amount of innovation. And let me just tick them off.

First off, we set up a model prescription drug waiver that the State of Illinois has taken. It is going to allow for 368,000 Illinoisans to be covered by prescription drugs.

We have set up an advance so that all of the waivers that were at the Department of Health and Human Services, some going back to 1986, are now current. We respond to every waiver within 90 days. We have been able to approve waivers and have a model waiver so that we have expanded health insurance coverage to 1.8 million Americans that did not have coverage through the waiver process. We have increased the benefits to 4.5 million Americans through the waiver process. And we are up to date. We have a model waiver for States to apply. We've got a model waiver for prescription drugs for States now to apply, up to 200 percent of poverty.

We have increased the response time so that you will get a response from CMS now within 20 business days. I am going to get it down to 15. When I started it was over 80 days.

We have a regulatory commission set up to reduce the regulations by one fifth in the Department of Health and Human Services dealing with doctors and nursing homes and home health agencies.

The department is working. We are making lots of improvements. We have 46 personnel departments that we are reducing down to 4. We have four bookkeeping agencies that we are reducing down to one. We have over 200 computer systems that we are going to get into an integrated computer system down to one. We are changing the contracting system so that it is much faster and more efficient and much more correct than it has ever been before. We are reducing the error rates at Medicare. Just to name a few.

In regards to this budget, we are putting $77 billion in, Congressman, so that States can have 90 percent money to set up their own prescription drug coverage any way they want to. If they want to only cover five or ten drugs and still get 90 percent coverage, we will be able to do it. Very innovative.

We are putting $89 billion in for health insurance credit so that your constituents can go to a regional IRS office, pick up a number, can go to an insurance agency, use that number as cash to pay for that premium. Something that has not been done before.

We are putting pooling in so that States can set up pooling, pools of uninsured that can be covered.

That is just the innovations.

In regards to public——

Mr. MORAN. Mr. Secretary, you knocked that pitch out of the ballpark. But it is not the one I threw.

Mr. THOMPSON. Let me tell you about public health.

Mr. MORAN. Well done. I understand. And while I do not want to be quite as parochial as Wes, I have a list of about 50 different

areas where Virginia has actually been cut in this budget. I could give you that.

Mr. FLETCHER. Let me interrupt the gentleman. The time has expired. I do think he teed it up nicely. You handled that very well.

Mr. MORAN. Yes. It was not the one I threw though.

Mr. THOMPSON. If I could just take thirty seconds to talk about public health.

Mr. FLETCHER. Mr. Secretary, go ahead.

Mr. THOMPSON. It is a passion of mine. We are putting out $1.1 billion to strengthen public health. This is bioterrorism money, but it gives us the opportunity. We have a great team. Jerry Howard here is the Deputy Commissioner, D.A. Henderson, who is the father of the eradication of small pox, is the head of it. He has brought together a group of scientists from all over America that is working out of Health and Human Services to strengthen and build a public health system that you are going to be proud of, that I am going to be proud of, and that we can put back and say, you know something, it was a terrible thing that happened on 9/11, but because of 9/11 we now have the best public health system that any of us could have ever envisioned.

Mr. MORAN. I would love to see that. And will you work with us on a vocational education initiative as well?

Mr. THOMPSON. Absolutely. That is not in my department, but I——

Mr. MORAN. Yes, that is Department of Education.

Mr. THOMPSON. Yes, but I would love working on it.

Mr. MORAN. I understand.

Mr. FLETCHER. Let me now recognize Mr. Putnam.

Mr. PUTNAM. Thank you, Mr. Chairman. Good morning, Mr. Secretary. I had an opportunity to chat with you in a different subcommittee hearing immediately in the aftermath of September 11 when we met in your building and talked about a number of the bioterrorism concerns. My concern continues to focus on the lack of adequate security measures at our airports and seaports for the goods coming in, particularly the agricultural products.

Mr. THOMPSON. Right.

Mr. PUTNAM. Tell me, if you would, how we have improved the coordination between the patchwork quilt of agencies who have various and sundry responsibilities for inspecting different items based on whether they were processed, whether they are raw, whether they are dairy, or whether they are produce. This is really, in my opinion, an outdated system. Please comment if you would on how you are cooperating with the other agencies to improve that.

Mr. THOMPSON. I am not as happy as I would like to be on the progress in that regard, Congressman. It is an area that needs a lot of improvement. But I do want to thank you and I want to thank Congress; we requested $61 million last year for food inspectors and Congress was generous and gave us $100 million. We only have 750 inspectors at FDA. We are only inspecting less than 1 percent of the food coming into America through 151 different areas. That is not nearly enough. We were asking for 400 new inspectors. But because of the generosity of the Congress giving us the dollars, we are going to be able to hire an additional 700 in-

spectors, almost doubling what we have right now. We are putting more money into laboratories and technicians and that should be able to improve our inspections.

But in regards to the who is inspecting between the Department of Agriculture versus FDA, I am working closely with Secretary Veneman and the Department of Agriculture but I am not satisfied with the progress that is made. There is a lot of bureaucratic inertia to keep it as it is and we have to break that down. And I look for any ideas that you might have or any other ideas anybody else might have in order for us to improve it. But I do want to tell you we are in the process of hiring those 700, purchasing new equipment, and I would like to be able to come back here a year from now and say we have made lots of progress as far as food inspections into this country.

Mr. PUTNAM. That is so critically important. When we have held hearings on terrorism and bioterrorism, it is not just a matter of the human casualties that can occur from these acts, but the economic disruption, the undermining of public confidence in the safety of our food supply.

The bottom line is, Mr. Secretary, we do not even get the everyday stuff right. Prior to September 11 this was a huge problem in terms of what it was costing us in economic damage and cost to the States from invasive pests and exotic diseases and these things that were coming in here that nobody was catching. I am willing to stipulate that a bright, intelligent, well-funded, well-resourced terrorist would find a way to exploit the weaknesses in our system. I would like it if we just got the ordinary stuff right, the citrus cankers, and the hoof and mouth diseases, and the whole host of snails, turtles, ticks and bugs that come in here that have a huge impact on public health, have a big impact on the economy, and undermine public confidence in the food supply. And this bureaucratic inertia, I agree that it is there, but if you and the Secretary of Agriculture and Fish and Wildlife and all at your level can agree that it is a priority, then I really have great hopes that we can streamline this and make it work.

Mr. THOMPSON. It is a passion of mine. I do want to point out one problem, and that is that we have 80 percent of the responsibility in FDA and we only have 700 inspectors. We have to inspect 56,000 different places. We only have 100 inspectors right now to inspect food coming into 150 different ports and airports and ports of entry in America. So you can see the magnitude of the problem.

Mr. PUTNAM. Sure.

Mr. THOMPSON. So this is something that I requested last year and I was not getting much support until after 9/11 and then this Congress responded tremendously and has given us a lot of help. Right now, if you come into El Paso, if there is any suggestion of any tainted foods, you have to unload the truck and then you have to take a sample, you have to send it to Kansas to have it analyzed, and then you have to send it back. That, to me, is just a very inefficient way to do it. So we are looking at many ways in which we can improve the system. But there needs to be further cooperation between Agriculture and the Department of Health and Human Services, and I am confident Secretary Veneman wants to accomplish it as much as I do.

Mr. PUTNAM. Thank you, Mr. Secretary.

Mr. FLETCHER. Mr. Holt.

Mr. HOLT. Thank you, Mr. Chairman.

Mr. Secretary, thank you for giving us your valuable time on this. A number of my colleagues have addressed some of the things that I have concerns about, dish payments, health professions training. I would also—if we had more time—address the attention to mental health in SAMHSA and the fact that it is frozen, and pediatric doctors training. But let me not take time with those and instead turn to something that is on the minds of some of us here, which is the Centers for Disease Control.

Coming from central New Jersey, I am very sensitive to the concerns about terrorism. It hit us hard. Many people in my district were killed. Anthrax was being spread, presumably from my district, and anthrax spores were also found in my office here on Capitol Hill. So it is something I hear a great deal about. I am concerned that CDC actually takes a cut in your proposed budget when indexed for inflation. It seems to me that is a necessary part of addressing terrorism. And it is so important to recognize that the actions that can be done to beef up and improve CDC, and by the way, I recognize there are some reforms and improvements that need to be made within the organization, within CDC, but many of the changes and steps that can be taken within CDC have benefits far beyond terrorism.

Mr. THOMPSON. You are right.

Mr. HOLT. So I am concerned that—although I am sure you would explain part of this as removing the one-time purchases from last year's budget of small pox vaccines and so forth—it seems to me this is not the time to cut back on CDC.

With regard to preparedness for bioterrorism, it seems to me hospital preparedness does not get adequate attention in your budget. You did address with Mr. Moran, public health to some extent. But we face a big problem. I cannot remember the last time I saw a student who said "I want to go to medical school so I can go into public health." We need to do a great deal more to attract good people into that field. That seems to be missing in your budget.

Also at NIH, a good part of that budget is directed to bioterrorism but it is not clear where it is heading. Where are we heading with this terrorism R&D? In general, I want to see more devoted to research and development, and your budget does that, although it seems to be two things: bioterrorism without good direction and cancer. And so the second question if there is time I would like to get to is, what is happening to the other institutes at NIH? We need an investment in bioterrorism, we need an investment in cancer, but I think it leaves a lot of the others high and dry. So that is a separate question.

But if you could address this hospital preparedness, CDC, public health matter, I would appreciate it.

Mr. THOMPSON. You have raised several topics, so let me try and get through as many as I possibly can. There is a shortage of a lot of people going into the health professions—nursing, pharmacists, laboratory technician is probably the number one, epidemiologists. We have to do a better job of convincing high school graduates and college students to go into these professions. I speak about this all

over the country and it is important for you and other Members of Congress to do it as well.

In regards to CDC, a big reduction in CDC is because we put so much money into purchasing antibiotics for small pox. We have now purchased enough small pox that we are going to have 288 million vaccine units so that every man, woman, and child will be covered. That is a big reduction. There were some administrative reductions made in CDC, but we also are improving the laboratories, the safety, as well as the perimeters. CDC is spread out all throughout Atlanta. We have three campuses plus 24 other locations rented. I am trying to consolidate them into those three campuses and get away from the rented property and build the buildings on there so we have much better improvements.

In regards to bioterrorism——

Mr. HOLT. So that is no time to cut CDC——

Mr. THOMPSON. We are putting money into that, putting money into the capital expansion. You may argue that it is not enough, but there is a huge amount of money that is going into new constructions.

In regards to bioterrorism, I have brought together I think probably the best team in America. We have D.A. Henderson from Johns Hopkins, Jerry Howard from New York, Dr. Mike Asher from the University of California, Dr. Phil Russell, retired Major General, who ran USSAMRAD. They are over there, they have set up, and they have hired and brought in people. We have set up an information war room over there so we are able to get out information on new science if there is any problem whatsoever. It is staffed during certain periods of time, 24 hours a day, 7 days a week.

With regards to NIH, we are putting $988 million into new research, mainly to come up with vaccines and new antibiotics for botulism, for plague, for the hemorrhagic viruses, as well as coming up with a new anthrax vaccine. Big portion of that is under Dr. Tony Fauci who is doing just an outstanding job.

In regards to the other institutes, we are trying to make sure that the other institutes—they are not getting the same increase percentage-wise as cancer or bioterrorism. In regards to bioterrorism money, we are building a BSL–3 lab on the campus at NIH, we are building a BSL–4 lab at Fort Detrick, and we have got a BSL–4 lab out in Montana, I cannot remember the name of it. But these are laboratories that are going to be tremendously useful for coming up with these new kinds of vaccines and to look at these viruses, the very virulent viruses. And we need that kind of laboratory capacity at NIH. And so this is money well spent.

And I want to assure you in regards to public health, we are sending out $1.1 billion over the course of the next 60 to 90 days to States. They have to develop a plan. So we have a national plan; we have to look at hospital preparedness, emergency wards, so that they get the information and are able to be able to utilize that information adequately.

Mr. HOLT. Thank you, Mr. Secretary. I look forward to exploring all of those further.

Mr. THOMPSON. I wish you would come over to the department and see what we are doing in bioterrorism. I think you would be very impressed.

Mr. HOLT. Thank you.

Thank you, Mr. Chairman.

Mr. FLETCHER. My understanding too is if you take out some of the supplementals, the small pox, there is no cut at all on CDC. In fact, it was $4.2 billion in 2001, $5.7 in 2003. So that is my understanding of that.

Mr. Secretary, if you would indulge us just another couple of minutes. The Ranking Member would like to have a few questions, and there is one other thing I would like to cover very briefly after he does that, then we will let you get on your way, if that would be OK.

Mr. SPRATT. Thank you. My only question is a request, Mr. Secretary. We would appreciate a copy of your response to Chairman Thomas. If you would copy me as ranking member as well as the chairman on behalf of the committee, we would very much appreciate it.

Mr. THOMPSON. Absolutely, Congressman. You know I will.

Mr. SPRATT. Thank you very much.

Mr. THOMPSON. And if you want myself to come up and talk to you after that, I would be more than happy to, Congressman.

Mr. FLETCHER. Mr. Secretary, one of the problems you noted when you first took over the helm of HHS was 240-some computer systems that could not talk to one another. In medicine, we have problems with quality, the Institute of Medicine reports. We do not have any incentives for digitalization of medical information. I would hope that our effort in bioterrorism and the need to be able to communicate medical information, along with the appropriate privacy and security, would be one of your priorities. I would like for you to address that. I think if medicine is going to move forward efficiently and make sure that we can provide quality health care, like other industries that have used technology to provide the basis for some of that, we need to allow medicine to do that and actually empower them to do that. I wonder if you could give me a few comments on that and then we will let you be on your way.

Mr. THOMPSON. You know, I think that is where we have to go. I think the way we deliver the medical system in America is really arcane and we have to bring in new kinds of technology. The technology is there. We have just got to find the way to do it. We are developing a program, as you know, I think it is called Infomatics and it is a combination of Department of Defense, Department of Veterans Affairs, Department of Health and Human Services. Department of Health and Human Services is the lead agency in this. We are trying to build together a common vocabulary for all of the patients so that we could build a uniform patient list for veterans, for Department of Defense, and for Department of Health and Human Services through Medicare, which would go to cover a great portion of the population in the United States, and use the same numbers, the same figures and so on and so forth and develop that. We are setting aside $1.5 million to get this set up and running this year. And I will be more than happy to keep you current as to the progress we are making.

Mr. FLETCHER. Well thank you. I would like to see, I know the veterans program and some of the others have a platform for medical data. We would like to see, at least I personally would like to

see a common platform across the Nation so that everybody can talk to one another. So I appreciate it.

Mr. THOMPSON. Vitally important. The veterans are doing a great job on dispensing the drugs. I think they have got one of the best systems. I would like to be able to take that system and get it mandated across America.

Mr. FLETCHER. Mr. Secretary, I think that is all the questions we have. Thank you very much.

Mr. THOMPSON. Thank God. [Laughter.]

Mr. HOEKSTRA [assuming Chair]. We are now going to continue with the second panel. Our first witness will be Dr. Tara O'Toole. She is currently the Director of the Johns Hopkins University Center for Civilian Biodefense Strategies and a member of the faculty of the School of Hygiene and Public Health, with a whole list of accomplishments and responsibilities that we will pass over. But we are very glad that you are here today. Welcome.

Our second witness will be Dr. Gail Wilensky, who serves as the John M. Olin Senior Fellow at Project HOPE where she analyzes and develops policies relating to health reform and to ongoing changes in the medical marketplace. She also co-chairs the President's Task Force to Improve Health Care Delivery for our Nation's Veterans. Gail also has a long list of accomplishment and achievements, including receiving a Ph.D. in economics from my alma mater, the University of Michigan. So Gail, welcome to you.

And our third witness is Steven M. Lieberman, who is the Executive Associate Director for the Congressional Budget Office. Steve, welcome to you. I do not have your whole list and litany of things that you have accomplished. I have got it for your boss but we probably do not need to go through that one. But Steve, welcome and thank you for being here.

Dr. O'Toole, we will begin with you.

STATEMENTS OF TARA O'TOOLE, DIRECTOR, JOHNS HOPKINS CENTER FOR CIVILIAN BIODEFENSE STRATEGIES; GAIL R. WILENSKY, SENIOR FELLOW, PROJECT HOPE; AND STEVEN M. LIEBERMAN, EXECUTIVE ASSOCIATE DIRECTOR, CONGRESSIONAL BUDGET OFFICE

STATEMENT OF TARA O'TOOLE

Ms. O'TOOLE. Thank you, Mr. Chairman. I am happy to be here today to offer my support for the administration's HHS budget in advancing our preparedness for bioterrorism. There were two large sections to this bioterrorism preparedness budget. One pertains to upgrading public health at the local and State level, and the other is support for research and development funds for NIH. Both of these are critical to our national security.

In the aftermath of 9/11 and the anthrax mailings, we began to get a glimpse of how essential public health capability is to national security in these days of catastrophic terrorism. I would caution the committee, however, that the anthrax mailings are not the story of bioterrorism. They are not even the prologue to the story of bioterrorism.

Biological weapons are highly lethal. If delivered perfectly with sophisticated preparation, they are comparable to nuclear weapons

in terms of their lethality. The know-how and the materials needed to build biological weapons are widely accessible and cheap. These weapons are very appealing to those who would mount a so-called asymmetric threat against the Nation, seeking to do great harm to America without coming up against our traditional military prowess. And finally, these weapons and their potency and diversity are yoked intimately to advances in the life sciences, in which we are making prodigious progress. As we better understand why a particular virus is virulent or what causes antibiotic resistance, we are going to garner great benefits for medicine and for agriculture, but we are also creating knowledge which, malevolently applied, can build more powerful and more diverse biological weapons. So this is a very, very important topic.

But in all of the media attention to the anthrax mailings and bioterrorism, I fear that it was lost how much we can do to prepare for these kinds of attacks. Preparation would greatly mitigate the consequences of a bioterrorist attack on U.S. civilians. But much of what we have to do, in fact almost all of what we have to do, has to be in place before the attack occurs. We have to have diagnostic tests that can rapidly distinguish those who are infected with a bioweapons agent from those who are sick from common illnesses. We have to have the drugs and vaccines we need identified and available. We have to be able to treat large numbers of sick people very quickly. We have to be able to communicate not just between health professionals and the public, but among health professionals, and between the hospitals and the public health system. All of this complex interplay of organizations and activities really needs to be practiced beforehand if it is to move smoothly in time of crisis.

The 18 cases—and there were only 18 cases—of anthrax significantly stressed our public health system. In the four States and the D.C. area which were affected by the mailings, people were literally sleeping in laboratories for weeks on end to get the analyses done. We were pulling in people from all over the Maryland public health department in order to handle the demands that these 18 cases imposed upon our system. CDC was also out flat. Twice in the course of the anthrax mailings, CDC's web site went down and one could not communicate with CDC from the public health system except by phone. We need to do better in public health and the funds that are being proposed will address many of the core bioterrorism functions that we need to have in place in order to mitigate the consequences of a bioterrorist attack.

I think that the guidance that HHS put out last week for the fiscal year 2002 monies is fantastic. I confess it was written by my former boss, D.A. Henderson. Nonetheless, it is a very clear, concise, and I think well-structured guidance that actually gives us a chance of standing up very able programs in the public health area.

I would caution the committee, though, we are asking for $1.1 billion for the States in fiscal year 2002 and similar amounts in fiscal year 2003 in these budgets. That is a lot of money. It will make a meaningful difference. But we have a history in public health of avidly funding the "disease of the day" and then that money quickly goes away. In New York City, for example, they stood up a terrific program after the West Nile Virus outbreak in 1999. Now hav-

ing had it in place for 1 year, they are seeing their budget, rumor is, cut in half, which is going to decimate a lot of the activities they have already just begun to get underway.

We cannot do that again with bioterrorism preparedness. It is going to be very difficult to sustain these budgets given the economic context the States are in. But we have to figure out a way to do it. We should be practical and forward-thinking about the need to sustain bioterrorism budgets.

Hospitals, I agree with one of the previous Congressmen, do not get enough money for bioterrorism preparedness in this budget. However, I think the request is an appropriate amount of money. We do not know how to create the capacity in the hospital system to deal with massive casualties. The appropriate investments right now ought to be in planning and studying the situation. We should do some simple things quickly, such as develop community-wide response plans, before we sink a lot of money in hospital preparedness. But at some point we do have to figure out how to take care of mass casualties. We cannot do this now. There is not a city or a contiguous geographic area of the country that could handle 500 sudden casualties today.

Finally, biodefense R&D gets a big increase as you have noted. I think this is appropriate. I agree with the Secretary: in the short term, our focus ought to be on the production of vaccines and treatments for those bioweapons agents that we think are likely to be used. In the longer term, however, we need to formulate a strategy for R&D that would help us get at the core of infectious diseases, that would help us understand innate immunity and the mechanisms of pathogenesis of infectious organisms generally.

Looking into the future at the advances that are going to come in the life sciences and which will propel advances in biological weapons, we are going to need to be able to diagnose, to treat, and to develop vaccines for anything that gets thrown at us, including bioengineered organisms. We could do that. The United States has absolutely phenomenal capability in biological sciences and we could, if we chose to do so, take on infectious disease to the end of removing biological weapons as weapons of mass lethality or mass destruction.

In the course of doing that, if we truly invested in that kind of research project, as we did after Sputnik went up in the race to the moon, I think we could make enormous progress in eliminating biological weapons as threats to the integrity of the country. We could, at the same time, start getting at the root causes of infectious diseases. Infectious diseases cause half of the premature mortality in the developing world. According to the National Intelligence Council, removing some of that overburden of infectious diseases in developing countries would aid them in their transition to democracy and could possibly help alleviate some of the root causes of terrorism.

Thank you, Mr. Chairman. I look forward to your questions.

[The prepared statement of Tara O'Toole follows:]

PREPARED STATEMENT OF TARA O'TOOLE, M.D., M.P.H., DIRECTOR, JOHNS HOPKINS CENTER FOR CIVILIAN BIODEFENSE STRATEGIES

Mr. Chairman, distinguished members of the committee, I am the Director of the Johns Hopkins University Center for Civilian Biodefense Strategies. I am a physi-

cian trained in internal medicine and public health and am on the faculty of the Johns Hopkins Bloomberg School of Public Health. I have had the privilege to serve, or am now serving on a number of advisory panels related to bioterrorism including committees sponsored by the Defense Science Board, the National Academy of Sciences, the National Academy of Engineering, and the Defense Threat Reduction Agency. I appreciate the opportunity to appear before you today to discuss President Bush's proposed Department of Health and Human Services (HHS) bioterrorism related programs and budget priorities for fiscal year 2003.

I am strongly supportive of the President's fiscal year 2003 HHS budget request for bioterrorism funding. The proposed budget is unprecedented in two ways: it includes an ambitious, realistically funded and comprehensive program to upgrade the capacities of State and local public health departments to detect and respond to bioterrorist attacks, as well as a huge increase for biodefense-related research and development. I believe that the objectives and requested funding levels of both of these programs are not only appropriate, but represent essential national security expenditures.

PUBLIC HEALTH AND MEDICAL RESPONSE

The emphasis which Secretary Thompson has placed on improving the capacity of State and local agencies to respond to bioterrorist attacks is absolutely the right priority from national security perspective. Although the terror and suffering that might be associated with biological weapons attacks has been glimpsed in the aftermath of the anthrax mailings, the true potential for civilian deaths and for economic and social disruption which these weapons hold have, fortunately, yet to be realized. It is notable that the Commission on National Security in the 21st Century chaired by former Senators Hart and Rudman cited biological weapons as possibly the "greatest security threat facing the country."

It is also important to recognize, that a great deal can be done to mitigate the consequences of bioterrorist attacks. Appropriate preparation on the part of the medical and public health community, coupled with effective medicines, vaccines and diagnostic technologies could significantly ameliorate the potential calamity of bioterrorist attacks on civilian populations. In this respect, biological weapons differ significantly from the threat posed by nuclear weapons. But once an attack is underway, it is too late to mount an effective bioterrorism response from scratch. The preparations and response systems have to be designed and implemented and practiced beforehand to be successful.

It is well understood that the response to a catastrophe—whether it be a natural event such as an earthquake, or a terrorist attack such as we experienced on September 11—is and must be carried out by local authorities. The immediate aftermath of such events, before Federal resources can be mustered and gotten to the scene, is critical. As we saw with the anthrax mailings, the first responders to bioterrorism threats are public health professionals, clinicians and laboratorians.

STATE AND LOCAL PUBLIC HEALTH

What the proposed HHS program for upgrading local and State public health capacities attempts to do is create a program "template" for health agencies which outlines the core functions that would be needed to respond to a deliberate epidemic. State/Territory health agencies are required to submit a self-assessment of their current ability to carry out such functions as well as a plan to implement needed upgrades.

This is not a plan to improve public health across-the-board—the functional capacities that the plan addresses are those specifically needed to respond to biological attacks. It is also noteworthy that the proposed program integrates what are now three separate funding streams (from the Centers for Disease Control and Prevention, the Office of Emergency Preparedness, and the Health Resources and Services Administration). This integration will greatly improve fiscal and program accountability and should also enable more efficient management of bioterrorism preparedness efforts.

HOSPITAL PREPAREDNESS

The amount requested for hospital preparedness (HRSA funds) are nowhere near sufficient to prepare the Nation's 5,000 hospitals to cope with mass casualty situations, i.e. contexts in which 1,000 or more people need immediate medical care. Over the past decade, hospitals and health care organizations have reacted to the financial pressures on health care by shedding "excess capacity," staff has been reduced and just-in-time models are used to manage everything from nursing rosters to medical supplies and pharmaceuticals. An HHS study reports that only 10 percent of

hospitals surveyed could handle 50–100 patients suddenly needing care, and only 3 percent had conducted bioterrorism disaster drills. Unfortunately, there is no "payer" for hospital disaster preparedness, and so operational plans that would be critical in a mass casualty setting have yet to be devised or tested.

The country will eventually have to determine how to pay for creation of adequate hospital preparedness, but it makes sense at this point to invest limited funds in planning what needs to be done. It is urgent that hospitals become engaged in community wide bioterrorism response planning. Hospitals would be a critical component of any response to bioterrorism—even much of the military and all of their dependents rely on civilian hospitals. Until now, however, hospitals and health care organizations have not participated in preparedness activities. The funds requested are essential to allowing and encouraging hospitals to begin such engagement.

SUSTAINED FUNDING NECESSARY

The HHS guidance for State health departments posits an extremely ambitious agenda. If accomplished, we will have substantially improved the country's ability to respond to a bioterrorist attack, and make important headway in minimizing loss of life and social disruption. However, rebuilding public health—or rather, creating a public health system for the 21st Century—will be a job of many years and will require sustained funding.

We have a long record of funding the disease or public health issue "du jour" and then abandoning these programs. For example, New York City built an excellent program to deal with West Nile Virus and then saw Federal funding for these efforts cut in half once the initial anxiety and media coverage subsided. How do we avoid having such a vital national security need as bioterrorism preparedness suffer a similar fate?

HHS appears to recognize this danger and has called for States to devise performance measures and set milestones to gauge progress—presumably in order to both affirm genuine progress toward preparedness goals and to keep investments focused on bioterrorism priorities. I hope both Congress and Governors pay close attention to these programs and their progress. Sustaining these investments—which will be difficult in the budget context States now face—is highly unlikely if States cannot demonstrate clear gains.

NEED TO ATTRACT NEW TALENT INTO PUBLIC HEALTH

State and local health departments have widely different levels of bioterrorism preparedness and functional capacity. Nonetheless, ALL are likely to need an infusion of new people to achieve an adequate skill mix and response capacity. Improving the talent base of the public health system should be a high priority, either through new hires or via on-the-job training and development.

Many States have imposed hiring freezes in response to the economic conditions and local budget constraints. It would be extremely helpful if the Federal funds required waivers for such freezes.

It would also be very helpful to the Federal workforce if we could find ways to allow mid-career professionals—especially experienced clinicians and public health experts—to work for Federal and State agencies for one to two years. This would provide an immediate infusion of expertise into the very stretched Federal system.

NEED GREATER EMPHASIS ON COMMUNICATIONS SKILLS AND CAPACITIES

One relatively neglected aspect of the otherwise comprehensive preparedness program proposed pertains to the need to improve health departments' ability to communicate with the media and the public in a timely way. Health officials at State and local levels could benefit from training in how to interact effectively with the media. It would also be advantageous to educate at least some members of media about bioterrorism issues and response plans in advance of actual attacks, and to have public health officials identify technical experts who could be available to the media during a crisis. Israel has done this with considerable success.

It is also important that health agencies develop prepared fact sheets and other materials that would be ready to go in an emergency. Prepared communications plans that are able to deliver clear messages to all facets of the community, including non-English speaking persons are also essential.

BIODEFENSE RESEARCH AND DEVELOPMENT

The unprecedented amount of money being requested for NIH/NIAID strongly signals that the administration understands the important role biological science and

biotechnology must play in protecting national security during this new era of catastrophic terrorism.

NEED FOR CLEAR R&D STRATEGY

Investing these funds wisely, and structuring the investment so that the country gets the products we need—e.g. effective treatments and vaccines, rapid diagnostic tests, etc.—will require a research and development strategy. It is not yet clear what this strategy will be—or who gets to have a say in its creation.

To its credit, the National Institutes of Health held a 2-day meeting of distinguished bioscientists earlier this month to discuss potential research directions. Such openness to the professional community's ideas is commendable and useful. However, the scope of the biodefense agenda and the urgent need for success may require a more innovative and aggressive approach to managing biodefense research.

ENGAGING TOP SCIENTISTS FROM UNIVERSITIES AND THE PRIVATE SECTOR

The United States has enormous talent in biomedical research, and of course we would like to have the best scientists involved in biodefense work. But this will not happen unless the practical aspects of the scientific enterprise are understood and taken into account.

The bulk of the talent in bioscience research works in either universities or the private sector—e.g. the pharmaceutical and biotechnology industries. University scientists are extremely reluctant to enter a new field of research without a high degree of assurance that funding in the field will be sustained. Funding concerns require that most research faculty solicit research grants years in advance. Thus, most top scientists have completely full dockets, and cannot easily change the direction of their studies on short notice.

Some universities forbid classified research. The constraints of classification, as well as the costs of implementing new research security standards now under consideration may discourage some university scientists from pursuing biodefense work.

Federal funding for biodefense research is now spread across multiple agencies, making it difficult for scientists who are working on relevant topics or interested in becoming engaged in biodefense work to "plug in" to Federal needs and funding opportunities. Biodefense research encompasses a rich and diverse spectrum of scientific disciplines including biology, medicine, engineering, information technology, etc. A Federal clearinghouse that provided a map of contract and grant offerings would be very useful. A clear articulation of broad government priorities would also aid private sector scientists who are trying to decide if participation in government-sponsored research is worthwhile.

In addition, there are a number of legal and procedural issues that must be resolved if the private sector is to become significantly involved in biodefense R&D. These issues include intellectual property matters—which are currently treated differently by NIH and DARPA; uncertainties associated with the FDA approval process for vaccines and drugs against bioweapons agents—which cannot, for ethical reasons, be tested in humans; and concerns about Federal contracts and grants processes themselves. The traditional NIH grant process, for example, requires elaborate proposals and incorporates long review times. These features make it difficult for small biotech companies, which often must move quickly to secure funding and produce product, to participate.

NEED FOR RESEARCH IN PUBLIC HEALTH AND SYSTEMS BUILDING

NIH is the premier basic biomedical research center in the world. It has an unsurpassed record of promoting top-notch bench research in basic biology and human disease. There are, however, areas of biodefense R&D that deserve critical attention, but which fall outside NIH's traditional scope of endeavor.

For example, there is an urgent need to develop—not just discover or test—certain urgently needed biodefense products, such as rapid diagnostic tests, vaccines and drugs for the most likely bioweapons pathogens. The biotechnology and pharmaceutical industries have far more expertise and experience in producing such products than do Federal agencies. Whether such product development should be based in NIH or in the private sector is a critical question worthy of careful deliberation. I do not have the answer to this, but our experience with vaccine production suggests it deserves focused attention.

Another essential area of research involves matters which pertain to public health practice and the design of public health systems. It is not clear if NIH intends to support this type of research, but there is no other obvious source of funding. For example, there is a clear need to develop criteria by which we could evaluate the

dozens of disease surveillance systems now being proposed throughout the country. Considerable effort and money is being invested in different prototype surveillance systems aimed at providing an electronic, population-based picture of the leading edge of epidemics. The idea is to detect an attack (or a natural disease outbreak) when the initial patients first become ill, thereby facilitating early intervention, saving lives, and preventing the spread of contagious disease.

But such surveillance systems require sophisticated analytical algorithms and depend on data collection from diverse sources. In most of the systems piloted to date, such data requirements have levied heavy burdens on the involved medical and public health systems. It also remains unclear which systems, if any, significantly contribute to epidemic control. Some proposed surveillance systems would link individual medical records to credit card histories and other sensitive information, raising important questions about privacy and confidentiality. The country needs to develop ways of evaluating these systems before we waste hundreds of millions of dollars on something that doesn't work. Integration of these systems into a national level database would be highly desirable, but is unlikely to occur without Federal intervention and significant investigation.

Similarly, we need research on ways to manage massive numbers of casualties without building an unsustainable infrastructure that is wasted on "normal" days. Indeed, the creating the public health system we need for biodefense involves research questions comparable in complexity to those in the basic bioscience research realm. Yet, as noted, it is unclear if NIH is to be the sponsor of such research.

SUMMARY

The proposed HHS fiscal year 2003 bioterrorism budget is very well thought out, and of sufficient scope and size to make a meaningful improvement in bioterrorism preparedness. The proposed investments in upgrading the bioterrorism response capacities of State and local public health departments are critical to US national security. We have seen how much suffering and disruption ensued from 18 cases of anthrax, a treatable disease. In the absence of significant improvements in our public health infrastructure, the country is vulnerable to the potentially calamitous consequences of a large bioterrorist attack.

The proposed funding streams, together with bioterrorism preparedness monies in the fiscal year 2002 HHS appropriation, constitute an important down payment on the construction of a 21st century public health system that could adequately respond to a bioweapons attack or to a large, naturally occurring outbreak of infectious disease. It is imperative that such investments be sustained over many years. The US public health system has been under funded and understaffed for decade, it will not be transformed in a year or two. As we go forward, it will be important to devise planning strategies that establish clear and reasonable expectations for future funding so that States and regions can sustain the cost of maintaining these systems in a state of readiness.

The proposed investments in biodefense R&D are also commendable and absolutely necessary. Science and technology can provide crucial tools needed to render bioweapons obsolete as weapons of mass destruction and high lethality. I would encourage the leadership of HHS and NIH to continue the open dialogue it has begun with the scientific community as it establishes priorities and directions for research. The development of R&D strategy will no doubt evolve as the science (and our understanding of the threats) progresses. An R&D strategy is needed that assigns priorities to urgent projects, such as the pressing need for second generation anthrax vaccine, and for rapid and reliable diagnostic tests for likely bioweapons agents. Such a strategy should be developed in collaboration with the scientific community to the maximal possible extent and should take into consideration the need for research in public health as well as basic biomedical fields.

Careful consideration should be given to how the country might effectively engage the tremendous talent inherent in the university research community and in the private sector. To this end, it would be important for the government to contemplate the establishment of different types of research grants and contracts to better accommodate the needs of these different communities. Innovative organizational and funding arrangements, such as those found at DARPA or the CIA's InQTel should be investigated as possible models. The Human Genome Project, a highly successful collaboration among government and academic scientists, which pursued a very complex and specific research goal, may offer useful lessons.

I urge the Congress to fully support the administration's funding requests for HHS bioterrorism programs in fiscal year 2003. The proposed investments in rebuilding the Nation's public health infrastructure are essential to national security.

The proposed biodefense research funds are likewise critical. President Bush is correct to emphasize the importance of this unconventional threat.

It should be recognized that these investments will not only better protect American civilians against terrorist attack, but will also yield additional benefits even in peacetime. A more robust public health system will be better able to cope with emerging infections and the consequences of natural disasters.

A half century ago, in response to another national security threat, the United States embarked on a research and development program designed to "send a man to the moon and bring him back within this decade." Given America's scientific talent and the extraordinary progress being made in life sciences research, it is conceivable that we could make enough progress in the understanding and treatment of infectious diseases to render biological weapons effectively obsolete as weapons of mass destruction.

In pursuing such an aim, we would undoubtedly also learn much that could diminish the scourge of infectious disease in developing countries, where they account for half of all premature mortality. The National Intelligence Council has written that this overburden of infectious disease, which accounts for account for half of all premature mortality in the developing world, is hampering some nations' transition to democracy. Lessening this burden would be a worthy humanitarian goal, and might also address some of the despair on which the plague of terrorism feeds.

Mr. HOEKSTRA. Thank you very much.

Dr. Wilensky.

STATEMENT OF GAIL R. WILENSKY

Ms. WILENSKY. Thank you very much, Mr. Chairman and Mr. Spratt, for inviting me to appear before you. I am here to discuss today the administration's proposals on Medicare, the general issue of Medicare reform and prescription drug coverage, and whether or not the administration's proposals are addressing these issues. Let me summarize the points in my written testimony as follows.

You have been hearing detailed descriptions about what the administration has proposed, including the $190 billion to be spent to modernize and reform Medicare. Some specific provisions are included. The more general long term reform goals of Medicare are presented but not many of the specifics of Medicare reform. However, the proposal funding will go to support a Medicare-endorsed prescription drug card, a new Medicare low-income drug assistance program, incentives for some new private plan options, and an ability to strengthen Medicare+Choice.

But let me step back for a moment and talk about the need for Medicare reform. Medicare is a program that has done much of what we have asked it to do; that is, to provide high quality care for seniors. But despite this, the program needs to be reformed. In many respects it still remains a 1960's program. As you well know, there are serious solvency and financial issues that Medicare will face. Seventy-eight million baby boomers are going to start retiring at the end of this decade. And behind the baby boomers come the baby bust generation. That means that at the very time we will have more and more seniors retiring, we will have fewer people there to support their retirement needs.

The problem is not just solvency, and it is certainly not just the Part A Trust Fund. Part B is growing even faster than Part A and faster than the economy. But in addition to the solvency issues, we need to reform Medicare because there are problems with Medicare. You have heard many times that the benefit structure is inadequate. There is also no outpatient prescription drug coverage. There is no catastrophic coverage. There are other inequities in Medicare as well. Large transfers go from high cost, aggressive

practicing States to low cost and conservative practicing States, and to the areas within them. That is not fair. We talk about the variations in spending in Medicare+Choice, but those same variations in spending levels exist in traditional Medicare.

The administrative structure of Medicare is excessively complex and bureaucratic. My understanding is today a report that was requested by Chairman Nussle from the GAO is being released which has the wonderful title, "Medicare Provider Communications Can Be Improved." What they found verifies what I know Members of Congress have been hearing loudly for at least the past year, although for many years before that, including when I was the administrator of HCFA. Among the findings, the information given to physicians is frequently difficult to use, out of date, inaccurate and incomplete. The Medicare bulletins contain dense language, are sometimes incomplete and are poorly organized. Consumer service lines do not fare much better. Some 15 percent of the test calls were fully complete and accurate, and the web site had only 20 percent of the time all of the information that was needed to respond.

I mention this to say Medicare's only problem is not that it lacks prescription drug coverage. This is a real issue but it is not the only issue that Medicare faces.

The reason I raise this point is I believe Congress has to ask itself whether or not it is ready to reform Medicare in its many dimensions to make it viable for the 21st century. If not, does it make sense to add a drug benefit to traditional Medicare? My assessment is that would be a very risky activity to undertake. I believe it is imprudent to substantially increase the spending needs of a program that is already financially fragile in terms of meeting its current obligations.

The second point, and this is probably something I need least to say to the Budget Committee, is that the actual costs of a new benefits are likely to be underestimated, no matter what the estimate of my esteemed colleague on my left is, if history is any guide. We know what happened with the end stage renal disease program introduced in 1972. The catastrophic program that was passed in 1988 and then repealed in 1989 increased by two and a half-fold from the time it was first introduced to the time it was repealed. Many people are waiting for the new CBO estimates for the legislative proposals on prescription drugs introduced in the last session of Congress. Everyone believes that the estimates will be higher, maybe substantially higher. And there is still a lot of dispute about design issues.

If you cannot reform Medicare this year, even if you were to pass a prescription drug benefit this year, it is likely to take at least 2 years to implement a new prescription drug benefit because of the time it takes to write new regulations. So the question Congress has to ask is whether some type of interim program would make sense. Several designs are possible. The administration this year has proposed a program that has a very highly leveraged Medicaid expansion for people who are above 100 percent of the poverty line to 150 percent of the poverty line, 90 cents on the dollar to the States. Last year, there was an immediate helping hand different designs of grants to the States. Congress could look to give prescription drug coverage first to specially designated populations

like the QMBY, the qualified Medicare beneficiary, or the SLMBY, those who are already getting special help under Medicare.

The question is whether or not Congress believes that the interim program would be worth the political capital it would cost to create it, whether it is possible to begin Medicare reform soon enough so that it does not seem worthwhile, or whether or not it makes some sense to help people who do not have coverage now for prescription drugs, understanding that at least as of today two thirds of the seniors do indeed have some prescription drug coverage.

Finally, let me end with a plea that this is really the time to start full Medicare reform. It will take time to build the infrastructure of a reformed program. Future seniors need to know the kind of design that they will face. And perhaps most importantly, it is urgent that Congress understand that future seniors will be different from today's seniors, many of whom will probably be exempted from most of the changes Congress ultimately decides to make in a reformed Medicare program. The new generation of seniors are likely to be substantially more educated, have higher incomes, have different experiences in terms of the kind of health insurance claims that they have faced. This is especially true for the women, most of whom will enter their senior years having spent a substantial portion of their adult life working, choosing their own health insurance, and frequently with their own income and assets.

To the extent it is possible to begin Medicare reform now, that would be the best move. If not, I urge you to be very cautious about implementing a major new expensive program without taking on the rest of reform that Medicare needs. If you want to do something for low income seniors, then I think you should consider the kind of prescription drug benefit that is specifically geared to low income seniors until you are ready and able to take on full Medicare reform. There is no question Medicare does need an outpatient prescription drug benefit. It is just not the only change that it needs.

[The prepared statement of Gail R. Wilensky follows:]

PREPARED STATEMENT OF GAIL R. WILENSKY, PH.D., JOHN M. OLIN SENIOR FELLOW, PROJECT HOPE

Mr. Chairman and members of the Budget Committee, thank you for inviting me to appear before you. My name is Gail Wilensky. I am the John M. Olin Senior Fellow at Project HOPE, an international health education foundation and I am also co-chair of the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans. I have previously served as the Administrator of the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) and also chaired the Medicare Payment Advisory Commission. My testimony today reflects my views as an economist and a health policy analyst as well as my experience directing HCFA. I am not here in any official capacity and should not be regarded as representing the position of either Project HOPE or the Presidential Task Force.

My testimony today discusses the administration's programs for Medicare and prescription drug coverage, the need for Medicare reform and the extent to which these needed reforms are being addressed.

THE ADMINISTRATION'S MEDICARE PROPOSALS

The administration has proposed to modernize and reform Medicare with a program that will include $190 billion in net additional spending. Although the details are not included in the budget, the framework was outlined last year. The reformed Medicare program would include an improved traditional fee-for-service plan and

improved health insurance options, so that ultimately, Medicare would look more like Federal Employees Health Benefits Program (FEHBP). Some of the important principles underlying the reform include giving all seniors the option of a subsidized prescription drug benefit, providing better coverage for preventive care, allowing seniors to keep traditional Medicare, providing better options to traditional Medicare, strengthening the program's financial security and streamlining Medicare's regulations and administrative procedures.

Because reforming Medicare is likely to take some time to implement, and perhaps also to pass, the administration is proposing some short-term changes that could be implemented quickly. The President has previously announced an initiative to create a Medicare-endorsed Drug Card. This could not only provide short-term relief, helping seniors get lower drug prices, but might also provide useful experience to Medicare in terms of administering a prescription drug program. The White House has indicated that a revised drug card proposal, with a public comment period, will be released shortly. The administration has also developed a model Pharmacy Plus drug waiver that States can use to provide drug-only coverage to low-income seniors through Medicaid.

In place of the Immediate Helping Hand Program that was announced last year, the President has proposed a Medicare low income drug assistance program where States could implement a comprehensive drug program for seniors with incomes up to 150 percent of the poverty line without waiting for a full Medicare prescription drug program to be fully phased in. States already have the option under Medicaid to cover seniors up to the poverty line. This new program would provide a 90 percent match to the States for seniors between 100 percent and 150 percent of the poverty line.

The administration has also provided incentives for new options to be included among Medicare's private plans, and has proposed to strengthen the existing Medicare+Choice program by correcting for previous underpayments. It has also proposed that two additional Medigap plans be offered in addition to existing ten currently available.

THE NEED TO REFORM MEDICARE

Although Medicare has resolved the primary problem it was created to address, ensuring that seniors had access to high quality, affordable medical care, there are a variety of problems with Medicare as it is currently constructed. The administration has correctly assessed the most important of these flaws: inadequate benefits, financial solvency, excessive administrative complexity and an inflexible Medicare bureaucracy.

A part of the motivation for Medicare reform has clearly been financial. Concern about the solvency of the Part A Trust Fund helped drive the passage of the Balanced Budget Act in 1997. Part A, which funds the costs of inpatient hospital care, Medicare's coverage of skilled nursing homes and the first 100 days of home care, is primarily funded by payroll taxes. The changing demographics, associated with the retirement of 78 million baby boomers between the years 2010 and 2030 and their longevity, means that just as the ranks of beneficiaries begins to surge, the ratio of workers to beneficiaries will begin to decline. The strong economy of the last decade and the slow growth in Medicare expenditures for fiscal year 1998–2000 has provided more years of solvency than was initially projected following passage of the BBA but even so, Part A is expected to face cash flow deficits as soon as 2016.

As important as issues of Part A solvency are, however, the primary focus on Part A as a reflection of Medicare's fiscal health has been unhelpful and misleading. Part B of Medicare, which is financed 75 percent by general revenue and 25 percent by premiums paid by seniors, is a large and growing part of Medicare. Part B currently represents about 40 percent of total Medicare expenditures and is growing substantially faster that both Part A and than the economy as a whole. This means that pressure on general revenue from Part B growth will continue in the future even though it will be less observable than Part A pressure. It also means that not controlling Part B expenditures will mean fewer dollars available to support other government programs.

However, as the committee understands, the reasons to reform Medicare are more than financial. Traditional Medicare is modeled after the Blue Cross/Blue Shield plans of the 1960's. Since then, there have been major changes in the way health care is organized and financed, the benefits that are typically covered, the ways in which new technology coverage decisions are made as well as other changes that need to be incorporated into Medicare if Medicare is to continue providing health care comparable to the care received by the rest of the American public.

Much attention has been given to the outdated nature of the benefit package. Unlike almost any other health plan that would be purchased today, Medicare effectively provides no outpatient prescription drug coverage and no protection against very large medical bills. Because of the limited nature of the benefit package, most seniors have supplemented traditional Medicare although some have opted-out of traditional Medicare by choosing a Medicare+Choice plan.

The use of Medicare combined with supplemental insurance has had important consequences for both seniors and for the Medicare program. For many seniors, it has meant substantial additional costs, with some plans exceeding $3,000 in annual premiums. The supplemental plans also mean additional costs for Medicare. By filling in the cost-sharing requirements, the plans make seniors and the providers that care for them less sensitive to the costs of care, resulting in greater use of Medicare-covered services and thus increased Medicare costs.

There are also serious inequities associated with the current Medicare program. The amount Medicare spends on behalf of seniors varies substantially across the country, far more than can be accounted for by differences in the cost of living or differences in health-status among seniors. Seniors and others pay into the program on the basis of income and wages and pay the same premium for Part B services. These large variations in spending mean there are substantial cross-subsidies from people living in low medical cost States and States with conservative practice styles compared to people living in higher medical cost States and States with aggressive practice styles. The Congress and the public is aware of these differences because of the differences in premiums paid to Medicare+Choice plans but seems unaware that the differences in spending in traditional Medicare is now even greater than the variations in Medicare+Choice premiums.

Finally, the administrative complexities of Medicare, the difficulties that CMS and the contractors face administering Medicare and especially the frustrations that are being experienced by the providers providing care to seniors are issues that have been raised repeatedly during the past year. Although these are not new issues, the frustration being felt by providers has increased substantially. Physicians, in particular, have become increasingly vocal, as was evidenced in a number of hearings held last year. Among the many complaints that have been raised—uncertainty about proper billing and coding, inadequate and incomplete information from contractors and discrepancies in treatment across contractors seem to be at the top of most lists.

In a report being released today that was requested by the chairman, “Medicare Provider Communications Can Be Improved”, the GAO verifies the validity of many of these complaints. Among their findings: information given to physicians by carriers is often difficult to use, out of date, inaccurate and incomplete. Medicare bulletins are poorly organized, contain dense legal language, are sometimes incomplete and are not always timely. Customer service representatives on toll-free provider assistance lines and websites didn’t fare much better. Only 15 percent of the test call answers were complete and accurate, and only 20 percent of the carrier websites reviewed contained all the information required by CMS. CMS, in turn, was also criticized for having established too few standards for carriers and for providing little technical assistance to providers.

ASSESSING THE ADMINISTRATION’S MEDICARE PROPOSALS

The administration understands that Medicare needs to be reformed in many dimensions. Medicare’s benefits are clearly outmoded, but Medicare problems are far greater than just the absence of prescription drugs and catastrophic coverage. Medicare needs to be modernized to accommodate the needs of the retiring baby boomers and to be viable for the 21st Century.

The principles the President articulated last July and reaffirmed in the budget lead to a long-term modernization of the Medicare program that would be modeled after FEHBP and the work of the Bipartisan Commission for the Long Term Reform of Medicare. The specifics of such a proposal have not yet been released. However, the budget does contain several provisions that could improve Medicare benefits immediately, such as the prescription drug card program and a new Medicare drug program for low-income seniors.

The budget as presented raises at least two questions. If there is a lack of agreement about other areas of reform, should a prescription drug program be added to traditional Medicare now, with other reforms to follow at some time in the future? If not, is there any place for a drug program for low-income individuals, particularly one that ultimately could be integrated with the Medicare prescription drug program when it is implemented?

Although I believe it is important to pass a reformed Medicare program soon and that a reformed Medicare package should include outpatient prescription drug coverage, I also believe that just adding this benefit to the Medicare program that now exists is not the place to start the reform process. The most obvious reason is that there are a series of problems that need to be addressed in order to modernize Medicare. To introduce a benefit addition that would substantially increase the spending of a program that is already financially fragile relative to its future needs without addressing these other issues of reform is a bad idea.

I personally support reform modeled after the FEHBP. I believe this type of structure would produce a more financially stable and viable program and would provide incentives for seniors to choose efficient health plans and/or provider and better incentives for health care providers to produce high quality, low-cost care. This type of program, particularly if provisions were made to protect the frailest and most vulnerable seniors, would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program for the plan that best suits their needs.

I recognize that the FEHBP is controversial with some in Congress, especially because of some of the difficulties the Medicare+Choice program has been having. It is important to understand, however, that many of the problems of the Medicare+Choice program reflect the exceedingly low payments that have been going to the plans where most of the enrollees live which the administration has proposed to address. Inadequate payments added to the problem of the differential spending on seniors between traditional Medicare and the Choice plans in the same geographical area plus the excessive regulatory burdens imposed on the plans during the first years following BBA helped transform what had been a vibrant rapidly growing sector into a stagnant and troubled one.

A second reason not to add a drug benefit without further reforms to Medicare is the difficulty of correctly estimating the cost of any new, additional benefit. Our past history in this area is not encouraging. The cost of the ESRD (end-stage renal disease) program introduced in 1972 was underestimated by several fold. The estimated cost of the prescription drug component of the catastrophic bill passed in 1988 and repealed in 1989 increased by a factor of 2½ between the time it was initially proposed and the time it was repealed. Many in Washington are now eagerly awaiting the next round of Congressional Budget Office forecasts for the prescription drug bills introduced in the last session of Congress.

In addition to cost and estimating concerns, important questions remain about how best to structure a pharmacy benefit. Most recent proposals have made use of pharmacy benefit managers or PBM's as a way of moderating spending without using explicit price controls. These strategies, when used by managed care, showed some promise for a few years although more recently they have seemed less effective. But most PBM's have relied heavily on discounted fees and formularies and only recently have begun using more innovative strategies to more effectively manage use and spending. If Medicare is to make use of PBM's, decisions will need to be made about whether and how much financial risk PBM's can take, the financial incentives they can use, how formularies will be defined and how best to structure competition among the PBM's.

All of these issues taken together reinforce my belief that just adding a prescription drug program to traditional Medicare is not a good idea. A better strategy would be to agree on the design of a reformed Medicare program and begin to implement changes now. It is likely to take several years to build the infrastructure needed for a reformed Medicare program and to transition to a new program. Producing the regulations needed to implement the legislation needed for a new drug benefit is likely to take at least 2 years.

Because of the delay in implementing major new Federal benefits, a reasonable interim step would be to put in a place a program providing prescription drug coverage to help those most in need. There are a variety of ways such a program could be designed. The current administration budget proposes one way. Last year, the administration had proposed the Immediate Helping Hand program, a grant program to States that allowed States to extend existing pharmaceutical assistance programs, expand Medicaid coverage or introduce a new program. Another strategy would be to provide coverage first to those populations who already get special treatment under Medicare, that is, the qualified Medicare beneficiary (QMBs) and the specified low-income beneficiaries (SLMBs)

Whether or not the benefits of providing an interim program of outpatient prescription drug coverage for selected needy populations is worth the costs, is a decision the Congress will need to make. Congress might well decide it's not worth the political capital it would take and focus its efforts directly on broader Medicare reform, which should certainly include a prescription drug program.

Let me re-emphasize the importance of making decisions on broader Medicare reform sooner rather than later. Concerns will always be raised about instituting significant changes in a program involving seniors. Whatever changes are made to the Medicare program may need to be modified for at least some subsets of the existing senior population. Some groups of seniors may need to be excluded from any change.

As we contemplate a Medicare program for the 21st century, it is also important to understand that the people who will be reaching age 65 over the next decade as well as the baby boomers have had very different experiences relative to today's seniors. Most of them have had health plans involving some form of managed care, many of them have had at least some experience choosing among health plans, most have had more education that their parents and many will have more income and assets. The biggest change involves the women who will be turning 65. Most of these women will have had substantial periods in the labor force, many will have had direct experience with employer-sponsored insurance and at least some will have their own pensions and income as they reach retirement age. This means we need to think about tomorrow's seniors as a different generation, with different experiences, with potentially different health problems and if we start soon, with different expectations.

Let me summarize my points as follows.

The administration proposes to spend $190 billion in fiscal year 2003–12 to modernize and reform Medicare:

- Specific provisions of long term Medicare reform have not yet been submitted; framework and principles are outlined in the budget;
- Funding includes support for a Medicare-endorsed Drug Card, a new Medicare low-income drug assistance program, incentives for new private plan options and strengthening Medicare+Choice.

Medicare needs to be reformed:

- Solvency and financial pressures will continue as important issues;
- The current benefit structure is inadequate and unfair; existing geographic cross subsidies are also unfair;
- Medicare's administrative structure is excessively complex and bureaucratic; information given to providers is often inaccurate, incomplete, untimely and difficult to use.

Adding a stand-alone drug benefit to traditional Medicare without further reform is risky:

- Imprudent to substantially increase the spending needs of a financially fragile program;
- Actual costs of a new benefit will be underestimated if history is any guide;
- Still a lot of dispute about design issues.

Interim program for those most in need seems a reasonable first step:

- Several designs are possible: increasing the Medicaid match for people just above poverty, limiting the program to special populations, e.g. QMB and SLMB;
- Interim program may not be worth the political capital it would require

Starting soon to design and implement a reformed Medicare is a good idea:

- Building the infrastructure will take time;
- Future seniors need to know the design of the future Medicare program;
- Future seniors will be different from today's seniors in terms of work experiences, income and education.

Mr. HOEKSTRA. Thank you very much.

Mr. Lieberman.

STATEMENT OF STEVEN M. LIEBERMAN

Mr. LIEBERMAN. Thank you, Mr. Chairman, Mr. Spratt. It is a pleasure to be here this afternoon. I would like to spend four or five minutes in my oral statement updating CBO's projections of Medicare spending and comparing our baseline projections of Medicare spending with those of the administration. I have a statement for the record that I would like to submit, and I would also like to express Director Crippen's apologies. Unfortunately, a scheduling conflict caused him to have to leave.

We have just completed updating our projections of Medicare spending as part of CBO's analysis of the President's budget. In

fact, next week we will be rolling out the entire analysis. But these projections are, if you would, the leading edge of that larger effort.

I would like to summarize by saying that CBO's new projections lower Medicare spending by about $80 billion relative to our January estimates. The revisions are primarily based on new information, and they leave our estimates about $225 billion higher than the administration's Medicare baseline. It is important to keep in mind that this difference is a small fraction of the more than $3 trillion that the Nation is going to spend on Medicare over the next 10 years.

Before turning briefly to our updated projections, I would like to underscore that the long-range fiscal picture remains unchanged. Baby boomer retirements which will begin within the current 10 year budget window—2003 through 2013—will double the number of Medicare beneficiaries over the next 30 years. As the chart shows the "big three" entitlement programs—Medicare, Medicaid, and Social Security—will virtually double as a share of GDP, rising from 8 percent to 15 percent of our Nation's economy. As you know, Mr. Chairman and Mr. Spratt, that 7-percentage point increase in GDP is about what we are spending on discretionary appropriations in total.

Let me turn now to our revised projections and then go from there to how they compare with the administration's. CBO's projection for 2002 of gross Medicare spending is now about 2.4 percent of GDP, or $248 billion. Beneficiary premium payments, mostly for Medicare Part B coverage, are projected to be about $26 billion, which results in projected net mandatory spending for 2002 of about $223 billion. After this, for simplicity, I am going to talk about net spending for benefits and ignore premiums as a separate calculation.

Over the 10 year budget window, CBO projects that gross spending—that is before deducting premiums—will be $3.6 trillion. Taking out the $0.4 trillion of premiums leaves us with net spending of $3.2 trillion.

As I mentioned, CBO's baseline is about 2.5 percent, or $80 billion, lower than it was a couple of months ago. Three factors, which mainly reflect new information, account for the $80 billion revision. The first and biggest part of the revision was for Medicare+Choice. A new regulation that the administration put out caused us to change our assumption about the cost of Medicare+Choice slightly. The second factor is that we reduced our projections of the cost of hospital outpatient services because, again, the administration had announced a new regulation. And third, we reduced projected spending by about another $15 billion for three additional factors.

The administration projects that net Medicare spending will total $3 trillion over the next 10 years. On a net basis, the administration estimate of growth is 5.4 percent. If you take the premiums out—as Secretary Thompson did—it is 5.7 percent. CBO and the administration both estimate that rates over the next few years will be lower than the average each project for the full 10 years of the projection period, and lower than the average each projects for the later years of the period. However, the administration's estimates of growth rates are lower than CBO's, on average, throughout the 10-year period.

The administration's cumulative 10 year baseline for Medicare, as I mentioned before, is $225 billion, or about 7-percent below CBO's, as shown by this chart. Hopefully, the chart also underscores that, although one would hardly want to sneeze at $225 billion, over this base, it is not that large a difference.

Differing economic assumptions, differing treatment of anticipated administrative actions, and differing technical assumptions account for the differences in the two baselines. To quickly run through these, about $40 billion of the difference over the 10 years is due to differing economic assumptions. In general, CBO assumed that the annual updates that drive Medicare payments will be one or two tenths of a percentage point a year higher than the administration's estimate. That is relatively small difference, but it accumulates to become the kind of change that we would all like to have in our pockets.

Another 10 to $20 billion of the difference between the baselines derives from the rules CBO uses; specifically, not anticipating administrative action. In contrast, the administration might announce that it was going to do something and then reflect that action within its baseline.

Differing technical assumptions account for about $175 billion over the 7 to 10 year period. It will be difficult to compare those assumptions, point-by-point, because one of the big areas in which CBO differs from the administration is in its projection of Medicare+Choice enrollment, which is currently in the range of 14 to 15 percent of all beneficiaries. CBO projects that Medi care+Choice enrollment will fall to about 8 percent of beneficiaries by the end of the period. The administration has it remaining basically at the same level—14 to 15 percent—at the end of the 10 years.

Growth in fee-for-service spending is often driven by increases in the volume and mix of services. Both CBO and the administration assume that per capita spending on services in the fee-for-service sector will grow faster than inflation, as Dr. Wilensky mentioned. However, CBO expects that increases in per capita costs above these arising from inflation will be larger than the increases assumed by the administration. The largest differences are in the areas of skilled nursing facilities, outpatient services, and home health services.

Both CBO and the administration estimate that growth in the so-called volume and mix of services will contribute less to spending growth than it did before the Balanced Budget Act was enacted in 1997. However, CBO's estimates of those contributions are somewhat higher than the administration's. We are assuming that rates will tail down from about 7 percentage points of excess growth in annual spending on skilled nursing facilities to only 4.5 percentage points, and from about 5.3 percentage points annually for hospital outpatient services to 3.8 percentage points. The administration also assumes that those contributions to spending growth will go down, but more rapidly.

One category where the two baselines diverge somewhat, is in home health spending. CBO assumes that the home health spending contribution to Medicare spending growth will decline from 12.5 percentage points to 7 percentage points a year. The adminis-

tration appears to assume a somewhat slower decline in that contribution that CBO assumes in the first 5 years of the budget window, but then a very rapid decline in the last 5 years.

Mr. SPRATT. Excuse me. I do not want to interrupt you, but I have a question to ask at this point. It will give you a breather anyway. Does this assume that the 15 percent across-the-board payment will be implemented since the law provides for it?

Mr. LIEBERMAN. I am glad you asked that, Mr. Spratt. Absolutely. We have assumed not just the 15 percent cut in home health payment rates but every feature of law, including full implementation of the new prospective payment systems. The only other point I was going to make is that place where CBO and the administration actually are quite similar is on the physician payment, the so-called substantial growth rate system. For hospital inpatient services, we are also generally quite similar.

To conclude, over the 5 year period—2002 through 2007—CBO's baseline and the administration's projections differ as a result of all factors by 4 percent. Considering the different economic and baseline assumptions, I believe 4 percent is a relatively modest difference. Not surprisingly, the difference broadens over the entire 10-year period, rising to 7 percent. The uncertainty associated with 7 to 10 year projections, the sheer complexity of the Medicare program, and the point that the Secretary was making about implementing new prospective payment systems—again we do assume those systems, but we have virtually no information about how providers will respond and how quickly spending will grow under them—those factors account for this $225-billion difference on a more than $3 trillion base of projected spending.

With that, I am happy to answer any questions.

[The prepared statement of Dan L. Crippen submitted by Steven M. Lieberman follows:]

PREPARED STATEMENT OF DAN L. CRIPPEN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE

Chairman Nussle, Congressman Spratt, and members of the committee, I am pleased to be here today to discuss projections of Medicare spending under current law.

As part of the Congressional Budget Office's (CBO's) analysis of the President's budgetary proposals, we have just completed updating our projections of Medicare spending. My testimony today will summarize those projections, which are part of our forthcoming March baseline, and discuss how they have changed since January. I will then compare CBO's baseline projections of Medicare spending with the administration's baseline projections. I will focus my discussion on projections of mandatory spending for Medicare benefits and on the premiums paid by Medicare beneficiaries.

CBO'S PROJECTIONS OF MEDICARE SPENDING UNDER CURRENT LAW

CBO projects that gross mandatory outlays by Medicare will total $248 billion in 2002. Benefits account for over 99 percent of that total, with spending for peer review organizations, efforts to control fraud and abuse, and other administrative activities making up the rest.

In 2002, beneficiaries who are enrolled in Part B of Medicare (the Supplementary Medical Insurance program) will pay a monthly premium of $54.00. Premiums in the Part B program are set to cover about 25 percent of spending for its benefits. A small number of beneficiaries who are not entitled to Part A benefits (through the Hospital Insurance program) on the basis of their work history (or that of a spouse) also pay a premium to enroll in Part A. CBO estimates that premium payments by beneficiaries will total $26 billion in 2002, resulting in net mandatory spending of $223 billion this year. In addition, the costs of administering the pro-

gram, which are funded by appropriations, will amount to an estimated $3.6 billion in 2002.

CBO projects that gross mandatory outlays for Medicare will total $3.6 trillion over the 2003–2012 period, with beneficiaries paying about $400 billion in premiums (see the table on the next page). Therefore, if current law remains unchanged, net mandatory spending is estimated at $3.2 trillion over the next 10 years.

Net mandatory spending for Medicare as a share of the Nation's gross domestic product will be 2.2 percent this year, CBO estimates. That share will remain relatively constant through 2007; it will then begin to rise, reaching 2.5 percent by 2012, driven both by the large increase in enrollment as the baby boom generation turns 65, and by the ever-expanding demand for health care.

SUMMARY OF CBO'S MARCH 2002 BASELINE PROJECTIONS OF MANDATORY MEDICARE OUTLAYS

[By fiscal year]

	Billions of dollars		Average annual rate of growth (percent)
	2002	2003–2012	
Gross Mandatory Outlays	248	3,590	6.9
Premiums	−26	−413	8.4
Net Mandatory Outlays:			
Unadjusted	223	3,177	6.7
Adjusted for timing shifts[1]	226	3,177	6.6

Source: Congressional Budget Office.

[1] Outlays adjusted to eliminate the effect of accelerating payments to group plans from October to September in some years.

SPENDING GROWTH HAS VARIED IN RECENT YEARS

Net mandatory spending for Medicare grew by 10.3 percent in 2001. However, that rate of growth was inflated by a provision of the Balanced Budget Act of 1997 (BBA) that accelerated $3 billion in payments to group plans from October to September 2001 or from fiscal year 2002 to fiscal year 2001. When spending is adjusted for that accelerated capitation payment, the underlying rate of growth in 2001 was 8.7 percent, a substantially larger increase than the changes in annual spending during the 1997–2000 period, which averaged 1.2 percent. Significant growth resumed in 2001, after Medicare absorbed the substantial changes in the program's payment rules enacted in the BBA in 1997. That growth also reflected increases in payment rates and other changes enacted in the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act of 2000. CBO projects that net mandatory spending in 2002 will be 7.1 percent higher than such spending in 2001, after adjusting for the accelerated capitation payment.

COMPONENTS OF SPENDING GROWTH IN THE COMING DECADE

Over the next 10 years, net mandatory spending for Medicare is projected to grow at an average annual rate of 6.6 percent again, after adjusting for shifts in the timing of payments to group plans. About 1.7 percentage points of that growth rate stem from increases in enrollment in the Medicare program, and about 3 percentage points are attributable to automatic hikes in payment rates in the fee-for-service sector to adjust rates for changes in the prices of inputs. Another 3 percentage points are due to changes in the use of services above those accounted for by changes in enrollment. The increased use reflects boosts in the number of services furnished per enrollee, and a shift in the mix of services toward higher-priced and often more technologically advanced services. Those increases are offset in part by a decrease of about 1 percentage point as a result of updates in the rates paid to Medicare+Choice plans, which will be lower than updates to payment rates in the fee-for-service sector.

Projected rates of growth in net mandatory spending are relatively low through 2006 (averaging 5.7 percent a year), because updates to payment rates for many services will be held below the increase in the prices of inputs in the next few years and because enrollment in Medicare is projected to grow by only about 1 percent a year. Rates of spending growth are higher after 2006 (averaging 7.7 percent a year) because updates to payment rates for many services will be fully adjusted for changes in input prices and because enrollment will grow at an average rate of about 2 percent a year (see Table 1).

PROJECTIONS OF SPENDING BY TYPE OF PROVIDER

Payments to hospitals for inpatient services and payments to physicians are the largest components of Medicare spending, accounting for about two-thirds of the program's outlays. They are also the slowest-growing components of spending in the fee-for-service sector. Payments to hospitals will grow at an average rate of 6.3 percent a year through 2012, CBO projects, and payments to physicians will grow at an average rate of 5.4 percent a year. By contrast, payments are projected to grow at rates that average 9 percent to 16 percent a year for services furnished by home health agencies; hospital outpatient departments and other facilities covered under Part B; and nonphysician professionals and other providers of ancillary services. CBO estimates that payments to Medicare+Choice plans and other group plans will decline through 2006 and then grow slowly, returning to their 2001 level by 2012.

CHANGES FROM JANUARY TO MARCH IN CBO'S BASELINE

CBO's March baseline projection of $3.2 trillion in net mandatory spending for Medicare over the 2003–2012 period is about $80 billion or 2.5-percent lower than its projection in January. Three factors account for that revision:

Reduction in projections of payments to Medicare+Choice plans about $30 billion over the period. That change reflects the administration's January announcement of preliminary payment rates for Medicare+Choice in 2003, as well as updates to CBO's projections of enrollment in those plans.

Reduction in projections of payments for hospital outpatient services about $35 billion over the 10-year span. That change reflects the administration's announcement of an implementation date for a final rule concerning pass-through payments and an analysis of updated data on the cost of "buying down" (contributing more to) co-insurance paid by beneficiaries for hospital outpatient services.

Reduction in projected spending, another $15 billion over 10 years to reflect an updated analysis of the effect on spending of the changing age distribution of Medicare beneficiaries; an improved method of converting the price indexes that the administration uses to update payment rates to price indexes based on CBO's economic projections; and the effects of revised projections of outlays on premiums collected from beneficiaries.

The change in CBO's projections of payments to Medicare+Choice plans reflects a significant revision in CBO's methods. Under the rules established in the Balanced Budget Act and modified in subsequent legislation, the rates paid to Medi care+Choice plans are supposed to move gradually to the higher of a floor amount or a 50:50 blend of rates based on local per capita spending in the fee-for-service sector and the national average amount of spending per capita, adjusted for variation in local prices. When the payment rate is at either the floor amount or the 50:50 blend, it will be increased each year at the same rate as the increase in spending per capita in the fee-for-service sector. The transition to the floor amounts took effect immediately with the legislation's enactment. The transition to the 50:50 blend is subject to a minimum update that is generally 2 percent and to a budget-neutrality provision requiring that payment rates, on average and overall, grow from their pre-BBA levels at the same rate as the increase in per capita spending in the fee-for-service sector.

In CBO's January baseline, as in previous baselines, rates paid to Medi care+Choice plans were assumed to grow, on average, at the same rate as per capita spending in the fee-for-service sector.

In January, the administration issued a preliminary notice of the rates that Medicare would pay to Medicare+Choice plans in 2003. The notice stated that because of revisions to estimates of growth in per capita spending in the fee-for-service sector, payment rates would be reduced to comply with the budget-neutrality provision in the BBA. However, the notice also stated that because of the minimum-update provision, all payment rates including rates at the floor amounts would be increased by 2 percent in 2003. The administration did not announce its projections of updates to payment rates for 2004 and later years.

CBO drew several conclusions from the administration's announcement: Medicare+Choice payment rates, on average, are above the budget-neutral amount and under current law will remain permanently above it. Overall, therefore, Medicare pays more for enrollees in Medicare+Choice plans than it would pay if those beneficiaries were in the fee-for-service sector.

All payment rates will increase again by 2 percent (the minimum update) in 2004.

Floor amounts will increase by more than 2 percent in 2005 and will grow with fee-for-service spending in subsequent years, but all other rates will increase by 2 percent each year until they reach the level of the floor or the 50:50 blend. (CBO

estimates that the proportion of payments made at floor rates or at 50:50-blend rates will increase from about 40 percent in 2005 to 95 percent by 2012.)

CBO has also revised its projections of enrollment in Medicare+Choice plans on the basis of the program's recent experience and projected payment rates. The percentage of Medicare enrollees in Medicare+Choice plans is now estimated to decline from 15 percent in 2001 to 8 percent in 2012. By contrast, CBO last year projected that the percentage of Medicare beneficiaries enrolled in Medicare+Choice plans would remain relatively stable throughout the 10-year budget window.

COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINES

The administration projects that net mandatory spending for Medicare will grow at an average rate of 5.4 percent a year through 2012. It also projects that growth will tend to be lower than that 10-year average rate through 2006 (averaging 4.0 percent annually) and higher after 2006 (averaging 6.4 percent). The administration also estimates that net mandatory spending for Medicare will total $3.0 trillion over the 2003–2012 period, which is about $225 billion, or 7 percent, lower than CBO's projection for the same period (see Table 2 and Figure 1).

DIFFERENCES ARISING FROM ECONOMIC ASSUMPTIONS

About $40 billion of the 10-year difference between CBO's and the administration's estimates is due to differing economic projections. Payment rates for most services are adjusted, or updated, each year to reflect changes in the prices of inputs. In general, CBO projects that those updates to payment rates will be one or two tenths of a percentage point higher than the administration's projected updates.

DIFFERENCES RESULTING FROM ASSUMPTIONS ABOUT ADMINISTRATIVE ACTIONS

Another $10 billion to $20 billion of the 10-year difference stems from possible administrative actions that the administration's baseline assumes, but that CBO's does not. The administration's baseline assumes that the payment method for outpatient prescription drugs covered under the program will be changed in 2003. However, the administration has not yet announced any specific proposal for changing the payment rules. As a result, CBO's projections incorporate the assumption that Medicare continues to use the existing payment method.

DIFFERENCES STEMMING FROM TECHNICAL ASSUMPTIONS

The remaining difference of about $175 billion over 10 years reflects different technical assumptions about participation in Medicare+Choice plans and in the rate of increase in the volume and mix of services furnished to beneficiaries in the fee-for-service sector. A clear comparison of CBO's and the administration's baselines by payment category is difficult, because the two groups of estimates reflect very different assumptions about the proportion of beneficiaries who will participate in Medicare+Choice plans.

Medicare+Choice. The administration projects that the proportion of beneficiaries enrolled in Medicare+Choice plans will remain fairly stable in the range of 14 percent to 15 percent over the coming decade, whereas CBO projects a sharp decline in that share to 8 percent by 2012. The administration's assumption that a relatively large share of Medicare enrollees will remain in those plans while their payment rates are growing much more slowly than rates in the fee-for-service sector may contribute significantly to the differences between CBO's and the administration's baseline projections.

Growth Stemming from the Volume and Mix of Services in the Fee-for-Service Sector. Both CBO and the administration assume that spending per capita on services in the fee-for-service sector will grow at a faster rate than will the adjustments to payment rates for changes in input prices. In general, however, CBO assumes larger increases in per capita spending as a result of changes in the volume and mix of services than does the administration.

The biggest differences between those assumptions about increases in spending are in the areas of skilled nursing services, hospital outpatient services, and home health services. The payment systems in all three settings have been changed substantially in the past few years, and how the volume and mix of services will change under the new systems is uncertain. Both CBO and the administration assume that increases in the volume and mix of those services will contribute less to growth in spending under current law than they contributed under the payment systems that existed before the BBA. CBO estimates that those effects will steadily decline over the coming decade as follows: From about 7 percentage points a year in the next few years to 4.5 percentage points by 2012 for skilled nursing services; from about

5.3 percentage points to 3.8 percentage points a year for hospital outpatient services and other payments to facilities for services covered under Part B of Medicare; and from 12.5 percentage points to 7 percentage points a year for home health services.

The administration appears to make a similar assumption about the steadily lessening effect of changes in the volume and mix of services although it projects a more rapid weakening than does CBO for skilled nursing services and hospital outpatient services. Compared with CBO's assumption about volume and mix changes for home health services, however, the administration's assumption seems to reflect more-rapid increases in the volume and mix of home health services through 2005 or 2006, and a more rapid decline in the volume and mix insubsequent years.

CBO and the administration make very similar assumptions about the effect of volume and mix changes in relation to the sustainable growth rate (SGR) system of payment for services on the physician fee schedule and in relation to payments to hospitals for inpatient services.

The SGR system automatically adjusts payment rates for services on the physician fee schedule to compensate for changes in the volume and mix of services. Therefore, the differences between CBO's projections of payments under the physician fee schedule and the administration's projections are almost entirely attributable to economic factors and to differences in the projected number of beneficiaries in the fee-for-service sector. Likewise, both CBO and the administration assume that changes in the mix and volume of services contribute about 1 percentage point to annual increases in payments to hospitals for inpatient services 1 percentage point, that is, above the growth resulting from increases in enrollment and adjustments for inflation.

In the near term, CBO's baseline and the administration's projections are similar, differing by only 4 percent over the 2003–2007 period. The differences between the estimates over the 2003–2012 period broaden, amounting to about 7 percent cumulatively. That difference is not very large in view of the uncertainty that is always associated with a 10-year budget window and, in particular, in view of the new payment systems that Medicare has recently instituted in a number of areas.

TABLE 1.—CBO'S MARCH 2002 BASELINE PROJECTIONS OF MANDATORY OUTLAYS FOR MEDICARE, 2002–2012

[By fiscal year, in billions of dollars]

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Part A: Hospital Insurance											
Fee-for-service program:											
Hospital inpatient care	102	108	115	122	130	138	147	156	166	176	188
Hospice	4	4	4	5	5	6	6	6	7	7	8
Skilled nursing facilities	14	14	15	17	19	21	23	25	27	30	33
Home health services	6	6	6	7	9	10	12	13	15	17	19
Subtotal	126	132	141	151	162	174	187	201	215	231	248
Group plans[1]	18	18	17	18	15	17	17	18	18	21	19
Total, Part A Benefits	144	150	158	169	177	191	204	218	234	252	267
Part B: Supplementary Medical Insurance											
Fee-for-service program:											
Physician fee schedule	43	44	44	46	49	52	56	60	64	68	72
Other professional and outpatient ancillary services[2]	19	21	23	26	29	32	35	38	42	46	50
Other facilities[3]	21	22	24	27	29	32	36	39	43	46	51
Home health services	6	7	8	10	11	13	15	17	20	23	26
Subtotal	88	94	100	108	118	129	142	155	168	183	199
Group plans[1]	15	16	15	16	13	15	15	16	17	19	17
Total, Part B Benefits	103	109	115	124	131	144	157	171	185	202	216
All Medicare Benefits	247	259	273	293	309	335	361	389	419	454	483
Other Mandatory Outlays	2	2	2	1	2	2	1	2	2	1	2
Gross Mandatory Outlays	248	261	274	294	310	336	363	391	420	456	484
Premiums	−26	−28	−30	−32	−35	−39	−42	−46	−50	−54	−58
Net Mandatory Outlays	223	233	245	262	275	298	321	345	371	402	426
Memorandum:											
All Home Health Agencies	11	12	14	17	20	23	27	31	35	40	45
All Group Plans	33	34	31	33	28	32	32	34	35	41	36

All Fee-for Service Programs	214	225	241	260	280	303	329	355	384	414	447
Outlays as a Percentage of GDP	2.2	2.1	2.1	2.2	2.1	2.2	2.3	2.3	2.4	2.4	2.5

Source: Congressional Budget Office.

[1] Group plans include Medicare+Choice plans, plans paid on a cost basis, health care prepayment plans, and some demonstrations. Nearly all enrollment and spending is in Medicare+Choice plans.

[2] Includes durable medical equipment, independent and physician in-office laboratory services, ambulance services, and other services paid by carriers.

[3] Includes hospital outpatient services, laboratory services in hospital outpatient departments, rural health clinic services, outpatient dialysis, and other services paid by fiscal intermediaries. Also includes payments to skilled nursing facilities for services covered under Part B.

TABLE 2.—COMPARISON OF CBO'S AND THE ADMINISTRATION'S BASELINE PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE, 2002–2012

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Net Mandatory Outlays (Billions of dollars):											
CBO	223	233	245	262	275	298	321	345	371	402	426
Administration	223	229	237	252	260	279	297	317	337	363	378
Difference (CBO minus administration)	0	4	7	10	15	19	23	28	34	39	48
Annual Percentage Change in Spending:											
CBO	4.0	4.7	4.9	7.3	4.8	8.3	7.6	7.6	7.5	8.3	6.1
Administration	4.0	2.8	3.6	6.4	3.2	7.3	6.4	6.6	6.4	7.8	4.2

Source: Congressional Budget Office.

Mr. HOEKSTRA. The bottom line then I think for the difference in the numbers is that, what I am hearing you say, given all of the uncertainty, it might actually be remarkable that two groups of experts taking a look at this and ending up as close as what you are is kind of surprising.

Mr. LIEBERMAN. That would certainly be the story that the estimators like myself would tell. We have worked very closely and keep working closely with the CMS actuaries. My characterization of the difference between the two baselines is that relatively minor honest technical estimating differences drive it. There are some economic differences because our economic assumptions are different from the administration's, and there is some variation as a result of where different conventions go on and what we put into the baselines.

Mr. HOEKSTRA. And then also would you dare admit that you are probably both going to be off by at least 7 to 10 percent if we are sitting here in 10 years and taking a look at these numbers?

Mr. LIEBERMAN. Mr. Chairman, I think we would be happy to admit that. As you know, in CBO's budget documents we regularly try to look at the uncertainty surrounding our forecast. Our estimators all do poorly in calling turning points, whether they are in the economy or in Medicare spending. None of us projected that Medicare spending a couple of years ago would decline below what it had been in the prior year. Let me just leave my answer as a, "yes sir."

Mr. HOEKSTRA. I think what I am just trying to say is that the numbers are very, very important to take a look at from a trend, because I do not think any of us are disputing the trends and that we are going to see significantly increasing costs and percentage of GDP, but if we actually start to try to take a look at the exact differences, we are talking about some issues that maybe are not necessarily that important. That both CBO and OMB agree on the trends and directionally where we are headed.

Mr. LIEBERMAN. I think that is absolutely fair. And again, I think the point is the one that you made, Mr. Chairman, that the one thing that we really do know is that we are doubling the number of Medicare beneficiaries as the baby boomers retire. Almost the entire history of the program suggests that the per-beneficiary cost increases faster than the growth of the economy. So when you put together the enormous demographic shift of a doubling of beneficiaries but only a 15 percent increase in the workforce with real inflation-adjusted growth in spending per beneficiary, you have very, very difficult fiscal circumstances starting just at the end of this budget horizon.

Mr. HOEKSTRA. I came out of the private sector and I did a lot of forecasting for new product sales. If two of us sat down and projected out what the sales might have been for a new product 10 years out and we were this close together, we probably would have been pretty happy and said, hey, we think we see the world pretty much in the same light and viewing it in the same context.

Dr. O'Toole, it went right by me. What did you say at the end of your testimony about additional research on infectious diseases and the impact that could have on bioterrorism?

Ms. O'TOOLE. I was saying that if we make substantial investments in research in infectious disease, which we will have to do in order to keep up with what I anticipate will be the advances in biological weapons we will, I think, outrun the weapons race. We will be able to create the vaccines and the drugs that we need to defeat any future weapons. And that same research, if appropriately directed and robust enough, will inevitably, as offshoots of this investigation and how to defeat weapons, also give us clues to how we could combat common diseases such as malaria, HIV/AIDS, and drug resistant TB, for example.

Mr. HOEKSTRA. Are you also saying that if we invest in this research, that you would find some kind of a magic key or combination that can be used multiple times against bioterrorism. I mean, is there some secret that we uncover that if we——

Ms. O'TOOLE. Well, I do not think there is any silver bullet that defeats all diseases.

Mr. HOEKSTRA. OK.

Ms. O'TOOLE. But if we knew more, for example, about how our immune system worked so that we could pump up the immune response more generally against different kinds of infections; if we understood what causes pathogenicity, the reasons why bacteria and viruses successfully attack human health, then we would probably have big clues and very powerful weapons against diseases generally whether they were intentionally inflicted through biological weapons or occurred naturally.

Mr. HOEKSTRA. Earlier in your testimony I know you said the more we learn the greater risk and the greater threats we may face.

Ms. O'TOOLE. Yes.

Mr. HOEKSTRA. So even with that kind of research it may give as much information to the bad guys as it does to the good guys.

Ms. O'TOOLE. Well, there is no avoiding that.

Mr. HOEKSTRA. Right.

Ms. O'TOOLE. The dark side of biology is upon us. Biology is now powerful enough that if you apply biological knowledge with malevolent intent, you can make terrible biological weapons. We are going to pursue biological knowledge because we desperately want the good stuff that comes of understanding the life sciences. We want the medical advances. We want the agricultural advances. And furthermore, that research is being propelled by international corporations with big capital budgets and whose products are avidly desired. So that is going to go forward, and it should. What we need to do is figure out how to responsibly manage that knowledge and also how to apply it to protect ourselves against the dark side.

Mr. HOEKSTRA. I think it is kind of interesting, and you may both want to address this issue, Dr. Wilensky and Dr. O'Toole, all of my hospitals now are being driven to be efficient, kind of like a just-in-time inventory, that there is just exactly enough inventory in terms of space and beds and all of these types of things to meet existing conditions or to meet the various demands that may be placed on them. It is kind of "OK, let's get this down to be as efficient as possible." Our private payers want us and need us to be as efficient as possible. The Federal Government keeps ratcheting this down.

So I go to my hospitals and they are closing wings, they are closing rooms, they are taking beds out of circulation, and they are doing in many ways what we have told them to do—become very, very efficient. And I am wondering whether we need to change that criteria in terms of, what you talked about earlier, the capacity issue.

In my district and I think, as you said, in no part of the country today, contiguous area, could they handle an instance of 500 people becoming ill because of an attack and have the facilities. You said research that. Do you have any suggestions or how we start going after that?

Ms. O'TOOLE. I do not have any easy answers. It is a very difficult problem and, as you point out, it is a structural problem. It is a consequence of what happens when you make health care into a business. The financial pressures on health care have caused hospitals and health care organizations to eliminate so-called excess capacity. So they do use just-in-time modeling, and not just for equipment, but also for nurses. Tomorrow's nursing staff is based on today's patient census. It makes it almost impossible to ramp up quickly in order to meet surges in patient demand, let alone a great big sudden surge such as you would see in a big bioweapons attack.

There are not any quick fixes to this. It really is a structural problem. You can get some marginal improvement if, for example, we coaxed hospitals into collaborating with each other during disasters instead of having them operate as autonomous competitors, which is what we have driven them to in the current context. But those are improvements at the margins.

I think that if we had a big bioterrorism attack, we would have to go to some dramatically new way of caring for patients, a real phase shift. It might be that you take over armories and schools and made them into makeshift hospitals, although you still need the staff to take care of such facilities and it is not clear where they would come from. It may be that we go to home-based care and use telemedicine capabilities and so forth. But there is no easy answer.

Ms. WILENSKY. I would like to offer a slightly dissenting view. I believe in certain areas, like in inventory control and in some of the meal production and laundry services, that hospitals have substantially improved their efficiency using some of the industrial engineering strategies that are available. But in the basic delivery of health care systems, I think we are very much at the beginning of the process. This is especially true in the number of medical errors that go on, the inability to get it right the first time. The kind of process engineering that has been very much a part of other sectors of the economy has not happened in health care delivery. It was part of the whole Institute of Medicine report on medical errors and could have very profound implications for being able to do a much more effective job in terms of delivering health care. It will require better integration of information than goes on now and perhaps that will be the up side of the very costly activities that are being undertaken now as part of HIPAA regulations.

But I think what you are raising is a somewhat different issue, although they are somewhat related. That is if you have a reason-

ably efficiently running health care system giving good quality of care, how do you make sure you can handle peak load-crises? I do not think anybody gave it much thought before 9/11, to be perfectly honest. Now they are.

There are all sorts of capabilities that might be considered. VA stands as the backup to the military when there is an emergency situation in the military in terms of being able to provide excess capacity. It may be important to step back and think about how health care delivery in the military, in the VA system, and in the public health part of our health care system could be mobilized in the event of an emergency. Because of the Presidential Task Force I am now co-chairing, I am spending much more time understanding how VA and DOD works and does not work together. But I think there has not been enough thought about how the rest of the health care system could interact.

We all understand, post 9/11, we need to think in ways we have not thought of before. But I do not think our economy can stand the notion of let's ramp up more excess capacity. We already are probably the most over-capacitated country in the world in terms of medical care capacity, and we should think hard and long about trying to increase that capacity for what are likely to be very rare, peak load problems.

Mr. HOEKSTRA. You have an interesting problem.

Ms. O'TOOLE. Could I respond?

Mr. HOEKSTRA. Part of the reason we have got the capacity issue is the demand side. But did you want to add something?

Ms. O'TOOLE. Yes. I think I agree with virtually everything Dr. Wilensky said. Just as one example, the medical errors systems that we need to cut down on the times that patients get the wrong drug dose in the hospital and so forth, if we build them correctly, we could use those systems on a normal day to track and reduce medical errors and then flip them during a catastrophe into systems that monitor the progress of an epidemic.

But in order to plan that far in advance, in order to inject that kind of innovation into the system, you have got to give something now so that there is a person there to plan. We may have some "excess capacity" but on a given day there are not a lot of people at Johns Hopkins standing around without ten things to do. And that is the problem: we have to be forward looking in the health care system even as we take care of the daily demands, which are many.

Mr. HOEKSTRA. Thank you. Mr. Spratt.

Mr. SPRATT. Thank you all for your testimony. Each one of you made a very substantive contribution to our discussion today. I am sorry more were not here to hear it. Nevertheless, be assured it will be part of our base of knowledge when we deal with the budget this year.

First of all, Mr. Lieberman, you describe the difference as relatively minor. But $225 billion is still a lot of money, even for government work.

Mr. LIEBERMAN. Absolutely, Mr. Spratt. I would note that the differences are smaller in the first couple of years and then they increase. But there are significant differences. I believe that there is a table in the written statement that shows the annual amounts.

I do not mean to trivialize them and—as I said in my response to the chairman, from a technical estimator's viewpoint and considering the complexity—I do not think there is anything certain in it; honest people can have differing interpretations. I think when you get down to it, there is a relatively modest but real difference.

Mr. SPRATT. What struck me is that in the near term the assumption is even more hopeful; namely, that costs will be about 4 percent through 2006, and after 2006 it picks up to between 6.5 and 7 percent.

Mr. LIEBERMAN. Yes, sir. That is the administration's projection.

Mr. SPRATT. That means we would have a pretty sharp break between the rate of increase over the last couple of years and next year, does it not?

Mr. LIEBERMAN. It does. It is not clear to me why the CMS actuaries are assuming quite the low rate that they are. Part of the low rate derives from some legislative cuts that are in effect, but those effects should be in both of our baselines.

Mr. SPRATT. They are in the baseline?

Mr. LIEBERMAN. They are in both baselines. My sense is that CBO's projection is about a full percentage point higher over the first 5 years than the administration's in terms of annual growth spending.

Mr. SPRATT. Yes. Now looking back 10 years, what was the rate of growth in Medicare costs?

Ms. WILENSKY. Ten to 12 percent per year from 1990 to 1997.

Mr. SPRATT. Ten to 12 percent. Then after 1997 it dropped to—well in 1999 it was just about zero.

Ms. WILENSKY. It was 1.5 percent the first year, minus a half a percent the second year, 3.3 percent the third year post BBA.

Mr. SPRATT. But last year it was?

Mr. LIEBERMAN. Last year, after adjusting for the shift in payments to group plans——

Mr. SPRATT. Yes. That is right, you had a——

Mr. LIEBERMAN. It was about 8.7 percent. So it was lower than it had been historically, but it was still significant.

Mr. SPRATT. That is a pretty significant drop when there is no policy change. You have got policy changes after 1997 that account for the sharp fall off. With no policy change, they are saying we are going from 8.7 to 4 percent.

Mr. LIEBERMAN. That is a correct observation, Mr. Spratt.

Mr. SPRATT. Let's hope it happens. But we have to formulate policy. We sat here last year looking at a $5.6 trillion estimate of the surplus. By August the economic and technical factors had taken that down 40 percent. No policy changes, just estimation forecasting techniques accounted for huge shrinkage in it. We have got a big policy decision to make about exactly what Medicare is going to cost before we add on additional expenses for provider payments and what have you.

In any event, I think there still is a significant difference between you and them even after you have made some accommodations to reflect their——

Mr. LIEBERMAN. Yes sir—a difference of 4.2 percent over the first 5 years, and 7 percent over the whole 10 year budget window. As Mr. Hoekstra just said, for throwing darts, it is probably reason-

ably accurate, but for making policy the way that this committee has to, I wish CBO's and the administration's projections were in tighter alignment.

Mr. SPRATT. Dr. Wilensky, you have been on the Medicare Payment Advisory Commission I believe.

Ms. WILENSKY. Yes. I was its chair for 4 years.

Mr. SPRATT. You are aware then of the recommendations that MedPAC made that Chairman Thomas of the Ways and Means Committee has sent to Secretary Thompson?

Ms. WILENSKY. I am aware.

Mr. SPRATT. Do you think that those provider payment adjustments need to be made for the sake of the system and for the sake of cost justice itself?

Ms. WILENSKY. Well, I was not part of their deliberations, but I thought it was an awful lot of money. I was surprised at how much it would cost.

I believe there is a problem with Medicare physician payments as they now exist, particularly with the updates which are tied to the growth in GDP. The previous year when I was still chair, MedPAC had recommended that it replace that system and make the updates more comparable in notwithstanding to the rest of Medicare. I wish it had happened then. Last year would have produced a smaller update. The physicians were very quiet about the changes upsides last year. For the previous three years they had unusually high updates because of the linkages with GDP. If it had been changed a year ago, it would have produced better policy and cost far less then now. The problem is how to make the adjustment now. Minus updates for three or four years, it appears to be likely now is probably going to produce some access problems, although this has not been a problem in the past.

I do not think you can fix the whole problem right away. It is too much. I think you need to look hard at the rest of the updates. Historically, market basket has not been the update in Medicare and yet many of the recommendations were for full market basket updates. There may be some reason why that now appears to be necessary but it is not historically what Congress has done.

Mr. SPRATT. Well the physician payment update is $128 billion out of $175 billion of the total package.

Ms. WILENSKY. I do not see how you can implement the full recommendation unless you have much more money than I am aware of. But I think there needs to be some accommodation both because otherwise I think series will experience problems, and because it is not good policy.

Mr. SPRATT. Dr. O'Toole, you noted that 18 anthrax cases overstressed the system. We had two witnesses here, I have forgotten the name of the commission they co-chaired, Lee Hamilton and Newt Gingrich. Newt made an interesting observation; namely, that the New York attack did not over-stress the system to the extent that it might have in different circumstances because, unfortunately, most of the people who were affected were killed. So, we did not have the wounded, and in addition it was to some extent, a macabre sense, a conventional attack as opposed to a chemical/biological/nuclear attack. Would you agree that we have yet to see the

system stressed and it could be vastly worse than what we saw in New York?

Ms. O'TOOLE. Yes, I think that is exactly right. We really have not seen the health care system stressed in a mass casualty disaster where people require intense medical care right away for many decades. Even the Oklahoma City bombing resulted in I think 72 hospital admissions and many of them were straightforward trauma victims. So we really have not had, thank Heavens, the experience of having to care for a lot of people suddenly needing intense medical care, let alone ICU-type care.

Mr. SPRATT. As you look at exposed and vulnerable facilities and all the places where terrorists willing to take the risk of their own lives might attack us, it is just infinite, it is endless. You have to draw a line somewhere. One of the recommendations the two of them made was that we probably could not do this in every locality, we needed to have it regionally based. New York, I guess, would be a region unto itself, so would Los Angeles and Chicago, the major cities would be, but for most of the country we would have a regional crisis preparedness. Do you subscribe to that view yourself, and is this a trend that you detect in the plans the administration has laid here?

Ms. O'TOOLE. Well, I think that is definitely the way to go. I think, for example, in Baltimore, the city that I know best, it would not make sense to make every hospital equipped to handle a chemical weapons attack which requires capital outlays for decontamination stations and so forth. We should probably have one hospital that can do that very well and everybody ought to have some capacity to do it. But I think regionalization of responsibilities and capabilities is absolutely the most sensible way to go.

I would like to see the Hospital Associations embrace that view. I think it is politically difficult for them to do so. There are many more rural hospitals in number than urban health centers, for example, and we do need to have a plan to make the rural areas in the country capable of dealing with an attack. Who knows where the next one will be? Who would have thought Oklahoma City would be the site of a terrorist attack?

But we do need to have some kind of regional plan. The HHS guidance at this point does require States to address regional capabilities. That is about all it says. It is a good place to start. I do not know that we could go much farther at this point. But I would hope that next year we would see a much more coherent "who is going to do what" blueprint laid out so that we could get some efficiencies in the system.

Mr. SPRATT. One final question. In the aftermath of 9/11 some Members went from here to Atlanta just to see CDC, what do they do and what kind of security preparations have they made. They came back very concerned about the physical state of their facilities, about the limit to which they are already pressed to their capacity, and about the lack of any really consciously laid security plan around the premises. You did not mention that. Do you think we are overlooking something here in the budget? There is no real plus-up for CDC in this budget at all.

Ms. O'TOOLE. Well I am always happy to advocate for more money for public health. I think if you set priorities, the priority

has to be on improving local response because that is where the burden is going to fall. And if you think CDC is in decrepit shape, let me show you a few State health departments. And that is the problem. If you have some extra money around, CDC can certainly use it and it would be of benefit to the rest of the country. But the emphasis I think is appropriately on local and State health departments in this budget. I do think, as Secretary Thompson said, CDC desperately needs money for improved infrastructure. My other plea for CDC would be for ways of bringing in more people from the medical and public health professions to CDC, particularly midcareer people who might be able to come in for two or 3 years and then go back out, infusing them immediately with some experienced folks.

Mr. SPRATT. Thank you very much, all of you, for your testimony.

Mr. HOEKSTRA. Mr. Holt.

Mr. HOLT. Thank you, Mr. Chairman.

Dr. O'Toole, I would like to pursue some points you raised. And forgive me, I had to be out of the room for your oral testimony but I have read your written testimony, and forgive me if I am asking you to repeat things that you have already covered. Along the lines of your discussion with Mr. Spratt, you say, I think appropriately, that when we are talking about bioterrorism we want to choose responses that have other humanitarian and peacetime benefits as well, and you make that case very well. And you say that in light of the expense in various ways, from the 18 cases of anthrax that you do not think that we are spending too much in the President's budget to deal with bioterrorism.

But you do point out a couple of problems having to do with the R&D. And that has to do with whether there is a real R&D strategy. I asked the Secretary earlier if he could explain how they know where they are going with the research. I would like you to expand on that a little bit.

Also, you talked about the need for a clearinghouse and some coordination. I certainly have observed, as I have looked into this work with pathogens, that there has been disorganization and sometimes turf fights. The Army, SAMRAD, CDC have not always worked as closely as I would like to see. What do you have in mind for coordination of this cross-agency government effort?

Ms. O'TOOLE. Well, as you say, what might be called biodefense research and development is spread over multiple agencies in the government and there is no one place where you can find out who is doing what. This has been very problematic, for example, for biotech firms who think they have something useful to offer who do not know how to plug in. Even a simple sort of clearinghouse, a web-based list of who is doing what across the government, could help us engage the talent in the biotech and university research communities to the benefit of these government programs.

It would be terrific if we could figure out some way of dealing with the congressional cross-jurisdictional issues in biodefense R&D. This is a very singular problem. We have a national security problem, bioterrorism preparedness. This is not a public health problem primarily, this is a national security problem and yet its jurisdiction is spread over multiple committees and is going to have

to mend with programs in the Department of Defense if we are going to get the best bang for the buck.

At the same time, in order to really utilize the real talents in bioscience in America, we must engage the university researchers and the folks in biotech who do not now do business with the government by and large except via the traditional NIH grant route, which may not be the best or at least the only mechanism through which we want to solicit R&D work, particularly the development work which NIH does not typically do.

So I think that it may be unfair to say that we have a problem with the absence of an R&D strategy. These monies just got out there within the last month, NIH has reached out to the traditional research community to solicit ideas. I think what we do need to do though is make sure that there is a strategy going forward and hopefully that strategy will reach across multiple institutions of government and multiple congressional committees.

Mr. HOLT. I do think that this—you refer to the development part of R&D—it seems to me this is a particularly noteworthy area where directed research can have great humanitarian and peacetime benefits.

Changing the subject to something that maybe you can answer quickly; in helping us here in Congress deal with this, and I think you have some experience in that, do you think we would benefit from having an Office of Technology Assessment?

Ms. O'TOOLE. Yes.

Mr. HOLT. Thank you.

Ms. O'TOOLE. How is that for brief?

Mr. HOLT. Thank you.

Thank you, Mr. Chairman.

Mr. HOEKSTRA. Chairman Nussle.

Chairman NUSSLE. I just wanted to thank our panelists. I wish I could have been here for the actual testimony. I read some of it. I think the one thing that I was most encouraged by, first of all, is that HHS has a huge budget and a number of different areas but health care is really the key component. We have a lot of successes and I know a lot of bipartisan support in a number of areas, but, boy, health care is going to be a tough nut to crack. And it is not even a partisan issue. As some of you know, it becomes regional, rural and urban; all sorts of things.

So more than anything else I just wanted to thank you for your advocacy in suggesting that Medicare should be tackled in total. As I said to the Secretary, while I certainly would be very interested in providing a prescription drug benefit to my seniors, if the hospital closes they do not have health care. So OK, great, you have got a really nice prescription drug benefit but you do not have a doctor anymore. Sorry. That is not going to fly. It does not make any sense. So solving prescription drugs—which seems to be a nice bumper sticker issue—does not help us in many of our areas, as you know because you have been tackling this as long as I have.

So I just want to thank you for your advocacy. I do not have any questions. Also, I want to thank you for testifying before our committee today.

Mr. HOEKSTRA. Yes. I guess the chairman knows that now with consumer advertising of prescription drugs you do not need doctors anymore.

Thank you very much. You have been a very good panel.

There being no more questions, the committee will be adjourned.

[Whereupon, at 1:10 p.m., the committee was adjourned, to reconvene at the call of the Chair.]