DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2008 BUDGET REQUEST

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2008 BUDGET REQUEST

TUESDAY, FEBRUARY 13, 2007

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

The Committee met, pursuant to call, at 2:05 p.m., in room 210, Cannon House Office Building, Hon. John M. Spratt, Jr. (Chairman of the Committee) presiding.

Present: Representatives Spratt, DeLauro, Cooper, Allen, Schwartz, Doggett, Berry, McGovern, Sutton, Andrews, Scott, Etheridge, Hooley, Bishop, Ryan, Bonner, Garrett, Hensarling, Conaway, Tiberi, Porter, Alexander, Smith.

Chairman SPRATT. Secretary Leavitt, welcome to our hearing today, and thank you for coming.

The purpose of the hearing today is to discuss the President's budget request for the Department over which you are the Chief Executive, Department of Health and Human Services, and to give our Committee members the opportunity to delve into the President's proposal in more depth and detail.

I extend a warm welcome to you. We appreciate your coming, and we look forward to your testimony.

There are some significant cuts or cost reductions in the budget that has been sent to us. Medicare would experience a cut over ten years, cost reduction, call it what you will, of $252 billion. Medicaid, at least $29 billion over the same ten-year period of time.

CHIPs, Children's Health Insurance Program, a program in effect since 1997, would be increased but not enough by our calculation to cover the existing beneficiary population of around four and a half million children. We are concerned that fewer children would actually be covered under the funding proposal that the Administration has put forth.

So we have some significant questions to discuss with you today.

The President's budget has to be viewed in a larger context. We note with some dismay that these cuts have been made, 252 billion in Medicare, 28 to $29 billion in Medicaid. And, yet, this money has not been, the savings to the extent there are savings, have not been redeployed or reinvested in other healthcare programs.

There are gaping needs in the realm of healthcare, and we are dismayed to see that these cuts, if they are taken, will not be used to shore up other problems with other programs.

The Administration tells us that big program cuts are necessary because entitlement spending is growing at a fast clip. We know that. We understand that our population is aging. It is going to put

unprecedented pressure on our healthcare entitlements. And we need to be looking for solutions, no question about it, not when the pressure comes to bear, but now.

But as we accumulate debt, and the budget before us will accumulate $900 billion in additional statutory debt over the next two years, as we stack this debt on top of debt, we are adding to something called debt service obligations and leaving a legacy for years to come of debt service, interest on the national debt that has to be paid which by the end of the budget period, the time frame we are talking about, 2012, the target year for balancing the budget, interest on the national debt by our calculation, by CBO's calculation will be $285 billion, a substantial sum of money.

As a consequence, these are dollars that are squeezed out of the budget that could otherwise be used for Medicare, Medicaid, or Children's Health Insurance or Social Security.

Federal healthcare spending does not exist in a vacuum. We all know that. And one of the problems with reining in the growing cost of Medicare and Medicaid and our healthcare entitlements generally is that they are all a subset of the cost of healthcare delivery in our economy as a whole.

This Administration understands that. We understand it. And what we need to be about and looking for, among other things, are holistic solutions and not nickel and dime, case-by-case, piece-by-piece solutions. In that connection, we are concerned.

We want to hear more about the Administration's proposal to remove the manner in which employer-provided health insurance is now extended to their employees such that it is deductible out of the employer and excluded from income by the employee. In its place will be a standard deduction of $15,000 for a family.

It raises lots of questions that we would like to raise with you today, so we can get a clarification of that and a better understanding of whether this is the route to a solution, not just opening Pandora's box with lots more problems to come from it.

So we have much to talk about, and we are glad to hear your testimony first and then put some questions to you about these vital issues, vital to us as we put a budget together, and vital even more to the American people.

Before receiving your statement, though, Mr. Ryan has a statement he would like to make.

[The prepared statement of Mr. Spratt follows:]

PREPARED STATEMENT OF HON. JOHN M. SPRATT, JR., CHAIRMAN, HOUSE COMMITTEE ON THE BUDGET

Good afternoon, and welcome to the House Budget Committee's hearing on the 2008 budget request for the Department of Health and Human Services. The purpose of this hearing is to discuss the President's budget request for HHS and give members an opportunity to delve into the President's proposals in more detail. I would like to extend a warm welcome to Secretary Leavitt, who is making his debut appearance before the House Budget Committee as HHS Secretary. We are delighted to have you here.

The President's budget for HHS must be viewed in the larger context of the fiscal policies this Administration has pursued. The President's 2008 budget continues the same policies that helped create the fiscal plight now facing the federal government. To help pay for nearly $2 trillion in tax cuts over the next ten years, the budget cuts Medicare by $252 billion and Medicaid by $28 billion over that same time period. Rather than reinvest those savings in improvements to the health programs on which tens of millions of Americans rely, the budget instead creates a new set

of tax incentives for the purchase of health coverage that gives the largest subsidies to the most well-off Americans and provides substantially less help to working families who have the most trouble affording health insurance. The HHS budget also cuts or freezes several safety-net programs and vital supports for struggling working families such as child care. These cuts won't make a dent in our long-term deficit picture, but they will cause real harm to millions of families that depend on these services to stay employed and make ends meet.

The Administration argues that big program cuts are necessary because entitlement spending is growing. We all know that the aging of our population is going to put unprecedented pressure on our health and our retirement systems. And we need to be looking for solutions now, not when the pressure comes to bear. But the solution does not lie in digging the fiscal hole deeper today. As long as we are accumulating debt and stacking debt on top of debt, we are making it more and more difficult to accommodate the demands that we know are coming as a larger share of the population becomes eligible for Medicare, Medicaid, and Social Security. For example, under the President's budget, we are going to spend an estimated $239 billion on net interest on the debt this year, rising to $285 billion in 2012. If this Administration would pursue a more fiscally responsible course, we could substantially reduce the amount of federal debt and spend significantly less on debt service, thereby freeing up hundreds of billions of dollars that could be dedicated to shoring up the solvency of Social Security.

Another thing to keep in mind is that federal health spending does not exist in a vacuum. The Federal Government is heavily invested in the health care sector. We have got two major health care entitlements and other, smaller entitlement programs that are significant as well: Veterans Administration, military health care, and Federal employees health care. All of these make the Federal Government far and away the largest purchaser of health care in our entire economy. But this reminds us that the problem of growing health spending that we are talking about today is not unique to Medicare or Medicaid or any of the other federal health care programs. It is part and parcel of the problem of health care in our entire society.

So the challenges we face are considerable ones, indeed, and I am glad that Secretary Leavitt is here today to help us understand the Administration's thinking on these issues. Before turning to the Secretary for his testimony, I recognize the Ranking Member, Mr. Ryan, for any comments he may wish to make.

Mr. RYAN. Thank you, Mr. Chairman.

Welcome, Secretary Leavitt.

I want to begin by commending Chairman Spratt on his choice of hearing topics and witnesses in the past few weeks. I think these have been very good hearings. We have had excellent witnesses, all speaking to the topics that we really have to get our hands around. So I want to thank the Chairman for this good panel of hearings.

And nearly all of us have largely focused on the need for immediate substantive reforms to our nation's largest entitlements. Considering that two of the most financially troubled entitlement programs, Medicare and Medicaid, are in HHS, I would imagine Secretary Leavitt, you know, that is why he is here today.

And I am glad you are here today because the big money accounts are in your agency, Secretary Leavitt.

We all know how we got here. Back in the 1960s when President Johnson created these programs as part of the great society, he created them on a pay-as-you-go basis. And certainly most Americans and most in Congress, for that matter, agree with the mission of these programs. That is not the question.

The question is, is there a better way to accomplish the mission of these programs without bankrupting our children, because according to GAO, by the year 2040, when my kids are my age, they will have to pay twice as much in federal taxes as we do now just to keep our largest entitlements going in the same form as they are today? No new spending, no new benefits, double the taxes just to pay the status quo for my kids when they are my age.

Clearly we cannot let this happen. How do we prevent it? That is the key question. How do we meet the mission of these programs and prevent that from happening to my kids and your kids and your grand kids?

The President proposes a particular set of reforms in these programs to help get on a path toward long-term sustainability, and we can and should debate whether these are the right combination of reforms or not. But I do not think there is an honest debate to be had on whether or not Congress should act on this. We simply must.

I will simply end with one quote from, I think, the first witness we had which was the Comptroller, General David Walker, who spoke to this Committee a few weeks ago where he said, "Healthcare is the number one fiscal challenge for federal and state governments. Number two, it is the number one competitiveness challenge for American businesses. Number three, it is a growing challenge for American families. Let me just tell you if there is one thing that can bankrupt America it is healthcare. We need dramatic and fundamental reform."

I clearly agree with that statement, that assessment. This is the Budget Committee, and the budget buster for America today and for sure tomorrow is healthcare. That is why we are going to have to figure how to meet the mission of these very important programs while making sure we can keep our budget balanced and not double the tax burden on the next generation.

With that, I yield. Thank you, Chairman.

Chairman SPRATT. Thank you, Mr. Ryan.

Mr. Secretary, you can offer your statement for the record. And without objection, it will be made part of the record so that you can summarize all or part of it.

In addition, I ask unanimous consent that all members who care to submit a statement be allowed to submit an opening statement for the record at this point. Without objection, so ordered.

Mr. Secretary, the floor is yours. Thank you again for coming.

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

Secretary LEAVITT. Thank you, Mr. Chairman, Mr. Ryan, ladies and gentlemen of the Committee.

I would prefer to have my statement as part of the record and would like to summarize just to give our discussion some context.

This is a big budget as you have indicated, and it has required hundreds of people the better part of a year. There are tens of thousands of individual decisions made. I found it best to have these discussions in the context of the guidance that I have given those who have prepared it. I think that might be helpful for you to know. And I will try to answer your questions in the context of those of the guidance I gave them.

Make no mistake about it. This is a budget aimed at reducing the deficit and looking to balance the budget by 2012. Any time that you are developing a budget, no one knows better than this Committee you are faced with making decisions about competing, noble ideas.

I have little question that the decisions that I made in some of those tens of thousands of decisions will not be the same ones that you would. I am here to explain to you as best I can the basis on which those were made.

I would like to just tell you in billboard phrases, if I could, the guidance that I gave the budget preparers at HHS. I pointed out first of all, it is a deficit reduction budget. Second, I indicated to them there would be some new things that we needed to add to the budget, but I wanted them to be truly critical.

I gave them four examples. One would be high-demand, highly-effective programs. I will give you an example of that, the Indian Health Service or Head Start. I wanted to protect that. Presidential initiatives, a good example would be the Community Health Centers. Pressing new problems, I was concerned and continue to be about drug efficacy and safety and the speed with which we are able to approve new generic drugs.

You will also see some things that have been here before, health IT. I am anxious to see progress made there. Fraud and abuse in Medicare, a subject that I feel some passion about right now.

So those are new things. Then I said to them we are going to have to make these decisions with respect to ongoing problems. I would like you to look for six or seven things in particular.

One, if you find any one-time funds that we finished the project, let us not repeat them.

Second, I said I want to have a bias towards actually providing services, not just building infrastructure for the future. We all know that you need infrastructure and you need services. But when you are working to devise a budget to balance, I wanted to emphasize direct services.

The next would be looking for grant programs where the activities have been completed. I see a lot of these at NIH. And in order to continue to focus on new science and to get the best of the best, rather than allow grants just to continue perpetually, when they reach the end of their term, I have asked for them to automatically be renewed and to put more new grant programs that they compete for.

And that is an example of the kind of thing. And sometimes that comes out looking like it is a reduction, but the reality is you are getting more new grants than you were before.

Under-performing programs, there will be disagreement on what is under-performing. We have tried to find programs that we could measure. And if we cannot measure it, then we have got to have some method of demonstrating that it is a performing program. And when we have not, it has been a candidate for reduction.

You will see some things that I have been back to this Committee and others for a couple of years now. One would be durable medical equipment, some old controversies that I still feel some passion about.

You mentioned the Medicare and the entitlements. There is no question that that is where we need to focus. And I have gone through Medicare as carefully as I can and looked for every component piece of it and asked the question, is there some way we can begin to turn the line down a little.

I made the point to them and I will to you today that I have been looking—this is weight reduction, not amputation. But you will see a whole series of very small changes. When I say small, they are individual components that when you add them all up, it gets to a big number over time.

If you went out ten years, it would be a much bigger number than that. And if you went out twenty, we would start into the trillions. The point is there is a time and a life of every problem when the changes are big enough you can see they need to be made, but still small enough you can make them. And right now we need to be focused on them.

The changes that I have recommended in this budget, if we did them all, would still only keep the Medicare Trust Fund solvent for four more years. So it is a start. And you may not agree with all of them, but I am prepared to defend them.

And if you want to talk them about them individually, I would be delighted to do it. And why don't we go directly to questions, Mr. Chairman.

[The prepared statement of Michael O. Leavitt follows:]

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

Chairman Spratt and Congressman Ryan, thank you for the invitation to discuss the Department of Health and Human Services' budget proposal for fiscal year 2008.

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

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

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

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

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

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

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

TRANSFORMING THE HEALTH CARE SYSTEM

Helping the Uninsured

• The President has laid out a bold path to strengthen our health care system by emphasizing the importance of quality, expanded access, and increasing efficiencies.

• The President's Affordable Choices Initiative will help States make basic private health insurance available and will provide additional help to Americans who cannot afford insurance or who have persistently high medical expenses.

• It moves us away from a centralized system of Federal subsidies; and,

• It allows States to develop innovative approaches to expanding basic health coverage tailored to their populations

• The President's plan to reform the tax code with a standard deduction ($15,000 for families; $7,500 for individuals) for health insurance will make coverage more affordable, allowing more Americans to purchase insurance coverage.

Value-driven Health Care

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

Health IT

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

ADDRESSING THE FISCAL CHALLENGE OF ENTITLEMENT GROWTH

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

Medicaid

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

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

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

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

Medicare

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

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

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

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

PROMOTING HEALTH AND PREVENTING ILLNESS

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

• Fund $17 million for CDC's Adolescent Health Promotion Initiative to empower young people to take responsibility for their personal health.

• Strengthen FDA's drug safety efforts and modernize the way we review drugs to ensure patients are confident the drugs they take are safe and effective.

• Enhance FDA and CDC programs to keep our food supply one of the safest in the world by improving our systems to prevent, detect and respond to outbreaks of food borne illness; and,

• Include $87 million to increase the capacity for the review of generic drugs applications at the FDA and increase access to cheaper generic drugs for American consumers.

PROVIDING HEALTH CARE TO THOSE IN NEED

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

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

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

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

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

PROTECTING THE NATION AGAINST THREATS

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

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

• The President's budget calls for nearly $4.3 billion for bioterrorism spending.

• In addition, we are requesting a $139 million in funding to expand, train and exercise medical emergency teams to respond to a real or potential threat.

• Our budget requests $870 million to continue funding the President's Plan to prepare against an influenza pandemic. The budget requests funding to increase vaccine production capacity and stockpiling; buy additional antivirals; develop rapid diagnostic tests; and enhance our rapid response capabilities.

• In FY 2008, the Advanced Research and Development program is requested within the Office of the Assistant Secretary for Preparedness and Response (ASPR). Total funding of $189 million will improve the coordination of development, manufacturing, and acquisition of chemical, biological, radiological, or nuclear (CBRN) Medical Countermeasures (MCM).

ADVANCING MEDICAL RESEARCH

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

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

PROTECTING LIFE, FAMILY AND HUMAN DIGNITY

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

Our budget request also includes $ 1.3 billion to help millions of elderly individuals and their family caregivers to remain healthy and independent in their own

homes and communities for as long as possible, including the $28 million for our Choice for Independence initiative that will help states create more cost-effective and consumer-driven systems of long-term care.

IMPROVING THE HUMAN CONDITION AROUND THE WORLD

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

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

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

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

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

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

Chairman SPRATT. Well, let us start with CHIP.

Secretary LEAVITT. All right.

Chairman SPRATT. That is a particular case where you are adding funds. But, unfortunately, under the Children's Health Insurance Program, as we understand the projections, in order just to keep the kids covered who are now covered, we need about 13 to $15 billion over and above the baseline funding, five years of $25 billion.

Is that different from your assumptions about it?

Secretary LEAVITT. It is. Let me state for you as clearly as I can the policies we intend to pursue in the reauthorization.

First, important to state we enthusiastically endorse its renewal. We see it as being valuable in the same way others do. We would, however, like to focus it on children. We recognize that some states have included adults, and we follow a policy that will allow existing adult populations to continue. However, we would like not——

Chairman SPRATT. Are these parents for the most part?

Secretary LEAVITT. For the most part, they are adult parents.

Chairman SPRATT. Guardians, parents?

Secretary LEAVITT. There are three states who have substantially more adults than they do children on the program. And we think it ought to be focused on children.

We also believe that if we are going to be subsidizing states in pursuit of populations over 200 percent of the poverty line that we should limit our match to be the same match that would be available to them under Medicaid.

In other words, we want to continue to the enhanced match up to 200 percent, but would limit our match to the regular FMAP or match that we pay each state.

Chairman SPRATT. Well, at 4.7 million children covered today, as I understand it, and there are grave doubts in Congress, CBO, this Committee staff, elsewhere that the amount you are providing is going to be enough over a five-year period of time. We have already got what, 16 states that are about to run dry. There is simply not enough provided there, even with these changes and eligibility, to even cover the 4.6 million kids now covered.

Is that a concern?

Secretary LEAVITT. We believe that the budget we have proposed is adequate to meet the policy guidelines that I have just articulated. We are prepared to engage in a conversation about what it takes to do that, but we believe our budget proposal to be adequate.

Chairman SPRATT. A concern as you look through this budget, it looks like kids take it on the chin repeatedly. The Children Care Development Block Grant costs $39 million. Not a lot of money, but it goes to children and child care. And by the estimates we have gotten, child care systems would drop by 100,000 in the year 2008.

The CHIP Program was specifically created for children, and I would agree with you. Without knowing more about the issue that it should be confined to children. It was created in 1997 as part of the balanced budget agreement. The Clinton Administration said we are going to make some tough, hard decisions, some big substantial cost reductions in Medicare and Medicaid. But our diligence and forbearance, we are going to do a few things that are positive as well.

And one of them was Children's Health Insurance. And it has been a very successful program except that only three out of ten children are covered. As I understand, only 30 percent of the eligible population of children are actually covered.

Is that your understanding also at HHS?

Secretary LEAVITT. I am not able to validate that statistic. I will say to you, Mr. Chairman, that we do believe it has been a very positive program as do you. We believe that it should be our aspiration as a country to assure that every American, children and adult, have access to an affordable basic insurance policy.

We see SCHIP being an important role, but not as the vehicle to provide it for everyone or, for that matter, even all children. It certainly should be the vehicle we use to cover those who are in specific financial need.

I was in a State yesterday where they are working to create, as many states are, a plan that would give everyone in their State access to an affordable policy.

I had discussions with the Governor about ways we could use SCHIP to connect to other policies that are being provided in the marketplace so that we could keep families together but not have to start using SCHIP as the vehicle to bring all adults.

There are ways to use this program efficiently to target a population who needs help, but we ought not to view it as the way in which we cover every child or any person under 18. There are other ways to accomplish that that we think are superior.

Chairman SPRATT. Would you submit for the record, please, your own analysis, your Department's analysis of how many children are likely to be covered and provided for under the CHIP Program at the level of funding you are requesting?

Secretary LEAVITT. We would be pleased to respond.

Chairman SPRATT. Fine. Others have questions. I want to turn to them. But thank you again for your testimony.

Mr. RYAN. I want to say Governor, but, Secretary——

Secretary LEAVITT. Thank you.

Mr. RYAN [continuing]. Secretary, you are a Medicare trustee, right?

Secretary LEAVITT. Yes, I am.

Mr. RYAN. Yeah. According to the trustees, the unfunded liability of Medicare totals 35 trillion over the next 75 years, so that is the three-generation window we kind of look at.

This budget reduces the unfunded liability by eight trillion over that same period, correct?

Secretary LEAVITT. Yes. If you go out far enough, it gets into the trillions.

Mr. RYAN. How would we make up the rest? Do you have any ideas about how we can, in addition to what this budget is proposing, take care of the rest and try and bend the curve even more to get more savings, so we do not have still a, you know, 20 plus trillion dollar unfunded liability?

Secretary LEAVITT. As you pointed out, the proposal that we are making today in this budget would reduce the growth rate from 6.5 percent down to 5.6 percent.

Mr. RYAN. So Medicare spending, even if every one of your recommended policies occurs, would still continue to grow at——

Secretary LEAVITT. Five point six percent a year.

Mr. RYAN. Instead of six point——

Secretary LEAVITT. That is right. The impact of that going out is substantial. The sooner we start making these changes, the better the result will be in the long term.

As I indicated, we have attempted in every case to make these weight loss, not amputation. We worked to find ways that we would not affect beneficiaries, but that we could deliver good, basic healthcare to our seniors in a sustainable way.

Mr. RYAN. Given that Medicare and Medicaid essentially sort of pay for today's healthcare for the targeted populations that Medicare and Medicaid want to help, the road sort of leads back to getting at the root cause of healthcare inflation in order to drive down these out-year costs and, you know, reduce this incredible unfunded liability. The Administration put out a very bold plan on healthcare itself.

Can you walk through the thinking, the methodology, and basically the strategy for going after high healthcare inflation and how your proposal deals with sort of bending the curve on medical inflation by more rationally getting benefits distributed by, you know, having the uninsured cared for and those things? How do you fix healthcare so that you can fix these entitlements and what is the Administration's plan to do that? That is basically my question.

Secretary LEAVITT. Mr. Ryan, I would argue that we do not actually have in this country a healthcare system. What we have is a large, robust, rapidly-growing healthcare sector that employs millions of people, but there is nothing that connects it into an economic system.

There are lots of economic systems in our lives. Our banks, for example. I have a bank card. You have one. Other members of the Committee have them. Banks competed for our business on the basis of interest rates and service, but they all use the same system to optimize the value that they provide us.

The same is true with many other systems. The internet itself is an economic system that is built with a group of standards that connect us all together.

We believe the first step is to move healthcare from a large, robust, undisciplined sector to a system. To build that system, we believe that there are five components. The first is electronic connectedness. We have to connect electronic health records.

Second, there is a need for us to have quality measures independently so that people know what they are buying and how good it is, so they can compare it.

The third would be what I refer to as episodes of care or buckets of care that you can compare so that you can take comparable cost and comparable quality and make a decision as to value.

Mr. RYAN. So real transparency and price and quality?

Secretary LEAVITT. I am talking about a system of competition based on value and the ability to compare so that the market actually works. There are other aspects to it, but that would give you a summary.

Mr. RYAN. And how does the Administration's plan advance this?

Secretary LEAVITT. Well, I will tell you that by April of this year, we will have 60 percent of the healthcare marketplace that will have committed, including the federal government, to use our purchasing power to adopt the four cornerstones I mentioned.

Health records. For example, it is now the policy of the federal government that if you are going to do business with us in the future, you have to have connected electronic health records. If you are going to do business with us, you have to have identifiable quality measures that have been developed by the medical community and use them. If you are going to do business with us, you have to have comparable costs and you need to know we are going to use these to create incentives to drive quality up and cost down.

We have been joined by the largest payers in the country in doing that, including states, including the largest employers, and we will have 60 percent of the entire marketplace committed to making that a criteria of selection for their vendors by April. And by 2008, you will see this begin to unfold.

Within two years, you will see competition based on value beginning to turn up in markets around the country. In five years, you will see this as value being a very important part of the market generally. And in ten years, this will be ubiquitous.

We believe that, in fact, competition based on value will begin to moderate that curve and give us the relief that we so desperately need to maintain a prosperous economy.

Mr. RYAN. OK. So if we take a given market and use the payers in a given market, let us take the private payers, take a couple big companies like Blue Cross and United and Aetna, big payers, but the biggest being you, the Medicare 100 percent file, that gives us enough of a data sample to measure the price of a good and to get into measuring quality as defined by the providers, and that will give us enough data to basically be able to make this value equation? Is that kind of what you are essentially saying?

Secretary LEAVITT. You properly point out that because there is no national market for healthcare, this has to be done regionally.

I was in Detroit, for example, two weeks ago, and I had the big three auto makers join with the federal government and states in that region and the largest other payers, and we all committed ourselves to pursue this as a policy of selection. When we buy healthcare, this is what we are going to ask for.

Now, Detroit and in that area, very soon you will begin to see hip replacements, knee replacements, and other things comparable cost and comparable quality based on standards that the medical family have developed.

Mr. RYAN. And this will be made available to the public, not just those who buy through these different networks, not just necessarily federal employees or people who are in the networks of the other payers?

Secretary LEAVITT. Once this information is available, it will find its way into the purchase of healthcare in many different ways. Employers will provide it. Health plans will provide it. I am sure there will be a travelocity for healthcare that will begin to develop. People will begin to have the capacity to make comparable purchases.

And we have all had experiences like this. We know how effective this would be. Competition works in healthcare if we have access to——

Mr. RYAN. Information.

Secretary LEAVITT [continuing]. Reliable, consistent information about the quality and the cost.

Mr. RYAN. And I will just finish with this because the Chairman has been liberal with the time. The Medicare 100 percent file, which is a HIPAA compliant claims file that you have, you do have the ability, do you not, to release that data in any given market so that payers, patients can use your data along with other data samples to get this measure? And you can and are you releasing that 100 percent file?

Secretary LEAVITT. I have authority to do that under certain conditions, and we are preparing a process by which it can be released in coordination with all of the other activities we are doing.

Mr. RYAN. That is what I am trying to get at. To the extent that you can simplify and make much easier the ability to release that Medicare 100 percent file, which is HIPAA compliant, that all to the better to get this transparency thing off the ground, and that would be very helpful.

Thank you.

Chairman SPRATT. Mr. Cooper.

Mr. COOPER. Thank you, Mr. Chairman.

And thank you, Mr. Secretary.

My five minutes, I would like to focus on the healthcare tax expenditure reform that the Administration is proposing and also a couple of Medicaid issues.

First, this may be surprising to you, but I would like to praise you and the Administration for your efforts to reform the largest individual tax expenditure in America, one that Congress never passed into law, and one that is horribly regressive. You are the first Administration to have the courage to face this issue. I hope that you succeed.

And I would like to give some of my Democratic colleagues a little bit of confidence here because no less a liberal figure than Andy Stern of the SEIU has proposed essentially abandoning the employer-based health insurance system.

Bob Greenstein, a noted expert on budget issues and health issues from the Center for Budget and Policy Priorities, says positive things about your tax proposal on his web site. And liberal senators like Ron Weiden have put forward health plans that make substantial changes in what many Americans assume to be the only health system we have.

So there are many good features to your proposal. A lot of us are worried that the deduction is too meager. If you are going to open this up, you might as well turn it into a tax credit so that lower-income people are benefited a little bit more than in the Administration's proposal.

And I would just urge you to be open to modifications like that so that we can both reform our tax code and have a more efficient healthcare system at the same time.

Secretary LEAVITT. Thank you, Mr. Cooper.

We do have a commitment to take this issue on because it is a prerequisite to any states who are currently striving to create opportunities for every resident of their State to have an affordable basic policy.

I am meeting over the next 100 days with every Governor and having a discussion with their legislature and with them about what tools they need. And without exception, they always run into one dilemma and it is the dilemma of the school aide that does not work enough hours to get benefits, married to a construction worker. Between the two of them, they make pretty good money, but they do not have enough money to pay their taxes and buy healthcare. And they are discriminated against.

And as you say, there is no defensible policy that would cause us to give one group of citizens a tax benefit to help them buy and not the other, and we are anxious and willing to have these conversations. We believe the proposal we have made has the impact, but we are open to talk.

Mr. COOPER. Mr. Secretary, while you are talking with the Governors in your upcoming meeting, it seems that federal, state tensions are at an all-time high in terms of reimbursement battles over Medicaid, the match, and I would assume the SCHIP match as well. Some people call this fiscal integrity issues.

I hope there is a way to align interest so that people are not gaming the system. A report I saw recently from a State-sponsored think tank said that the states are essentially playing a game of catch me if you can as they use provider donations, provider taxes, DISH payments, UPLs, every possible acronym you can think up to gain the match.

But as we are looking at the states, there was one element of your budget proposal that worried me. I have been told that you try to eliminate best price for Medicaid drug reimbursement.

And we just had a hearing in the Government Reform Committee last Friday that said states and the federal government could be saving four or five billion dollars a year if we just had a better and more efficient comparing of best price among the states because

some states are still using antique average wholesale prices. They are not bargaining. They are not using their Medicaid rebate like they should, and they are leaving billions of dollars on the table.

And when we are scrapping for pennies to cover children, that seems to be a terrible problem. And I hope that abandonment of best price is not part of the Administration's budget.

Secretary LEAVITT. Our strategy is to deal with the issue because Medicaid right now is the highest payer of prescription drug in the market. And there is clear evidence of that.

We want to give states the ability to deal with large prescription drug benefit managers the same way that the healthcare plans so that they can get the benefit of competition. And we believe that will have a positive impact on those costs.

Mr. COOPER. How about your efforts to persuade your former fellow Governors to behave a little bit better and if they have—for example, the average Medicaid match is supposed to be 57 percent. Some states are higher, some are lower. But a lot of states have gained this so that they get 80 percent federal dollars, 90 percent federal dollars.

Secretary LEAVITT. There are many instances in Medicaid finance that could use purification. The reality is a lot of that has happened. And all I think we should look to have is a true partnership where we are both putting up our share of the money in real dollars.

And there is nothing inherently wrong with an intergovernmental transfer so long as it is not a scheme to take federal dollars and to put them up as match for other federal dollars and begin that cycle. And that has happened a lot, and we are doing, frankly, everything we can to dissuade states from doing that and to close their opportunities to do it because we do not think it is fair and it is not in the interest of the program.

Mr. COOPER. I see that my time is expired. Thank you.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Mr. Ryan has an announcement to make to the Committee.

Mr. RYAN. It is with a great deal of sadness that I want to announce that our colleague and friend, Charlie Norwood, lost his battle with cancer today. Charlie just passed away earlier today of cancer. He was 65 years old.

And I know I speak on behalf of all my colleagues and friends that this is a sad day for all of us. And Charlie and his family are going to be in our thoughts and our prayers. And I just simply wanted to take this time to announce that.

Thank you.

Chairman SPRATT. Charlie Norwood was as tough and partisan a fighter as you ever met in this institution. But on certain occasions, he crossed the aisle and worked with us as Democrats on healthcare issues. He was a worthy member of this institution. And I would ask everyone to observe a moment of silence in his memory and service here.

Thank you.

Let us see. Mr. Conaway.

Mr. CONAWAY. Thank you, Mr. Chairman.

It is with great sadness with the loss of Charlie. What an incredible fight he put up over the last two years to go through what he did and still try to do the job that we all want to do here.

Mr. Secretary, thank you for coming today.

I want to talk to you a little bit about SGRs and all of that, but it seemed to me while you were discussing this grand plan of 60 percent of the payers and arguably one of the largest sectors we have got for our economy banding together to do whatever you want to do.

Is there an example where in the free market system without the government being involved where 60 percent of the payers were able to do that and not run afoul of our antitrust laws? I mean, how are we going to square those two?

Secretary LEAVITT. They are not coordinating their actions as a contractual matter, but what they are doing is we have identified these four cornerstones of health IT, quality assessment, price packaging into identifiable episodes of care and the use of incentives, and we have created a—actually, the government did not create it. The HR officers of the country in cooperation with the medical community created a series of questions that could be provided to those who are procuring health insurance to use as a criteria for their purchase.

And it has been done with the guidance of counsel and all of those that would—and not just government counsel, but you can bet that the major purchasers of the country have, in fact, scrutinized.

Our purpose is not to create any kind of effort other than to begin creating some standards upon which we could go from a sector to a system.

Mr. CONAWAY. The one sector that we do set the price at and that is physician reimbursements for those who are under the Medicare system. It does not seem that that current system works very well. We are constantly ratcheting down physician reimbursements. They are at the same level they were at 2001. It is now six years later. You know, pick a number for inflation, and I do not think that is a sustainable model where you have got the government setting the price and doing that to these physicians.

The impact is we have got evidence that the number of physicians who are accepting new Medicare patients has dropped in Texas from in the 70 percent range to 62 percent and falling.

And so as we go through this process, let us not kill the goose that laid the golden egg, and that is the ability of folks to feed their families and to make money at this system.

The broader question, I guess, is, we talk about government keeping its promises. What have we promised in regards to Medicare/Medicaid? What is this promise that we can look at and say, all right, can we afford the promise? We have got $32 trillion of unfunded promise out there right now, but can we afford this promise? What does it look like? What level of care? What should be covered in that? Do we have a good idea of what that promise ought to look like that this government is making day in and day out?

Secretary LEAVITT. Well, it bears constant review in terms of how we are delivering on the promise. There would be lots of people in

this government who would and in this country who would articulate the promise differently.

But what we do know is that we need to provide those who are elderly, those who are poor, those who are disabled, those that are children who need protection. We know that we need to provide for mothers who are expectant, to protect their children. We need to provide them with basic health insurance and we need to pay for most of it.

We have made that commitment. Now, we also need to do it in a way that is efficient enough that we can keep it. And right now I think the evidence is we are not doing it efficiently and we are not doing it in a way that will allow anyone in the future generation to maintain that promise.

Mr. CONAWAY. One of your comments, you said that we are going to do this in a way that we do not affect beneficiaries. How do we do that?

Secretary LEAVITT. Well, there would not be a single person on Medicare who would not continue to receive their Medicare benefits. But there may be a difference in the way a person who makes a half a million dollars receives them over a person who makes $50,000.

Mr. CONAWAY. So we will affect beneficiaries, it just—I mean, I did not understand how.

Secretary LEAVITT. They will not lose their benefits. They may pay for some of them if they have the ability, but that is the way our tax system works.

Mr. CONAWAY. OK. And the SRG system? Any hope on the horizon?

Secretary LEAVITT. Well, I point at the fact that——

Mr. CONAWAY. SGR system. Excuse me.

Secretary LEAVITT [continuing]. The system requires retooling. We cannot just continue to go on every six months putting in the so-called doc fix and then moving on. I would argue that the system of competition based on value that I described ultimately has to be part of the solution.

We ultimately need to begin to reward those who provide medical services for the highest possible quality at the best price. And if we do, they will have an economic model they can sustain and our country will have a capacity to keep the promise for future generations.

Mr. CONAWAY. My time has expired. Thank you, Mr. Secretary. Appreciate you being here.

Chairman SPRATT. Mr. Allen of Maine.

Mr. ALLEN. Mr. Secretary, thank you for being here.

I could not help but think that if Charlie—Charlie and I had a number of lively debates on healthcare policy in the Commerce Committee, and I wish he were here. He would enjoy the conversation with you.

You and I differ on the issue of legal abortion, but I believe that people can work across that division because to the extent we can reduce unintended pregnancies, I think we are in search of a common goal.

I have two simple questions and then a more difficult one, I think.

You agree, I assume, that the correct and consistent use of condoms and other methods of contraception is an effective way to prevent unintended pregnancies?

Secretary LEAVITT. As you know, this Administration supports the ABC approach. And to the degree that that is consistent, yes.

Mr. ALLEN. And are you prepared to work to prevent unintended pregnancies by supporting sex education programs that offer young people medically-accurate information about both contraception and abstinence?

Secretary LEAVITT. It is my belief that those programs are best determined at the local level with the involvement of parents. And to the degree that we are supporting programs, then, yes, we need to work for medical accuracy.

Mr. ALLEN. In Maine, my State has now rejected abstinence-only money from the federal government because our experience has been that more comprehensive programs turn out to be more effective at reducing unintended pregnancies.

And in looking at your budget, it looks to me like funding for abstinence-only programs is expected to be about 176 million in fiscal year 2007 and in the 2008 budget request, the President is proposing increasing that to $204 million.

But Title 10 money is flat funded. And so, you know, where I come from, we see the Title 10 money as more scientifically-based, more likely to reduce unintended pregnancies.

Why not an increase for Title 10?

Secretary LEAVITT. I respect what you have suggested and also the State of Maine. And it is obviously their decision as to whether or not they pursue those monies. Title 10 is substantially larger as a matter of absolute dollars than the $204 million, but it has been the belief of this Administration that those dollars pay off and that we want to increase them in some proportion, though it is small by comparison to the other dollars that are invested by this government.

Mr. ALLEN. So it is a choice. Let me turn to one other issue I wanted to raise with you. I have a number of issues with the President's healthcare proposal that go to the problem of what happens when you enhance the individuals market. I am afraid you will wind up leaving people who are older and sicker without the opportunity to get health coverage.

But the question I have for you is, as I understand the President's proposal, it diverts Medicaid disproportionate share hospital payments away from hospitals and other healthcare providers in order to fund this new program. But Medicaid DISH payments today are about $17 billion a year and that money goes to a variety of hospitals that are providing uncompensated care to people who simply walk in and need the service.

What in your proposal do you propose to do for those hospitals? The issue of uncompensated care is not going to go away. The people are not going to go away. Have you thought through what happens when you divert that much money?

Secretary LEAVITT. Yes. Let me speak on both of those matters, especially with respect to the employer market. The employer market is the vast majority of our market today, will likely continue

to be that way perpetually, and it needs to be protected because it is such an important delivery system.

However, there are many people, for one reason or another, who end up having to leave the employer market. They either go out on their own or their job changes in such a way. And it is that problem we have to create a viable alternative for because the goal here has to be to get every American access to an affordable basic policy.

There are certain parts of that problem that the states cannot solve on their own. One part is the issue of the tax deductibility and the indefensibility of the policy that we currently have evolved to. No one voted for it. We just evolved to it.

Now, with respect to the matter of uncompensated care funds, there are some $30 billion that we currently send from the federal government into states for the providing of essentially three important ongoing needs.

The first would be to have uncompensated care, and there is no question that we will continue to have people who do not have insurance and there needs to be a means by which those hospitals can meet those obligations. It is something we all feel committed to.

A second purpose would be to assure that public hospitals are able to remain open and viable.

The third area is in helping sustain the overhead of various hospitals.

The principle at play here is rather than perpetually paying the bills of people who are uninsured, does it not make sense that we use at least some portion of that to help them get insurance? No one is suggesting we take all of that money.

We are saying let us look at this in order of magnitude and figure out how best to get them insured because they are better off and so is the system if they have insurance because they get preventative care, they get regular primary care. Right now they get it in the emergency room, and it is not a healthy system.

So the President has asked that I actually go out and sit with the states, and I have been in, I think, eleven of them since the State of the Union, and I will be in another ten or eleven in the next two weeks.

And I am sitting with the Governor, I am sitting with the legislators, I am sitting with the people who run their health system and saying to them how can we use this money better to meet those three needs. And if, in fact, we could actually get everybody insured, would it not make sure that we would not need to spend all of that money perpetually paying their bills.

There is no specific proposal on the table except to sit down and collaboratively come up with a better way to do what we all intend, which is to provide high-quality care to people and to have everyone have access to an affordable basic policy.

Mr. ALLEN. Thank you. My time has expired. We could go on for a while, but I appreciate your comments.

Chairman SPRATT. Mr. Alexander.

Mr. ALEXANDER. Thank you, Mr. Secretary.

I apologize for the way my voice sounds. I am getting improper healthcare, I guess.

But the first thing I want to do is thank you for the attention that you have given Louisiana. We have many people there that are depending on the charity hospital system that has provided healthcare for Louisiana citizens for years. And you have been there on numerous occasions, and we appreciate it.

Quite frankly, I am surprised you have not pulled out all your hair dealing with that issue down there. But, again, thank you.

My question is about nursing homes. The nursing homes that provide skilled nursing care are looking at a pretty sizable reduction and not a cut but a reduction in growth of their program as we look at a freezing of the market basket the first year and then a reduction in the next five years.

My question is, are market basket and inflation synonymous and, if not, how are they different as you look at them?

Secretary LEAVITT. This is a very good illustration that I think will help members of the Committee understand the way I went about dealing with this and other Medicare issues.

Skilled nursing is a—we get a Med Pac recommendation. They also give us an analysis of the marketplace. They told us, for example, that the skilled nursing facilities now have a 9.7 percent margin in 2006 and an 11 percent in 2007. They recommended that we have a zero update in 2008.

We also concluded by looking at Med Pac that there would be a 1.3 percent productivity gain. Well, frankly, I looked at those margins, I looked at the fact that we are seeing an increase in the market, and I said we have got to do something to turn that line down a little bit. It looks to me like here is a place we could afford to do it.

Now, frankly, I would prefer as we talked to have a more market-based system. But given the fact that we set prices essentially here, and that is my job, that is the rationale I use.

Let us just take the productivity gain, give half of it to them, we will put half of it into taxpayers, and they are still having substantial operating margins and we are seeing an increase in the number. That tells me what the market, in fact, if it could find its way to a level, would likely find its way to a level that I have suggested. And, you know, it is not perfect, but it is the best logic given what I have to work with that I could come up with.

Mr. ALEXANDER. Thank you, sir.

That is all, Mr. Chairman.

Chairman SPRATT. Ms. Schwartz.

Ms. SCHWARTZ. Thank you, Mr. Chairman.

Secretary Leavitt, good to see you again.

I wanted to follow-up on some of the conversation we had last week at the Ways and Means Committee, and I appreciated some of your answers then and thought maybe we could follow-up on some of them today. And this is really about the proposals around the additional coverage for the uninsured as you see it and some of the tax provisions.

And, again, I am going to try and do this in a sort of a yes, no and see if we can get to it and just to be clear what some of your intentions are and the Administration's intentions are. And there may be ways for us to find some common ground for us to move

forward. And I certainly hope there are because we have a shared agreement that we need to get more people insured in this country.

I think you would start out by agreeing that there are currently about 46, 47 million uninsured Americans, this is without ongoing insurance in this country, and about 160 million rely on employer-sponsored coverage.

So those are numbers, I think, we agree to. And that the President's tax scheme that, according to your own estimates, would still leave about 90 percent of those who are not insured now uninsured.

Secretary LEAVITT. It is important to look at the two proposals the President has made together because as I go out to work with the State of Pennsylvania and the State of New Jersey and all those states that are currently working on proposals to increase the number of insureds, it is evident to me that they have this tax problem that they have to solve.

And if they had the tax problems solved and then combined it with their own access, the number of people who would actually gain coverage would be very high than if we just had a tax program. There will be a limited number of people who will better be able to afford it and will. But if you combine that with a basic affordable plan, you are going to see lots of people get insurance who currently——

Ms. SCHWARTZ. Well, let us flesh that out if we may. You are using numbers like lots of people, and I think your own estimate is—and it sounds like lots of people actually if you want to talk about two, three, four million people will get some tax advantages, you know. And that is about six percent, though, of the number of uninsured.

So you are saying that is a great goal, that is what we can afford to do, that is all we can do? What sort of——

Secretary LEAVITT. Well, how many would Governor Rendell's proposal in Pennsylvania cover?

Ms. SCHWARTZ. Well, it is interesting. As you know, he is relying on some things that you are going to take away. One of them is the enhanced SCHIP reimbursement, and working with the federal government to be able to use the CHIP Program, you are taking away with one hand what you are offering with the other. And there is——

Secretary LEAVITT. Well, that is one way to get——

Ms. SCHWARTZ. Let me just say it is complicated and it is not going to be in one fell swoop. But the proposal that you are putting out, that the President has put out basically says that we have to reduce benefits to those who get health insurance through their employer.

And I think that you have stated yourself that one of the intentions here is that the President believes or you do that people are getting too much healthcare, that it is too comprehensive. You want to make sure that people get a basic coverage, but that you are going to reduce the tax advantages for a very comprehensive plan, one.

Two, you are going to put the people who are in the individual marketplace are going to have to find insurance on their own rather than in a group. And while you have said that the marketplace

may respond to that, we do not, in fact, know that. It is a very expensive way to buy health insurance now.

And for families that have family incomes of maybe $50,000, even 60 or $70,000 before tax dollars to find seven, eight, ten, twelve thousand dollars out of pocket to buy health insurance in the expectation of maybe getting a tax deduction or tax credit later is really not realistic.

So that the number of people who will actually be helped by your proposal, even in Pennsylvania where our Governor is hopeful that they can do through waivers and a whole other combination of factors, cover more people, in fact, you are not helping them anywhere near as much as you might if you actually did not have to take away with one hand in order to give to another group.

Secretary LEAVITT. It will not surprise the gentlewoman from Pennsylvania that I disagree with a number of your conclusions.

Ms. SCHWARTZ. OK.

Secretary LEAVITT. The principle here is, what we are discussing is what will government do to subsidize those in need. And the question is, is there more virtue in a thousand people having a basic affordable plan or five hundred people having a comprehensive plan and five hundred of them having nothing?

Now, I believe that——

Ms. SCHWARTZ. So let me just stop you there. You are saying then that it is the Administration's intention to reduce benefits for people who have them because they get too much and——

Secretary LEAVITT. It is not. It is not.

Ms. SCHWARTZ [continuing]. And to make sure that—and maybe you are saying it is a good thing—is to help those who are the poorest maybe be able to get them the most. And I represent a lot of lower, middle-income folks who are struggling to be able to meet all their expenses, to pay health insurance if they can. They value their employer-based health insurance. It is not easy to buy it in the individual marketplace.

The fact is that you are really driving this to just those who are really—you are not really helping them. Let me just end it there. You are not really helping them enough to truly make a difference.

Secretary LEAVITT. Well, may I point out that the President's proposal, his tax proposal alone would benefit 80 percent of your constituents and every person in this country who is on an employer-sponsored insurance plan, and it would benefit 100 percent of those who have nothing.

Now, that sounds like serious help to me. And I would also point out that there are a lot of people in this country who end up leaving the employer-sponsored health insurance plans because of changes in their employment, because of changes in their circumstances, and they have nowhere to go. And this is about creating pooling where they have the ability to buy it in the individual market if they have to go there.

Ms. SCHWARTZ. Let me just interrupt. I am sorry. I did not see any proposal around pooling. You are putting people into an individual marketplace and I have not——

Secretary LEAVITT. Well, you have not looked at the proposal.

Ms. SCHWARTZ [continuing]. Seen any of those proposals. Maybe you have them, but we have not seen any of them because if you

do it without pooling, it is very expensive and sometimes unacceptable even with a tax deduction.

Secretary LEAVITT. The proposal is that we create a basic affordable plan for everyone in a State and that would require a State to choose a method of developing funding for those that are chronically and seriously ill. That is why these two proposals have to be done together.

You cannot just say here is one proposal, here is another. The value of the plan is that we are working collaboratively with the states to actually get at solving the problem and having every American have a basic affordable policy.

Chairman SPRATT. Mr. Smith from Nebraska.

Mr. SMITH. Thank you, Mr. Chairman.

Mr. Secretary, I appreciate this opportunity.

I will begin by saying that when the proposal was newly released, I was not as big of a fan as I am now after learning more. And I do have to say that in many cases, even some employer-provided pooling of healthcare right now, adverse selection is taking place based on the generosity of some plans. And I do not say we should take that away necessarily as we should use more market-based principles with that.

So I appreciate, and I look forward to learning even more about it.

That being said, within the context of public health in general and the programs that states and the federal government offer, I hear concerns from the front lines of healthcare that many beneficiaries are not utilizing the appropriate channel of benefits perhaps.

What is being done perhaps to delineate the difference in services? Say the emergency room versus the clinic or walk-in urgent care, whatever the case might be. Are we able to provide the states the flexibility to address those so that consumers and beneficiaries can take advantage of what is most appropriate utilizing the most cost-effective manner?

Secretary LEAVITT. Your seat mate, Mr. Alexander, spoke some of Louisiana. In Louisiana, 43 percent, almost double the number of people, almost triple the number of people go to emergency rooms to get the most basic of care because they do not have existence of those facilities there.

They have a two-tiered system where if you are employed and have insurance, you go to one system. If you are not employed and poor, you go to another. And the quality of care that they receive is not what it would be if they had access to preventative medicine.

And this is a good example. In Louisiana, the federal government sends them about a billion dollars a year. We could provide as a government assistance for virtually every person under 150 percent of the poverty line to have a basic affordable policy, have almost $300 million left over to pay for uncompensated care to support hospitals. And those people would have access to preventative care.

So our policies do impact that, and that is one of the reasons that the President feels so strongly about having 1,200 new community health centers. That is where we can provide assistance, but those would be so much more viable financially if people walked in with an insurance card instead of to the community health center or to

a clinic as opposed to going to an emergency room where they are not going to get that care. It is more expensive and less efficient, and they are not as healthy as a result.

Mr. SMITH. OK. Thank you.

I yield back the balance of my time.

Chairman SPRATT. Mr. Doggett.

Mr. DOGGETT. In our discussion about the plan that you and President Bush have to raise taxes, to provide more coverage for the uninsured, we discussed this last week. You said to Ms. Schwartz here as you told me last week what you thought were the purported benefits of your plan.

In terms of the purported cost, there are, as you said, 20 to 25 percent of the people. I believe that is a little over 30 million people, as I described it to you last week, who receive insurance through an employer, who will pay more taxes if your proposal is adopted.

Secretary LEAVITT. On that day, the Chairman of the Committee asked me if the President's tax cuts were not made permanent, would I see that as a tax increase. I said if the federal government raises more taxes as a result, it seems like to me that might be considered a tax increase.

Mr. DOGGETT. Well, I am glad for you to take that up with him. I am asking a specific question. If your proposal is adopted, will there not be 30 million people plus in this country who receive insurance today through an employer plan who will pay more taxes the year after your plan is adopted?

Secretary LEAVITT. There will be three who receive benefit and one that will not, and they will——

Mr. DOGGETT. Mr. Secretary, is it not true, under your estimates under the written documents that you proposed, under all the assumptions that you have outlined that over 30 million people—you can call it 20 percent. You can call it one in four. You can call it one in five. But 30 million plus people will pay more income taxes after your plan is adopted than do today?

Secretary LEAVITT. I am prepared to stipulate to that to the extent that——

Mr. DOGGETT. You agree with that?

Secretary LEAVITT [continuing]. If you will understand and stipulate that 120 million people will receive a benefit——

Mr. DOGGETT. I understand you and the President——

Secretary LEAVITT [continuing]. And that the federal government will not collect a dollar in taxes more.

Mr. DOGGETT [continuing]. At the State of Union address want to talk about the benefits. I want to talk about the person who has got a wife with breast cancer, a child with a disability, or is a high-risk job. And of all the people for you all to propose a tax increase on, you are proposing a tax increase on that person because they happen to have a decent health insurance policy.

Secretary LEAVITT. That is not true.

Mr. DOGGETT. And as I—well, it—you just——

Secretary LEAVITT. It is not true.

Mr. DOGGETT. You just, quote, stipulated that you are going to raise taxes on 30 million people who——

Secretary LEAVITT. Mr. Doggett, you continue to make that assertion. I would like to be clear that you believe that.

Mr. DOGGETT. Yes.

Secretary LEAVITT. I would like it clear I do not.

Mr. DOGGETT. Well, you just stipulated. You do not want to say that it is a tax increase because you claim it is revenue neutral.

Secretary LEAVITT. That is exactly what it is.

Mr. DOGGETT. Yes. But if I am the person paying the tax bill, it is sure a tax bill on me if I have that kind of insurance policy. I am going to be paying more taxes and so are 30 million people.

And, indeed, the numbers actually go up now that I have had a chance to look at your ten-year figures because they show that by the end of the ten years, 40 percent, twice as many, will not be within the deduction area, and that is because you have chosen to treat people with good insurance differently than you treat the Medicare Advantage plans that you want to benefit under Part D. You let them adjust their benefits according to the CPI for medical expenses, but on these health insurance plans, you limit it to just the cost of living, do you not?

Secretary LEAVITT. Well, I would assume then by your position that you would think it is a good idea for us to continue to have people who have to buy it from——

Mr. DOGGETT. Well, I am glad to answer questions from you after this hearing. But my question to you, sir, is, is it not true that you go up to 40 percent of the plans that are not within the standard deduction because you have applied a different and discriminatory cost-of-living index here different from what you do for the Medicare Advantage Program?

Secretary LEAVITT. It is true that we believe that by targeting those increases at a lower rate that we can have a positive impact on medical inflation.

Mr. DOGGETT. But you do not want to do that for Medicare Advantage programs. In fact, the Commonwealth Fund came out with a study within the last couple of months that I am sure your office is familiar with that in year 2005 under Medicare Part D, you paid the Medicare Advantage programs almost a thousand dollars per beneficiary more than it cost us under the traditional Medicare.

You do not have any disagreement with that study, do you?

Secretary LEAVITT. What I do have a disagreement with is that it is not about paying more. It is about getting integrated care and establishing a policy where we can have more——

Mr. DOGGETT. So you think you are getting value for your thousand dollars more per person?

Secretary LEAVITT. We do, and we are also of the understanding or when I say understanding, we also have established policies in the law that over time would begin to reduce that difference. It was done as a deliberate policy matter to assure that we have integrated——

Mr. DOGGETT. Well, in order to——

Secretary LEAVITT. Could I continue?

Mr. DOGGETT. Let me just ask you to respond at the same time since my time is expiring. Would you be in favor of applying the same cost-of-living index there that you now propose for this new tax on health insurance policies?

Secretary LEAVITT. We are working to establish a policy with Medicare Advantage that allows for beneficiaries to have integrated healthcare, and we want it to be available in every part of the country because we believe that part of establishing this long-term benefit is integrated care.

And when you have integrated care and not just fee-for-service medicine where we are paying providers for how much they provide as opposed to the benefit, we think in the long term, and evidence bears this out, that the Medicare Trust Fund benefits and that those who are the beneficiaries themselves——

Mr. DOGGETT. Is that a yes or no on whether you would treat the Medicare Advantage Program the same way you propose——

Secretary LEAVITT. We would not.

Mr. DOGGETT [continuing]. This health insurance tax?

Secretary LEAVITT. We would not.

Mr. DOGGETT. So you are going to keep giving them more benefit?

Secretary LEAVITT. The law is what it is, and we support the current law.

Mr. DOGGETT. Thank you.

Chairman SPRATT. Mr. Tiberi of Ohio.

Mr. TIBERI. Thank you, Mr. Chairman.

Governor, thank you for being here today.

Last week after the budget was introduced by the Administration, predictably I saw headline after headline claiming that there were deep cuts in Medicare and deep cuts in Medicaid in particular. Upon closer look, it appeared to me that every year in the budget, there is actually growth in both Medicare and Medicaid spending.

Can you comment on that?

Secretary LEAVITT. The Medicare rate of growth right now is 6.5 percent a year. If we made every change that we have proposed, we would reduce the growth rate from 6.5 percent down to 5.6 percent. It would sustain the viability or the solvency of the Medicare Trust Fund by just four years. But it is an important start.

Mr. TIBERI. Which was my follow-up question. I heard a lot over the last year about entitlement spending and particularly Medicare and Social Security.

When you look at those programs particularly under your jurisdiction, Medicare and Medicaid, what is your biggest fear over the next two years if we do not begin to tackle the problem with the growth of those programs?

Secretary LEAVITT. I am trustee of the Medicare Trust Fund as well as Secretary of Health and Human Services. We now measure Medicare as a percentage of the entire gross domestic product.

I have a grandson that was born last year. When he reaches his father's age, it will have gone from 3.2 percent to 8.1 percent. When he gets to be my age, it will be 14 percent. And I am not talking about the federal budget. I am talking about the gross domestic product of the entire country.

My biggest fear is that we will not make the logical small changes now that could prevent that from happening because we all know that will not occur. We will either have been eliminated

from the economic playing field as a country or we will have changed it. And let us hope we do not change it too late.

Mr. TIBERI. Mr. Secretary, one of the programs that I support and initially opposed was the Medicare drug benefit. I opposed it initially because of the cost. I supported it after meeting with two surgeons in my district, heart surgeons, who convinced me that the way that the Medicare system was structured, we were incentivizing the wrong way. Rather than on preventative care and focusing on preventative care, we were paying them to do opening chest cavities and repairing hearts.

The number of the dollars that were told to us that were going to be spent on the drug benefit have come in significantly lower than what we were told. I believe after talking to physicians in my district that prevention does work.

How do we as policy makers here put more of the focus on preventative costs up front so we can save on the long-term cost both in our regular healthcare system and with respect to Medicare and Medicaid?

Secretary LEAVITT. Well, prevention is the key. Frankly, the prescription drug benefit was an important step in that direction. I am sure as your cardiologist friends would tell you, Medicare reimbursed heart operations that would cost 150 or $200,000 a piece that we could have prevented for $1,000. And we are now changing that.

I will tell you another very important change and that is beginning to gravitate away from the fee-for-service reimbursement and moving toward an integrated care.

You walk into a hospital, you ask a hospital administrator what is the most expensive—in fact, a hospital administrator asked me this. He said what do you think the most expensive medical device is in this hospital. I said I do not know. Is it a CAT scan? He said, no, it is a ballpoint pen in the hand of a physician.

We do not know in many cases the degree or cost that each individual—you put five people who are being treated for the same thing, they will end up with radically different treatment patterns and the result is much higher cost.

So having integrated care where you have the—we talked earlier before you came about quality measurement, cost measurement begins to create a market of competition based on quality. When we do that, we will begin to see quality go up and cost go down.

Mr. TIBERI. Thank you, Mr. Chairman.

Chairman SPRATT. Thank you.

Mr. Andrews from New Jersey.

Mr. Etheridge from North Carolina.

Ms. Hooley from Oregon.

Ms. HOOLEY. Thank you, Mr. Chair.

It is nice to have you in front of Committee.

Secretary LEAVITT. Thank you.

Ms. HOOLEY. It is interesting because the questions I am going to ask you are all bits and pieces of our healthcare system because, as you stated early, and I totally agree with you, we do not have a healthcare system. It is very much a piecemeal system. But since that is what we currently have, I am going to ask you those piecemeal questions.

This budget gives rural healthcare initiatives, it is a $142 million cut, and leaves 17 million for rural healthcare. That is going to be difficult because for many of our rural communities, that is the only healthcare they have. It is very hard to get doctors out there. It is very hard for the rural communities to get healthcare.

And I know you have increased funding for community-based health centers. I am happy about that. I think that is a very good thing to do. Again, it is nice for people in all areas to be able to go into a community health center. So I am happy about that.

But those community health centers do not specifically target rural communities. And, again, it seems like we continually spend less money in those under-served rural communities. I find it unacceptable.

So I do not know if you want to comment on that or not, but——

Secretary LEAVITT. I mentioned the other day at the Ways and Means Committee that I governed a State for eleven years that had areas that were so rural you had to order a haircut out of the catalogue, let alone healthcare, and that delivering healthcare to those areas, I understand the difficulties of it.

We have made a substantial investment through the "Medicare Modernization Act" to increase by $25 billion the amount going into rural healthcare. There are as a result of that areas where in this budget I felt like we have other ways of reaching the same goal. And so we have chosen to do it that way. But I am sensitive to the problem you are talking about.

Ms. HOOLEY. And, again, I just think 17 million for this whole country for rural healthcare is just too little.

Secretary LEAVITT. Well, we spend a lot more than 17 million for rural care. That is one program that we have chosen. We are actually proposing about a like amount to increase nurse visits that can in large measure be used in rural areas.

Ms. HOOLEY. I was talking to one of my hospital administrators and this is a nonprofit hospital. And he was worried about CMS's proposal released on January 18th that will cut $3.9 billion in Medicaid funding over the next five years.

The rule is designed to cut funding for public providers, but you know and I know that those cuts are going to be felt by all providers, including the not-for-profit hospitals. Those cuts are in addition to across-the-board cuts to hospital, hospice, ambulance providers.

Then you include the budget's failure to fund Medicare physician payment reform which will result in a payment cut of ten percent for physicians next year. And all of that adds up to a pretty dire situation for our safety net providers.

They are getting hit hard by this budget. And, again, I want to tell you that I think it is particularly difficult for rural providers.

Have you done anything specific to examine how these cuts are going to impact patient access to care if more providers stop accepting Medicare and Medicaid patients?

And let me just talk to you a little bit about that. Some of my communities literally, they will not accept any more Medicare patients. I mean, they cannot. They are filled up or they cannot afford to accept any more with the cuts.

What are we going to do about that? I mean, I am worried about our whole system because of the reimbursement rate, the way our system is currently.

Secretary LEAVITT. Congresswoman, I worry about that too. It is one of the reasons that I am so passionate about making certain that there are Medicare Advantage plans available in every part of our country, because they provide an integrated care with the assurance that there will be physicians who are, in fact, able to treat Medicare patients and to accept new ones.

Now, I have already acknowledged that I think the way we reimburse physicians, it is kind of a witch's brew that nobody really understands. It is a very complicated system, and I would like to see a system that is different than that.

So I worry about the same thing. As you said, we have what we have. We need to migrate towards something better. But in the meantime, that is one way we can do it.

Ms. HOOLEY. Well, again, I find physician after physician has told me they just simply cannot afford to accept Medicare patients any longer. So I jokingly tell them this, but I am dead serious when I tell some of my friends who are my age, make sure when you get a new physician before you retire that you get a young physician because if yours retires on you, you will never find another physician to go to. And I think that is actually a really horrible message to give to people, but that is what I tell people.

Secretary LEAVITT. I mentioned earlier that I am very anxious to see us find ways to make the business model of physicians, particularly small-practice physicians, viable. And part of that will be in developing a system that can gather information and reward high quality and at the best price. And if we do that, both physicians will be sound and able to make their businesses work and we can provide care.

I would say that there are few people with more to worry about in this area than me. I have 43 million beneficiaries, including my parents, who depend on that. And we will do all we can, but we have got to deal with how we finance this system in the long term. We have got to work on this because we cannot go on just every six or eight months trying to figure out how to keep it together for the next six or eight months.

Ms. HOOLEY. Thank you.

Chairman SPRATT. Mr. Hensarling.

Mr. HENSARLING. Thank you, Mr. Chairman.

Welcome, Mr. Secretary.

Secretary LEAVITT. Thank you.

Mr. HENSARLING. Just as a point of clarification, since we continue to hear the word cut used over and over and over, is the Administration proposing to spend more money on Medicare in this budget or less?

Secretary LEAVITT. We will spend 5.6 percent more per year going over the course of the next——

Mr. HENSARLING. And how about Medicaid?

Secretary LEAVITT. Same, 7.1 percent.

Mr. HENSARLING. And how about the life of the Administration? Have you spent more money on Medicare and Medicaid each and every year of the Administration?

Secretary LEAVITT. Each year.

Mr. HENSARLING. That is what I thought. I missed some of this hearing. When I walked in, I must admit I was a little incredulous by what I was hearing. I heard nothing from the other side except how tax relief has been the source of all of our problems and that we must increase taxes on the American people.

And now I hear voices from the other side of the aisle castigating the Administration for what they view as a tax increase. I am having a little hard time seeing how they can have it both ways.

How do you say we need tax increases and then when you purport to have a tax increase, all of a sudden, you are being criticized?

Furthermore, as I understand it, if there are people who will see a short-term increase in their tax liability, is it the poorest of Americans that might see such?

Secretary LEAVITT. No. It will be the upper 20 percent of income. This would perhaps be the most progressive tax policy move that we will have seen in decades.

Mr. HENSARLING. So you might be said to be taxing the rich; is that correct?

Secretary LEAVITT. Well, it is not a tax increase because it does not gather any additional revenue. Those that it affects——

Mr. HENSARLING. Well, I agree with you, Mr. Secretary. I understand that this is——

Secretary LEAVITT. I might add that——

Mr. HENSARLING [continuing]. Revenue neutral.

Secretary LEAVITT. I might add that those who are in that situation have options. They——

Mr. HENSARLING. Well, indeed, there is a way that they can align their affairs such that they do not have any increase in their tax liability; is that correct?

Secretary LEAVITT. That is correct. They can.

Mr. HENSARLING. Well, I for one want to congratulate you and the Administration for this policy. I certainly reserve the right of final judgment until I see all the details.

But I would hope that what we would do as a Congress is try to come together and work in a bipartisan fashion to find ways to make healthcare more affordable, more portable, more accessible, of high quality and with patient choice. And, yet, we have had this odd quirk in federal policy where we essentially have third parties buy our health insurance for you.

To the best of my knowledge, we do not have analogous program for letting third parties buy our homes or our automobiles. Are you aware of any other federal policy that——

Secretary LEAVITT. I am not.

Mr. HENSARLING. Well, again, I would like to congratulate you for taking a very bold step forward that would empower millions of self-employed people and not to mention people who are now for all intents and purposes forced to take the health insurance of their employer's choice and empower them to go out and buy the health insurance that is best for them and their families.

It is a very empowering thing and it puts them in control of their healthcare. I frankly think it is one of the greatest steps forward

I have seen to improve healthcare, not only its quality, but its affordability.

Mr. Secretary, prior to you coming to our Committee, we heard from the head of CBO, the head of OMB, and I believe the Secretary of the Treasury, and I do not care to put words in their mouth, but I think they have all said something along the lines of the number one fiscal challenge of this nation is to find out ways to reform entitlement spending because if we do not, within a generation, some models differ, we are looking at either, A, having no federal government to speak of except Medicare and Medicaid and Social Security or a tax increase of somewhere between 50 and 100 percent on future generations.

If people refuse to embrace entitlement reforms and entitlement spending, imagine, if you would for me, please, what does the world look like if the next generation is saddled with a new tax burden of between a 50 and 100 percent increase and what does that do to their healthcare?

Secretary LEAVITT. I mentioned a little earlier today, but it bears repeating, that I have a grandson who today lives in a world where 3.2 percent of the gross domestic product is Medicare alone. If you add Medicaid to that, it about doubles it. When he becomes his father's age, it will be eight percent of the gross domestic product. When he becomes my age, it will be 14 percent of the entire economy.

Now, it does not take a lot of imagination to recognize that you cannot sustain a competitive economy with that kind of expenditure going into one sector.

Mr. HENSARLING. Thank you, Mr. Secretary. I see my time is up.

Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Andrews of New Jersey.

Mr. ANDREWS. Thank you very much, Mr. Chairman.

Thank you, Mr. Secretary.

I want to ask you about the allocation of the benefit that you are proposing with respect to covering the uninsured with healthcare.

First of all, do we have any data on the—I think you used the phrase 20 percent of those whose health insurance plans have a value of more than $15,000 for a family and who, therefore, would pay taxes on the value of the healthcare benefit that exceeds $15,000.

Do we have any income distribution data about who those people are that would get that tax increase?

Secretary LEAVITT. We do.

Mr. ANDREWS. What does it look like?

Secretary LEAVITT. If you divide the economic spectrum into five parts, they are the upper 20 percent.

Mr. ANDREWS. Is everyone in the upper 20 percent?

Secretary LEAVITT. Well, just like any other statistic, there are those that are not, but on balance, they are in the upper 80 percent.

Mr. ANDREWS. Could you supplement the record with a written answer to that question for us so you could show us? What I am specifically interested in is the income distribution by either adjusted gross income or gross income.

Secretary LEAVITT. The Department of Treasury has that information. I would be happy to——

Mr. ANDREWS. If you would supply that.

Second thing I want to ask you is under this plan, let us say we have a person who is uninsured—well, let me just give you this statistic. Forty-one percent of the people who make between 20,000 and $40,000 a year are uninsured according to a recent study. Forty-one percent of people's incomes are between 20,000 and 40,000.

Say if someone has an income of $30,000 a year, their gross income, and they are a renter and they say they have two children and their adjusted gross income with exemptions and whatnot is down at about 23,000, tell me how this proposal affects them.

Secretary LEAVITT. It is clear that the benefits of this proposal alone would not provide an adequate assistance for them to buy health insurance.

Mr. ANDREWS. What would it provide though?

Secretary LEAVITT. Well——

Mr. ANDREWS. A person with, let us say, a $23,000 AGI who has no health insurance, what is the value of this proposal?

Secretary LEAVITT. Well, if they had no health insurance, it would not benefit them.

Mr. ANDREWS. So they get nothing?

Secretary LEAVITT. That is right.

Mr. ANDREWS. So in my State, for example——

Secretary LEAVITT. Get nothing now.

Mr. ANDREWS. That is right. In my State, a family health insurance policy may cost 12, 13, $14,000 a year on the average. So the value of this tax benefit to someone who cannot afford to buy the family policy is really nothing?

Secretary LEAVITT. As you will recall earlier, I mentioned that you cannot look at this as one proposal. There are two proposals. The second would be to have the federal government assist the states in closing the affordability gap——

Mr. ANDREWS. How much money are you putting into that——

Secretary LEAVITT [continuing]. Just like the ones that——

Mr. ANDREWS. And how much money are you putting into that proposal?

Secretary LEAVITT [continuing]. Just like the ones you have described.

Mr. ANDREWS. I understand.

Secretary LEAVITT. We are working now with the states to develop a proposal. We would like to work with the Congress in the same way. It is clear to us that we have to, first of all, assure that there are basic plans available and, second, that they are affordable. An important part of making them affordable would be to have this tax equalization. It is indefensible, but we——

Mr. ANDREWS. How much is budgeted toward that initiative?

Secretary LEAVITT. That has not been budgeted yet because we want to work with the Congress and with the states to determine how it should be developed.

Mr. ANDREWS. Well, you say yet. I mean, is there a place holder? Is it correct to say that in the proposal before us, the amount is zero right now for that?

Secretary LEAVITT. The proposal has not yet been made, but it is very clear from what the President said is he wants to work with the Congress to do two things. One is to provide supplement to states to close the affordability gap to be able to help exactly the person that you are talking about be able to afford policy and then close the gap on the tax issue.

Mr. ANDREWS. My understanding is that the revenue loss you are projecting for the first five years of this 20/80 plan is $126.4 billion. Why did we not take the $126.4 billion and put it into SCHIP? Would that not have been a more rational way to try to get to the people who are uninsured?

Secretary LEAVITT. We do not think so. We think——

Mr. ANDREWS. Why not?

Secretary LEAVITT. Because we think it is the responsibility of the federal government to assure that if a person is elderly, disabled, if they are poor, if they are a woman who is pregnant, if they are a child needing protection, it is the responsibility of the federal government to assure that they have health insurance.

And we do that through Medicare, Medicaid, and SCHIP. Everyone else, we believe that it is better for the states to assure that there is a marketplace that will provide a basic affordable policy and that we should do two things in the federal government.

One is to resolve the indefensible position that we currently have, which I assume you would want to change, where those who——

Mr. ANDREWS. My time is expiring. My own observation is that this is a continuation of the indefensible, an exacerbation of the indefensible because you are taking 126 billion in tax expenditures and not putting it toward the people who are most in need.

Chairman SPRATT. Mr. Ryan has a question for clarification.

Mr. RYAN. Rob, I want to ask a clarifying question of Secretary Leavitt because I think there may have—at least I got confused in a stage of it.

If a person has an adjusted gross income of $23,000, you said no value whatsoever would come to them.

Secretary LEAVITT. They have no insurance. They have to buy insurance as a condition to get the benefit.

Mr. RYAN. OK. But their tax benefit would be—because this refund—this is deductible. The deduction applies to FICA taxes as well, correct?

Secretary LEAVITT. It does, but they would have to buy insurance in his example that they do not have any insurance.

Mr. RYAN. OK. So they buy insurance. Then the deduction in that person's case would basically just apply to what they pay in FICA taxes, correct?

Secretary LEAVITT. That would be true if their adjusted income was what you suggested.

Mr. RYAN. You would not have—yeah. OK. You would not have an income tax liability at that AGI on income taxes?

Secretary LEAVITT. That is right.

Mr. RYAN. You would have a FICA tax liability and so the deduction would just be the value of the deduction on FICA taxes? If then you bought insurance, it would reduce the cost by that amount? Is that basically how you calculate it?

Secretary LEAVITT. That is correct.
Mr. RYAN. OK. Thank you.
Mr. ANDREWS. Will the gentleman just yield?
Mr. RYAN. Yeah, sure.
Mr. ANDREWS. That is sort of my point.
Mr. RYAN. Yeah. No. I just——
Mr. ANDREWS. Someone in that position, A, does not get any benefit if they do not buy insurance, which I do not think they can afford to do. And even if they did——
Mr. RYAN. It does not cover the cost.
Mr. ANDREWS [continuing]. Their marginal rate is so low that it is really a pretty minimal subsidy.
Thank you.
Chairman SPRATT. Mr. Porter from Nevada.
Mr. PORTER. Thank you, Mr. Chairman.
Mr. Secretary, it is good to see you again. Thank you very much.
Secretary LEAVITT. Thank you.
Mr. PORTER. First, at the 2,500 foot level in Nevada, you know, in prior campaigns, I heard frequently from seniors how the Medicare prescription drug benefit was going to damage their current health plans. We had thousands of phone calls, of course funded by political action groups.
I just want you to know that many of those seniors that called back then are now saying thank you, and they felt that they were not necessarily given the facts.
But in Nevada, we have close to 90 plus percent of our seniors have signed up. A lot of that has to do with your efforts and many, of course, volunteers helping in Nevada. But I get calls frequently from these seniors that really appreciate the program. So I wanted to say something very positive.
Almost 90 some thousand of those seniors are in my district, and certainly it is not perfect and certainly it has challenges, but I want to send you that message. Many of those folks that were complaining are now telling us it is working and they appreciate it.
On the child welfare side, we have had a chat in the last week, and your staff has been very responsive to a very serious emergency in Nevada on child welfare. And I want to thank you.
Now I want to get back to 40,000 feet for a moment. A few weeks ago, we heard that, in this Committee, that close to $600 billion, and I could be off on the numbers, but close to $600 billion is being spent a year on child welfare programs.
Now, there is, of course, variation of number of children that are on welfare, and I realize every one of these children has a name and a family and a challenge, so I do not mean to discount them individually.
But there is somewhere between 12 and 20 some million children a year that are in poverty. If you divide those kids into 600 billion, that is almost 30 to $50,000 a child a year is being spent currently by the federal government.
Now, I can say facetiously we should give each child a check for $50,000 a year, but we know that is never going to happen, nor should it.
But what can we do to make sure that this 20 to 50,000, and it is appalling to me that that much money is being spent and not

reaching the child, what can we do to help cut through the red tape, through all the bureaucracy so these kids can benefit from this massive budget, because this is not a question of we need more money? And there is a lot of programs that we do. It looks like we need to make sure that that child gets that money.

Is there anything else that we can be doing to make sure these kids reap the benefit?

Secretary LEAVITT. Without validating a specific number——

Mr. PORTER. Absolutely.

Secretary LEAVITT [continuing]. Let me just acknowledge that having served as Governor for eleven years and managed these programs, we have done remarkably well in this country with a change of direction.

We concluded that we ought to turn the responsibility for management of the programs over to the State. We allowed them to have the flexibility. We began to create requirements that would require people to work and begin to integrate in a way that would provide the building of lives and the fostering of self-reliance as opposed to the perpetual maintenance.

I believe that that was a sound policy. I think it is a sound application in the area of healthcare as well as welfare.

Mr. PORTER. And, again, not to discount the child and his or her trauma, we looked at government agencies last year and we have six or seven agencies looking at frozen pizzas. You know, one looks at pepperoni and one looks at cheese, one looks at sausage.

I just hope there is some way that there is not duplication, overlapping of these services. And I appreciate what you are doing to try to give the states more control.

But the factor remains is that money is still not getting to the child, and I appreciate your efforts in making sure that we can channel those monies to the right place and not duplicate services. And I know you are in a unique situation. You suggest any kind of cut anywhere, it sounds like you are cutting an essential program.

I am assuming that some of these things that you are making an adjustment to are because of overlaps and because of duplication; is that not correct?

Secretary LEAVITT. One of the guidelines I gave the preparers of the individual decisions that needed to be made was that we ought to look for places in the federal government, and there are many, where because of siloed budgets and because of siloed approaches, there are more agencies of government dealing with the same problem than one. And it happens a lot.

And so there are instances where we have eliminated programs because they were being covered by other places. And there would be those who champion the program that is being reduced or eliminated, but if you are going to have a deficit reduction budget, you have got to deal with those priorities.

Mr. PORTER. Thank you, Mr. Secretary.

Thank you, Mr. Chairman.

Chairman SPRATT. Mr. Etheridge of North Carolina is not here, I do not believe.

Mr. Bishop.

Ms. BISHOP. Thank you, Mr. Chairman.

And thank you, Mr. Secretary.

I have some statistics I want to share with you and then ask you a question. I represent a district in New York. In 2003, the HMOs in New York operated at an aggregate profit of a billion dollars. The hospitals operated at an aggregate loss of 391 million.

In 2004, the HMOs had an aggregate profit of 847 million, the hospitals a loss of 127 million. In 2005, the HMOs had a profit of 1.1 billion. Hospitals lost only 95 million. And over that same period of time, the HMOs increased their premiums on an annual basis by about ten percent.

So my question is, why when we are looking to bend the rate of growth in the Medicare program and, as I understand it, there will be some $66 billion worth of lost payments over the next five years and that those payments will be principally taken out of the providers, why is it that we are taking the Medicare payments out of the providers and keeping in place the subsidies to the HMOs?

Secretary LEAVITT. I am not expert, Mr. Bishop, on New York hospitals, but I know enough because of my interaction with Governor Pataki and now Governor Spitzer on New York hospitals to know that there were too many of them and that their business model was floundering as a result and that you have been through a so-called BRAC commission-like process. And we have helped in being able to reduce the number of beds and hopefully increase the profitability.

I would argue that there may be a difference in the cases of the hospitals in New York and HMOs because the care has been managed more carefully, and we all aspire for that to happen with the hospitals in New York as well.

Ms. BISHOP. More to the point of my question, though, why do we continue to subsidize entities that have such a healthy profit margin at the expense of entities that even if they are exceptionally well-run, at full capacity, are struggling to operate at a break even?

Secretary LEAVITT. Well, first of all, I am not able to validate the statistic. I will assume that you got it from a credible source, but the principle obviously here is that we desire to see integrated care and we want to see it everywhere. We want to see it in the rural areas that we had just spoken of.

And this system was established over time working our way starting with a subsidy and then moving out the way we do, and we are having success. We have over seven million people now that are on Medicare Advantage, and they are very happy with it and they are receiving excellent care and they are not having trouble getting a physician on Medicare.

Ms. BISHOP. But don't those Medicare Advantage plans cost us more than traditional fee-for-service Medicare recipients?

Secretary LEAVITT. We believe that having integrated care and having them available in every part of the country ultimately provides our system with an advantage that we hope to preserve.

Over time, built into the law is the ability to normalize those payments in a fashion that will assure we have a robust system of integrated care.

Ms. BISHOP. Let me switch the subject. Head Start, arguably the central domestic public policy initiative of this Administration has been No Child Left Behind. There is a fairly substantial body of

evidence that suggests that if you get kids started right, the chances of them succeeding as they go through the system is increased over those who do not have in this case early childhood education or pre-k education.

Why is it if that is the case, and if we are all agreed that we all want students performing at grade level, we all want to eliminate the achievement gap between rich kids and poor kids and White kids and African-American kids, why is it that we would not be increasing our investment in a proven success story like Head Start?

I mean, you talked before, and I do not mean to be disrespectful, but you talked before about siloed decision making. Is this a case of siloed decision making where we have one program that has a set of goals and another program that might contribute to those set of goals, but because of some financial imperative, we are not funding it to the extent that it should be funded?

Secretary LEAVITT. It is a good example of siloed decision making, but not perhaps in the same way you have thought about. It would be in my judgment lots better if we had the ability to coordinate what goes on in Head Start with what goes on in our schools, our public schools much closer. And there are clearly silos there.

We send Head Start about $8 billion a year. It is a very important program. Do we believe it could be more efficient? We do. And I did protect it from any significant cuts. But in a deficit reduction budget, we concluded that we could reach greater efficiency there and that we are going to work with them to achieve it.

Ms. BISHOP. OK. Thank you, Mr. Secretary. Appreciate it.

Chairman SPRATT. Mr. Garrett.

Mr. GARRETT. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here for all this time. Appreciate it. And I appreciate the efforts that you and the Administration are making in a difficult area.

As previously indicated, we have a number of people coming before us earlier testifying to the dire situation that we may face or will face when it comes to mandatory spending. And I would hope that we have bipartisan agreement that we are facing that. Although at times, I am not quite sure that we are even yet to that point of agreeing that if we do not do something down the road, we will face that problem.

Let me just make this one observation. When these proposals come down from the Administration, what happens then, as you are probably aware, is the healthcare community in general gets whipped up, if you will, about the dire warnings, right or wrong, that may be coming down the track, whether it is the hospital community or the provider community. And then we as members hear from them in our office.

Part of that is because while I again applaud the attempts to make some overall structural changes that you have in here, you address the subsidies to upper income retirees for services under Medicare Part B and D, and also we talked about the standard healthcare deduction. Part of the savings does come, I will use the word tinkering around the edge with regard to provider services.

I come from the State of New Jersey where it is the high cost of healthcare, high cost of living in general. Hospital funding is an issue. Obviously you can appreciate it is difficult in our area.

The nonpartisan Medicare Payment Advisory Committee recently voted and recommended to Congress that hospitals receive a full inflation update in 2008 stating that the Medicare margins were at the lowest levels recorded.

Likewise, we can hear from other providers in the State, and they would look at these things and say we should not be tinkering around the edge. I guess I would suggest that we may need to make some broad changes than just addressing that.

So that would be my first question is whether we should be going in that direction. And, secondly, it is hard to get around some of these numbers and get your hands around them.

My understanding is, according to the Medicare trustee, the unfunded liability of Medicare totals $35 trillion over the next 75 years. I have a hard time, quite honestly, getting my hands around a billion dollars. Well, I would never get my hands around a billion dollars. But if I could, 10,000 $1,000 bills stacked up in front us would equal a billion dollars, and we are talking about an unfunded liability of $35 trillion.

Are we doing enough, I guess, is the question to the equation of addressing it with this legislation or should we be doing even more?

And the last question goes to the suggestions that come from the other side of the aisle, and that is could we not just simply maybe use some of the savings that you are talking about in here and throw them into programs like increase funding for SCHIPs or increase funding for some of these other programs that are already on the books? But if we did that, would that actually bring us to the solution that we see in the charts and that is addressing the long-term dire predictions that we have?

Secretary LEAVITT. Congressman, the healthcare financing system is—I referred to it earlier as a sort of witch's brew that nobody fully understands. I have spent a lot of time studying it as have others.

There are those who believe that there just is not enough political will in the world to change healthcare and the way it is financed. I would argue that the inverse of that may be true.

There is just too much political will because every time a proposal like the one that I am making today comes onto the table, everybody just unholsters their political will and aims it at each other. And there is an ongoing proprietary ideologic debate that just keeps us from making any change.

I am of the belief that the only power strong enough to begin to reshape the financing of our healthcare system is a market where people are able to make decisions based on quality and cost comparisons and that when competition based on value begins to happen, it begins to allow the hospitals that are efficient to emerge.

It allows those that are not—we can make deliberate, overt decisions about whether or not we ought to subsidize them as opposed to the covert subsidies that we currently have in place that no one understands, that no one accounts for, that no one is in a position

to predict the outcomes. Whenever there is a proposal like this one comes on the table, the outcome is predictable.

Now, I am of the belief that if we construct a system of healthcare that is based on competition, on value, that we will begin to see it rationalize. It will not happen over night.

But, you know, you ask about Med Pac. I made a recommendation that we take the full so-called market basket and we cut it by .65 percent. I had a rationale for doing that. I am not sure if the market would have guessed that exactly, but I believe strongly that if there were productivity there, that other people would begin to mirror that and we would see that would be a pretty good estimation. I am saying a lot more than you asked.

Mr. GARRETT. No. That is fine.

Secretary LEAVITT. And I am enjoying saying it and the time is up.

Mr. GARRETT. I appreciate it.

Chairman SPRATT. Mr. McGovern of Massachusetts.

Mr. MCGOVERN. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here.

I want to take my five minutes to talk about the issue of hunger in America. I think we cannot talk about any health or education issue if we do not first talk about hunger amongst America's children.

And this is, as you know, a very serious issue, a very real issue all throughout our country. There is not a community in America that is hunger free. We are the richest nation in the world, and I think that is something that every one of us in this Congress and every one of us in government should be ashamed of.

If we want to make sure that no child is left behind, then we need to make sure that all of our children are fed, especially our youngest children. If we are going to make sure that we have healthy children ready and able to learn, then we must be much more serious about eliminating child hunger and malnutrition in America.

Yet, when I look at this budget, to be honest with you, I do not see the kind of bold commitment that I think is called for, and it is a challenge for you and it is a challenge for this Congress.

When my colleague, Mr. Bishop, talked about Head Start, well, the fact of the matter is Head Start has been basically flat funded since fiscal year 2003. And in the fiscal year 2008 budget, it is actually cut by $100 million.

Now, you said at the beginning that you protected the program. I would just respectfully differ with you on that. The House Committee on Education and the Workforce estimates this year's budget means Head Start, early childhood education programs would experience a 13 percent cut in funding in real terms since 2002.

And, you know, we can argue about the efficiency of the program, and that is a nice argument for us to have here, but the impact, you know, for many of the children served by these programs, I mean, Head Start provides the only meals that they will receive on any given day. And for low-income and poor families, Head Start and Early Head Start is the only access to child care.

You can say, well, we are not really targeting food and feeding these kids, but we have stories here from people all across the

country who are involved in these programs, they are cutting back on the days of service or they are cutting back on transportation. Well, if you cut back on the days of service or you cut back on transportation, so a child cannot get to one of these programs, then you are literally taking food out of that child's mouth.

As for our senior citizens, there has been a lot of questions already here and a lot of discussion about the proposals on Medicare and Medicaid. But we all know that one of the most fundamental issues facing the low-income elderly is making sure that they are adequately fed.

Now, from our own experience with our elderly family members, everyone on this Committee knows that many prescription drugs do not work correctly if they are taken on an empty stomach. And some drugs will actually do you grave harm. We also know that many senior citizens require special diets.

I was in Massachusetts yesterday and was talking to some doctors who work in an emergency room at one of our major hospitals who was telling me about the number of senior citizens that they treat in emergency rooms who have severe illnesses because they are taking their prescription drugs on an empty stomach because they do not have the food. They are making choices, and they do not have enough to be able to have the meals that they need to remain healthy.

Yet, when I look at the budget between HHS and USDA, this budget eliminates or reduces or further restricts eligibility in nearly every one of the cornerstone programs that provide food, meals, nutrition, or income support to senior citizens.

I guess my point is that we all talk about the numbers here, about how we are trying to consolidate programs and be fiscally responsible, but a hungry child most likely will end up being an unhealthy adult. A hungry child will not be able to learn in school. A senior citizen who is shortchanged on their food and is taking prescription drugs on an empty stomach gets all these other illnesses that we end up all paying for. The societal costs are great.

I think what troubles me about what is before us here, I mean, the cuts in Head Start, the "Older American's Act,"Title 3 programs, some of the Social Services and other income support programs for children and elderly, I mean, the reduction and the cuts, however you want to call them, I think in the long run will end up costing us more.

And I am just trying to figure out, you know, what does it take, I mean, for the Administration or for the Congress here, for that matter, I mean, to deal with the issue of hunger head on? I mean, it is a huge problem. Not a community in America is hunger free. And, yet, it hardly gets any discussion, and this budget, I think, makes the situation worse. I would just be interested in your response.

Secretary LEAVITT. Mr. McGovern, I am not for hunger and I do not think——

Mr. MCGOVERN. And nobody ever is. I mean——

Secretary LEAVITT. I can tell you, I will offer this. As Governor and as Secretary of Health and Human Services, you brought up Head Start. I have been in a lot of Head Start programs. I believe it is a good program. However, I believe we could do better with

the program if we were coordinating it closely with children and with, rather, schools, with our public schools, and with the school lunch programs and all of the other programs that go into it. We do not.

And I answered the question earlier. I believe we can do better with what we have. We are making a substantial investment in Head Start. We are reducing budgets. We are in a position of having to make hard decisions between different competing priorities, and this is the way I made them. And I respect what you have said.

Mr. MCGOVERN. No. And I appreciate your answer, Mr. Secretary. I guess my point is that, you know, as we have this debate about how we can better run Head Start, there are Head Start programs that are cutting back on services. And there are children who cannot take advantage of those programs and there are children going without food.

And I would think that there needs to be more coordinated effort to deal with the issue of hunger, not only amongst children, but amongst senior citizens. I mean, you must be hearing the same stories I am from doctors who are talking about the prescription drugs—no matter what you say about the prescription drug bill, that is great, but, you know, if senior citizens are going without food and we are not providing them the necessary safety net to be fed properly to be able to support themselves, then we have a problem.

Secretary LEAVITT. One of the real privileges that my service in the federal government has provided was an opportunity for almost a year to travel all but two states, Hawaii and Alaska, and most of them, many times, and to go into senior centers, to go into churches, to go into the—I saw the fabric of compassion that is available or is established for people because we care about our neighbors, we care about our family members.

And the federal government plays an important part in that, but we are not the only part of it. And the question before us today is, what is the right thing for us to do with the limited number of dollars we have in order to weave it into the fabric of our community.

And, you know, could we do more? Yes. With the available monies that we are dealing with here, this is how I would propose to do that.

Mr. MCGOVERN. I appreciate your answer, Mr. Secretary. I would just close with, you know, I appreciate your statement that you are not for hunger, but, as I said, nobody is. It is a real problem. It is a growing problem, one that for whatever reason, we do not want to address.

I will just say one last thing, and that is when you go to a food bank in any State in this country, what you will see is the group in terms of growing clientele are working families. And it is a problem that is getting worse. And I think we need to do something about it. But I appreciate your answer.

Secretary LEAVITT. Thank you.

Chairman SPRATT. Mr. Bonner.

Mr. BONNER. Thank you, Mr. Chairman.

Mr. Secretary, I am sorry. I just got here late, so I will try to be careful with my questions because I am sure you have probably had two or three times at the apple.

But one that if you could repeat the answer if you have been asked it. It seems that we are constantly putting a band-aid on the physician reimbursement issue. And I was wondering if you could share one more time.

Is there a permanent fix out there so that we do not have to at the end of each year cobble together an agreement that basically keeps physicians at a level playing field, does not allow them the flexibility to grow and take advantage of the technology that is out there today?

Secretary LEAVITT. I believe there is one and we need to find it because this doing it every six months is an exercise that need not happen. I do not have a formula for you today, but I will tell you that the future needs to include the capacity for us to compensate physicians and hospitals at least in some measure on the basis of not just the quantity of services they provide but the outcomes and the quality of the services they provide. Now, physicians want to provide quality. What they want is to be measured fairly.

I have spoken at length today about a system of healthcare. I do not believe we have a system of healthcare. We have a sector of healthcare. We have got to shape it into a system, a system that has electronic medical records that will allow us to gather the needed information and to find quality measures and define what quality care is with the help of the medical community.

Once we begin creating a system of competition based on value, then we will have the capacity to solve the so-called doc fix on a more permanent basis. Frankly, there are parts of that we are not very good at yet, but we are getting better at it and we are spending a lot of time and energy not just in government but within the medical community, within the technology community, within the large payers.

I reported before you came that we will have 60 percent of the entire healthcare marketplace by April who will have committed themselves to four important cornerstones of shaping a system. Once that system is in place, and I do not believe we are a long ways off from where we will start to see its early manifestations, we can not only solve the SGR problem, but we will be able to begin managing our healthcare expenditures in a more rational fashion.

Mr. BONNER. Let me try to get a couple more questions in. You were in Mobile, Alabama where I am from during the selling, if you will, of the Part D Program. A quick assessment on your feeling. I know we had some bumps early in the journey, but the folks in my district, by and large, the calls I get are very appreciative of the new program.

Secretary LEAVITT. May I just say that this was a great American moment. This was not just about the creation of a new program. This was America rallying together.

I had the personal privilege of seeing, as I mentioned earlier, in church basements, in parking lots of shopping centers, in senior centers, in hospitals, in clinics, in schools, and people going door to door. I saw family members who stepped up and helped. In the

course of a six-month period, we saw 90 percent of the people in this country who are eligible sign up for a new benefit.

And now a year later, we find that 80 percent of them are happy with the decision they have made. And the good news is the 20 percent who are not have a choice where they can go out and improve their situation.

We saw billions of dollars being saved over what was originally planned. A hundred and thirteen billion dollars in this budget that is reduced because of the efficiencies that are being developed. We have been able to see seniors saving an average of $1,200. Most important, we are seeing seniors who are getting prescription drugs who did not have them before.

This was a great American moment. It was not simply about the victory of implementing a program. Well, this entire country rallied together in a way that allowed this to occur, and I am not sure it could have happened in any other place in the world besides this country.

Mr. BONNER. All right. Last question from me. I have asked the previous witnesses the last few weeks, the Director of the CBO and head of OMB and the Secretary of the Treasury, a tax related question, that if we in Congress allow the tax cuts of 2001 and 2003 to expire, is that a tax cut or a tax increase. I will not ask you that question. But some of the candidates running for President this year for 2008 are already talking about the need for universal healthcare. You said in your statement there will never be enough money to satisfy all the wants and needs and we had to make some tough choices.

Do you have any idea how much money you all would need in the Department to provide universal healthcare coverage to the American taxpayer and could you do it in your existing budget or would new revenue have to come in to pay for it?

Secretary LEAVITT. We spend 16 percent of the entire gross domestic product of this country on healthcare. In an earlier hearing today I saw a poster that indicated that is about twice what our economic competitors provide.

It is my belief the money is in the system. We have the capacity to provide an affordable basic health insurance policy to every American to give access if we were to, first of all, have a basic plan in most states and, second of all, use the tools of the federal government to level the playing field so that the states can solve the problems.

There are proposals being considered right now in at least 18, maybe more, states I know of. They are reaching out to solve this problem. There are two problems they cannot solve. One is the tax problem we spent a lot of time talking about today. And the second is they need help in being able to close the affordability gap, and we ought to do that, period.

Mr. BONNER. Thank you.

Chairman SPRATT. Ms. DeLauro.

Ms. DELAURO. Thank you, Mr. Chairman.

And welcome, Mr. Secretary.

Let me change topics, if I can, for a moment. About two weeks ago, the GAO designated that the federal oversight of food safety as a high-risk area and need of a broad-based transformation, and

that if we did not deal with this kind of a transformation and deal with both services and expenditures in this area, that, in fact, we are at great risk and we needed to move sooner than later in this effort.

And we have seen E-coli outbreaks last year involving spinach, Taco Bell restaurants in the northeast. The designation by the GAO is one that is significant given that they have been doing this over the last 17 years, and it involves substantial resources and significant government, as I said, services in order that we try to get this food safety effort off of this high-risk effort.

FDA is one of the two main agencies responsible for much of the food safety responsibilities, which is in your jurisdiction. It is my understanding that the budget request is about $10.6 million for food safety. That is in addition to what the—from a baseline of about what, $375 million. And that after you factor in inflation for salaries, the spending would be flat and it even declines.

One or two other points, and I would just like to have you comment on this. FDA is responsible for food safety for 80 percent of the food in this country, USDA, about 20 percent. The funding for FDA is about a quarter of the $1.7 billion that we deal with for food safety. USDA and other agencies get additional funding for that.

Now, my question to you is, how seriously are you taking this high-risk designation by the GAO? Is it not within your jurisdiction to change the funding on this area for food safety at FDA?

And, in fact, what I want to do is to ask you what are you prepared to do to deal with implementing this, if you will? It is not an order from GAO, but what it lays out is clearly an urgent need to remove our food supply system from its high-risk designation.

Secretary LEAVITT. I have not read that report. It sounds like something I need to read. And I——

Ms. DELAURO. Mr. Secretary, it is imperative that you read this report. I will be flat out with you. FDA and food safety—I have said this at a public meeting the other day—food safety is a stepchild at FDA and it would appear—and I should say that I do not know what the priority of food safety and FDA is within your jurisdiction.

Secretary LEAVITT. I commit to you that I will get a copy of the report and read it, but that sounds as though something I need to see. I have not at this point.

Ms. DELAURO. But tell me who deals with the FDA budget? What role do you have in putting together the FDA budget and in this instance—we will get to drug safety at another point—but the food safety budget for FDA?

Secretary LEAVITT. The FDA brings a budget to me and to my budget office and we review it based on the principles and priorities. And the report sounds like something that I need to read.

Ms. DELAURO. Well, I think it is and I would urge you to do it as quickly as possible. And I will make one final comment.

It is one of the reasons why, Mr. Secretary, I want an independent food safety agency whose only purpose with the wonderful scientists, epidemiologists, the people that we have day in and day out when they get up in the morning, their view is how we make our food safe in this nation, and it is not a part of either an FDA

or a USDA or some of the 13 other agencies that are out there that are dealing with our food safety, and we have one independent agency that puts its imprimatur and a gold standard on our food safety in this country.

Thank you. My time is up.

Chairman SPRATT. Mr. Etheridge.

Mr. ETHERIDGE. Thank you, Mr. Chairman.

Mr. Secretary, thank you. I have been in and out and I apologize. I have been on the floor, so please understand. And I hope I am not going to ask a question you already answered. If you have, raise your hand and I will move on.

But I do understand regarding physician payments, I would like to have a comment on that because in your testimony today, you said that you are committed to making the Medicare and Medicaid programs more attractive to physicians and other providers. And I admire you for that.

I join my colleague, Representative Hooley, in the fact that in rural areas, and not just in rural areas really, it is nearly impossible to find a doctor who will accept Medicare or Medicaid. Yet, most of the savings in your proposal comes from cutting payments to hospitals and other providers.

I would encourage you to go back and take a look at that because if you are making those cuts, it is going to be awful hard to get them to move in and take it when we are cutting the resources. And I would encourage you and your staff to review that one because I think that is going to be hard to do.

Let me move on a question, and maybe I will just ask you here. How do you propose to do that?

Secretary LEAVITT. I was just going to make the point that our budget proposes to increase the amount of funding available through Medicare by 5.6 percent. We are not cutting. There are areas in which we are slowing the growth rate, but we are proposing that it continue to increase by 5.6 percent.

Mr. ETHERIDGE. In talking to doctors, though, I think that will be a real problem. I would just say that. We will talk about that later.

The budget cuts public and preventive health funding that can address disease, help control healthcare costs over the long term. The budget reduces funding for CDC, substance abuse, training, and provides insufficient funding for NIH, and that is really what I want to ask you a question about, so you can keep up with inflation.

Some of these programs, including important cancer prevention research performed at NIH, which is the National Cancer Institute, as you know, have long time spans for their studies and, thus, need to have funding streams that are pretty predictable over a period of time.

I am told that organizations running experimental trials normally funded by NCI are considering halting planned trials due to the uncertainty.

My question is, why does the Administration budget reduce or eliminate these priorities at a time when we may have something in the pipeline that will make a huge difference?

Secretary LEAVITT. The National Cancer Institute is a very good illustration to answer your question. We made the decision to reduce the number of noncompetitive grants that had been concluded. We want to keep focused on the new science.

Now, this budget does reflect the fact that there is a slight reduction in the total amount. But what is not reflected in the number you see is that we will have an increase in the number of new investigations.

What I have found is that over time, some of the proposals just were not producing the result that was hoped for and we designed a system that would make more grants available. And there will be more frequent grants, more of them on a competitive basis.

Mr. ETHERIDGE. Well, let me move to one other area, Mr. Secretary, under block grants. The budget that you propose is, as you know, cuts block grants to a pretty healthy tune, pretty much devastates some of the programs.

Consider, for example, the Social Services Block Grant is one of the most effective federal efforts, I think. The National Governors Association calls it the glue that holds state and local social service programs together.

In 1999, you said further reduction in funding for SSBGs will result in cuts to vital human services for our most vulnerable citizens. Now, that was when you were Governor.

Despite that, your budget cuts SSBGs' total funding by the tune of 1.2 billion a year, a 29 percent cut below the 2007 level and 37 percent lower than when you wrote the Congress as Governor in 1999.

Secretary LEAVITT. Congressman, it will not surprise you to know that that is not the first time I have seen that letter recently. But I would reflect the fact that——

Mr. ETHERIDGE. I am going to let you answer. The reason I ask that question is because you know what these programs provide for. They help reduce poverty. They reach to employer services, a host of issues that there is no safety net for if we are not there.

Secretary LEAVITT. In 1999, in my own State, we were facing a substantial budget deficit, and that was true in most states. Today my own State is seeing a $1.7 billion surplus, a different situation.

At the same time, I am presenting a budget hoping to cut the deficit to balance the budget by 2012. There is a substantial amount of difference in the budget circumstances of the states and the budget circumstances of the federal government today than there was in 1999 and, hence, I feel quite justified in having taken both positions.

I will also mention, given the fact that I am quite knowledgeable about what those grants go for, there is an area of categorical funding for almost everything that those grants are used for.

Now, do Governors like to get money from the federal government? Yes. Did I feel like we could continue to send it to them at the same rate that we have in the past given their financial situation and ours? No.

Mr. ETHERIDGE. Mr. Secretary, you would have to agree, though, these programs go to some of the most vulnerable people in America and it is very difficult for me to understand. I am for balancing the budget. That is why I am on the Budget Committee. But to do

it on the backs of the most vulnerable citizens is very difficult for me to accept.

Secretary LEAVITT. I am not suggesting that we not help the most vulnerable. I am suggesting that the states are better able to do it right now than we are.

Mr. ETHERIDGE. Thank you, Mr. Chairman. I yield back.

Chairman SPRATT. Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

Secretary LEAVITT. Mr. Scott, you have been very patient. Thank you.

Mr. SCOTT. Well, that is what you get for being late.

Secretary LEAVITT. I was early.

Mr. SCOTT. Thank you.

You indicated that the budget situation is different now than it was just a few years ago. You are absolutely right. For the ten-year budget starting in 2001, we have got eight and a half trillion dollars less to work with than we thought we would have.

So that does put pressure, and we are making choices. We are talking about repealing the estate tax, which would be about 80 billion a year. This year, the F&P's tax cuts will be about 20 billion a year. People under $100,000 will get no measurable benefit from that. So we are making choices.

Let me ask you on energy assistance under LIHEAP, do I understand that the President's budget cuts the amount under LIHEAP?

Secretary LEAVITT. We accelerated a billion dollars from the 2008 budget to the 2007 budget last year, and what you are seeing is a reflection of that. It is clear to me that if we have a deficit there that we are prepared to step up and work with Congress. We have anticipated, given the nature of what we have done in the past, what is necessary. And if more is necessary, we will obviously step up and——

Mr. SCOTT. We will not reduce the amount or the number of people presently served under LIHEAP?

Secretary LEAVITT. If it were and there was a need, then we would be prepared to step up and help with Congress to remedy it.

Mr. SCOTT. Under Head Start, will the number of students served go up or down under the budget and will we have additional funds to make improvements in the program?

Secretary LEAVITT. We believe that we can find greater efficiency in Head Start, and I have talked about one way we could do it. We have held the budget essentially in neutral and we believe we can find the efficiencies there to not just serve the ones that are there but slightly more.

Mr. SCOTT. Well, you hope. I mean, do you have specific legislation pending in the Education and Labor Committee to effectuate these efficiencies or you just cut the money?

Secretary LEAVITT. Mr. Scott, we recognize that Head Start is a very important program. We are also trying to balance the budget. And——

Mr. SCOTT. We are making choices.

Secretary LEAVITT. We are. That is right. And one of the things we have got to do is to keep a strong economy because the strong

economy keeps those tax dollars rolling in, which makes it possible for us to fund Head Start. And the President's tax proposals have done a good job in being able to stimulate the economy and generate revenues. And we are making——

Mr. SCOTT. So the answer is, no, there is no legislation pending in the Education and Workforce Committee——

Secretary LEAVITT. You would have to talk——

Mr. SCOTT [continuing]. Education and Labor Committee?

Secretary LEAVITT [continuing]. To Secretary Spellings, but none at HHS.

Mr. SCOTT. OK. Under CHIP, it is my understanding that 13 to 15 billion is needed to maintain the present number of children and you have substantially less than that in the budget.

Will we be able to serve the number of children that we are now serving?

Secretary LEAVITT. I articulated earlier in this hearing the policy of the Administration for reauthorization, and we believe the budget is adequate to fund that proposal.

Mr. SCOTT. Will the number of children served go up or down?

Secretary LEAVITT. It would go up.

Mr. SCOTT. The number of children served will go up?

Secretary LEAVITT. It will.

Mr. SCOTT. How much would it cost to make sure that all children under 200 percent of poverty are served?

Secretary LEAVITT. You mean with SCHIP?

Mr. SCOTT. Right.

Secretary LEAVITT. I do not know the answer to that.

Mr. SCOTT. Are pregnant women eligible in all states?

Secretary LEAVITT. Under Medicaid?

Mr. SCOTT. Through SCHIP.

Secretary LEAVITT. No.

Mr. SCOTT. Are any states——

Secretary LEAVITT. I could be wrong about that. I do not know the answer for sure about all 50 states. States have the ability to craft their programs, and I do not know the answer.

Mr. SCOTT. Now, the tax plan under the President's plan, as I understand it, some people will pay more tax, some people will pay less tax. How much more tax will people—if you just took one side of the ledger, how much tax increase are we talking about?

Secretary LEAVITT. There will be no additional taxes collected by the U.S. Government under this proposal.

Mr. SCOTT. Aggregate?

Secretary LEAVITT. An aggregate.

Mr. SCOTT. Yes. But you will be paying some. Of those who are paying more taxes, how much taxes will they pay?

Secretary LEAVITT. I cannot give you——

Mr. SCOTT. The 20 percent.

Secretary LEAVITT. I cannot give you the breakout. I can tell you that those who do pay will be in the upper 20 percent of their income and that it does benefit 80 percent of those who have employer-sponsored insurance and 100 percent of those who have zero.

Mr. SCOTT. Right. But you are doing both sides of the ledger at the same time. Could you give us an estimate of how much more

we would be collecting on one side before you start talking about how much less people will be paying on the other side?

Secretary LEAVITT. There will be no additional dollars in any tax adjustment, any tax adjustment. There are pluses and there are minuses.

Mr. SCOTT. That is right.

Secretary LEAVITT. There are three winners here, and I cannot give you the actual balance of it. I do not know it.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman SPRATT. Thank you, Mr. Scott.

Mr. Secretary, you have been forthcoming as well as forbearing, and we very much appreciate your testimony.

Secretary LEAVITT. Thank you, Mr. Chairman.

Chairman SPRATT. We may have a few questions for the record, and I would ask unanimous consent that those members who did not have the opportunity to ask questions should be given the opportunity to submit questions within seven days of the hearing.

[The information follows:]

QUESTIONS SUBMITTED TO SECRETARY LEAVITT FROM HON. JAMES P. MCGOVERN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Question 1: Do you or anyone on your staff regularly consult with infectious diseases experts to identify current and emerging threats to public health, such as resistant infections?

Answer: CDC has ongoing conference calls with the Infectious Disease Society of America regarding antimicrobial resistant infections. CDC also works with its Prevention Epi-Centers on several projects to monitor the development, spread, and response of infections to antimicrobial agents. CDC also monitors rates of antimicrobial resistance to a variety of healthcare associated pathogens through its National Healthcare Safety Network. These activities allow for CDC to converse with infectious disease experts throughout the field to identify and discuss current and emerging threats to public health in regards to infectious diseases, including resistant infections.

Question 2: A true solution to resistant bacteria requires scientific breakthroughs and discovery. It's my understanding many pharmaceutical companies have left the antibiotic market in favor of more profitable markets, such as treating chronic conditions. What incentives are currently available to encourage research and development in this area? If there are any, are they being used?

Answer: The National Institutes of Health (NIH) is the primary Federal agency for conducting and supporting medical research, helping to lead the way toward important medical discoveries that improve people's health and save lives. To this end, the NIH supports extramural and intramural scientists in their efforts to investigate ways to prevent disease, as well as the causes, treatments, and even cures for common and rare diseases.

The National Institute of Allergy and Infectious Diseases (NIAID), a component of the NIH, is the lead institute for research related to antimicrobial resistance. The NIAID has developed new funding mechanisms to foster research and development collaborations with industry and academia, including the Challenge Grant and Partnership initiatives, for product development. Moreover, NIAID has provided longstanding support for a number of drug development resources. For many pathogens, there are resources for target identification and validation, and for assay development. For selected pathogens, including the NIAID Priority Pathogens, there are additional resources for acquiring compounds, conducting screening, performing in vitro and in vivo assays, evaluating animal efficacy and preliminary drug exposure studies, and performing safety testing and pharmacokinetic/pharmacodynamic analyses.

The NIAID will continue to promote and facilitate interactions among industry, academia, public-private partnerships, and government to advance product development, and will continue to increase the number of targeted initiatives to enhance all phases of product development.

Question 3: Does the Biomedical Advanced Research and Development Authority, created under the Pandemic and All-Hazards Preparedness Act, apply to gram

negative and other dangerous bacterial infections that threaten a significant number of Americans annually, but do not necessarily threaten "national security"? If not, shouldn't it, and can HHS provide tailored language to this Committee to accomplish that?

Answer: The mission of the Biomedical Advanced Research and Development Authority (BARDA) is to develop and acquire medical countermeasures to establish public health emergency preparedness against CBRN threats and naturally occurring epidemics such as an influenza pandemic. The current top priority medical countermeasures have been identified in the recently published HHS Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) Implementation Plan, and address threats for which the Department of Homeland Security has issued a Material Threat Determination (MTD). Broad spectrum antibacterials are identified as one of these top priority medical countermeasures to address multiple drug resistant anthrax as well as a number of Gram-negative biodefense threats.

BARDA will look for opportunities to leverage the existing commercial base of antimicrobial research and development for biodefense uses. We will use advanced development and acquisition funds to develop, license, and procure antimicrobials for the Strategic National Stockpile for biodefense indications. These efforts should both provide incentives for industry participation and expedite the acquisition of new antimicrobials for the Strategic National Stockpile.

In addition, NIH has a significant role in this area with a robust antimicrobial resistance research and development program. NIH also currently supports a comprehensive program to identify and develop broad spectrum antimicrobial agents that will address biodefense bacterial pathogens, as well as more common bacterial agents.

Industry partners can obtain further information about this issue by visiting the following NIH web site: *http://www.niaid.nih.gov/factsheets/antimicro.htm*

Question 4: As I mentioned, I've been reviewing current law in this area. Section 319E(b) directs the Secretary to provide for research related to the development of "new therapeutics, including vaccines and antimicrobials, against resistant pathogens" and "medical diagnostics to detect pathogens resistant to antimicrobials." Can you update me regarding what has been done in this area and how much money has been committed to this effort?

Answer: The National Institute of Allergy and Infectious Diseases (NIAID) supports a robust antimicrobial resistance research portfolio that spans basic, translational and clinical research efforts aimed at combating the problem of antimicrobial resistance. Current research efforts include studies on the basic biology of resistant organisms; applied research on new diagnostic techniques, therapies, and preventive measures; and studies of how bacteria develop and share resistance genes.

The NIAID has specific research initiatives designed to address some of the most crucial, unaddressed aspects of antimicrobial resistance. For example, recognizing that prompt and accurate diagnosis is key to effective disease management, NIAID has supported several research initiatives focused on the development of new diagnostics. NIAID is also pursuing new, targeted clinical research studies in an effort to focus and mobilize clinical capacity to test interventions on methicillin resistant staphylococcus aureus (MRSA) and community acquired (CA)- MRSA infection and evaluate the efficacy of off-patent antimicrobials. NIAID-supported investigations have also led to the identification of a potential vaccine against Staphylococcus aureus, which showed promise in mouse studies. Early findings suggest development of a vaccine that would protect against S. aureus regardless of the antibiotic resistance profile is possible.

In fiscal year (FY) 2006, the total funding provided by the NIH for research on antimicrobial resistance was $221M. The projected NIH funding amount for FY 2007 is $221M.

Question 5: Section 319E(e) requires you to award competitive grants for demonstration programs to "promote judicious use of antimicrobial drugs or control the spread of antimicrobial-resistant pathogens." Would you provide me with a list of demonstration programs funded by this program?

Answer: The CDC has funded the following demonstration programs through its extramural grant program in antimicrobial resistance:

2001: AR in Rural Areas and Microbiological Mechanisms of Resistance Samore, Matthew—Rural program in antimicrobials in the intermountain region (Inter-Mountain Project on Antimicrobial Resistance and Therapy, IMPART); University of Utah

Lautinbach, Ebbing—Microbiologic mechanisms of dissemination of antimicrobial resistance genes and relationship to antimicrobial drug use and relationship to drug use: Epidemiology of quinolone resistance in Escherichia coli; University of Pennsylvania, PA

Belongia, Edward—Resistant Enterococcus faecium in humans and poultry; Marshfield Epi Research Center, Marshfield, WI

Zervos, Marcus J.—Molecular epidemiology of resistant Enterococcus; William Beaumont Hospital, Royal Oak, MI

2002: Validation of National Committee for Clinical Laboratory Standards (NCCLS) Breakpoints for Human Pathogens of Public Health Importance

Paterson, David L.—NCCLS interpretive criteria for Salmonella; University of Pittsburgh, PA

Craig, William G.—Validation of NCCLS methods and breakpoints for ESBLs: University of Wisconsin-Madison, WI

James H. Jorgenson—Development of interpretive breakpoint criteria for Neissera Meningitidis; University of Texas Health Science Center at San Antonio, TX

2003: Community Associated MRSA

Chambers, Henry S.____

Molecular Epidemiology of MRSA ; University of California, San Francisco

Daum, Robert S.—Community Associated MRSA; University of Chicago, Chicago, IL

Miller, Loren G.—Clinical, Epidemiologic, & Molecular Descriptions of Epidemic Community Associated MRSA; Harbor-UCLA Research and Education Institute, Torrance, CA

Lowy, Franklin—Prevalence of CA-MRSA in Northern Manhattan; Columbia University, NYC, NY

Zervos, Marcus J.—Characterization of Community-Associated MRSA in Three Urban Areas; William Beaumont Hospital, Royal Oak, MI

2004: Estimates of Economic Cost for Antimicrobial Resistant Human Pathogens of Public Health Importance

Fraser, Victoria J.—Outcomes and costs of antibiotic resistant blood infection; Washington University, St. Louis, MO

Engermann, John—Applied Research on Antimicrobial Resistance, Duke University, Durham, NC

Johnson, James R.—Resistant E. coli in humans and poultry, University of Minnesota Twin Cities, MN

Wittum, Thomas E.—Public Health importance of Agricultural Ceftiofur Use; Ohio State University, Columbus, OH

Lynfield, Ruth—Applied Research on Antimicrobial Resistance: Minnesota State Department of Health. St. Paul, MN

2006: The development of new methods to prevent transmission of Antimicrobial Resistant (AR) pathogens (R01) and reducing Community-Associated Methicillin-Resistant Staphylococcus aureus (CA-MRSA) Infection in households (U01)

Harris, Anthony—New nosocomial interventions to decrease antimicrobial resistance transmission; University of Maryland, Baltimore, MD

Daum, Robert S.—MRSA colonization and control in the Cook County Jail; University of Chicago, Chicago, IL

Climo, Michael W.—Multicenter trail of daily chlorhexidine bathing to reduce nosocomial infections; McGuire (VAH) Research Institute, Richmond, VA

Lautenbach, Ebbing—Novel application of infection control strategies to limit transmission of ESBL's; University of Pennsylvania, Philadelphia, PA

Question 6: In the professional judgments of the various agencies under HHS (e.g., CDC, NIH, FDA), what level of federal funding is necessary to implement fully the elements of the interagency PHS Action Plan to Combat Antimicrobial Resistance under each agency's jurisdiction?

Answer: Antimicrobial resistance is a complex problem that encompasses many classes of microorganisms including bacteria, fungi, viruses, and parasites that adversely affects the treatment of both human and veterinary diseases. It is a problem that requires attention by many diverse interests, including public health experts, the medical community, veterinarians, agriculture experts, and regulatory agencies. In the United States and around the world, many important human infections have become resistant to the antimicrobial drugs for therapy. In some areas of the United

States, more than 30% of infections with Streptococccus pneumoniae, the most common cause of bacterial pneumonia and meningitis, are no longer susceptible to penicillin. In the 1970s, virtually all were susceptible. Similarly, over 50% of Staphylococcus aureus infections acquired in U.S. intensive care units in hospitals are now resistant to the semi-synthetic penicillins, the preferred class of drugs for therapy. Some bacterial infections are now resistant to all available antimicrobial agents. Resistance to antiviral drugs, including those targeting, herpes viruses, influenza, and the Human Immunodeficiency Virus also continues to increase. Thus, action now is paramount in curtailing this growing problem.

In 2001, an interagency task force, co-chaired by CDC, the Food and Drug Administration (FDA), and the National Institutes of Health (NIH), along with other federal partners published A Public Health Action Plan to Combat Antimicrobial Resistance, PART I, Domestic Issues. *www.cdc.gov/drugresistance/actionplan/index.htm.* The plan addresses the critical areas of surveillance, prevention and control, research, and product development.

In 2007, NIH spent $220.6 million, CDC spent $17.2 million, and FDA spent $24.71 million on antimicrobial resistance activities.

Chairman SPRATT. Thank you again very much for your testimony and for coming and being with us today.

Secretary LEAVITT. Thank you.

[Whereupon, at 4:24 p.m., the Committee was adjourned.]

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