Testimony of

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before the

Committee on Ways and Means

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Chairman Rangel, Congressman McCrery, and Members of the Committee, thank you for the invitation to discuss the President's FY 2009 budget request for the Department of Health and Human Services (HHS).

I wish to begin with Medicare, which makes up 56 percent of the $737 billion budget HHS presents today.

The Medicare portion of this budget should be viewed as a stark warning. Medicare, on its current course, is not sustainable. In 2007, the Medicare Trustees reported the Hospital Insurance Trust Fund will be exhausted in 2019 -- 11 years from now – and Medicare represents a $34.2 trillion unfunded obligation for the federal budget over 75 years. This is a serious matter.

Let's acknowledge that American sensitivity to entitlement warnings has become numbed by a repeated cycle of alarms and inaction. Such warnings have become a seasonal occurrence, like the cherry blossoms blooming in April, part of life's natural rhythm. We hear the warnings, but do nothing

This budget warns in a different way. It illuminates with specificity the hard decisions policy makers, no matter what their party, will face every year until we change the underlying philosophy. We can keep our national commitment to insuring the health of beneficiaries, but we need a change in how we manage Medicare.

Currently, the Medicare fee-for-service program is a centrally-planned, government regulated system of price setting. Price setting systems allow government regulators to decide the priorities.

Government's tools are blunt and inexact. Government decides which treatment to cover. Government decides how much treatment is provided based on how much government is

willing to pay for. Government tries to determine how much value different procedures have. It is a bad system and needs to be changed.

If consumers were allowed to make these decisions through an efficient and transparent market, their decisions would be far more precise and wise.

One need look no further than our experience with Medicare's prescription drug benefit, where government organized a market and let consumers decide what drug plan worked best for them. Entering the third year of the program, we see enrollment continuing to rise, beneficiary satisfaction extremely high, and costs to beneficiaries and taxpayers considerably lower than originally projected.

Just last month we announced that, compared to original Medicare Modernization Act (MMA) projections, the projected net Medicare cost of the drug benefit is $243.7 billion lower over the 10-year period (2004-2013) used to score the MMA. Beneficiaries are saving as well. The most recent CMS estimate of the actual average premium beneficiaries will pay for standard Part D coverage in 2008 is roughly $25. This is nearly 40 percent lower than originally projected when the benefit was established in 2003.

While there are several important factors that contribute to lower costs, a key factor is that competition has been strong from the beginning of the program and the plans have achieved greater than expected savings from retail price negotiations, manufacturer rebates, and utilization management.

That said, however, using the blunt instruments we have available to us in other parts of Medicare, we have prepared a budget with three goals in mind: long term sustainability, affordable premiums for beneficiaries and a balanced national budget by 2012.

Some will be unhappy with this budget. While Medicare spending will increase by an average of 5 percent annually under our budget, they will see any attempt to slow the rate of Medicare's growth as a cut.

Our proposed budget includes a group of legislative and administrative improvements aimed at extending Medicare's viability for today's seniors and future generations. The slower growth rate they produce saves $183 billion over five years.

The proposals include:

- Encouraging provider competition and efficiency
- Promoting high quality care
- Rationalizing payment policies
- Improving program integrity
- Increasing high-income beneficiary responsibility for health care costs

The slower growth rate also reduces the premiums beneficiaries face by $6.2 billion over the next five years. Let me emphasize that generally, changes we make that reduce future government spending also gives a financial break to beneficiaries.

I mentioned Medicare warnings earlier. In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress included a provision requiring the Medicare Trustees to issue a formal warning if two consecutive annual reports show that regular tax dollars exceed 45 percent of total Medicare spending within the current or next six years. I am a Trustee of the Medicare Trust Fund. Last year we triggered the alarm. As usual, there has been no action.

The same law requests the President propose legislation that will change the trajectory enough to bring general revenues back below 45 percent. We will formally respond to the trigger in coming days, but real solutions in Medicare will require genuine change in the way in which health care is conducted in America. And, if I can comment on that broader topic for a moment, let me say this:

There are two competing philosophies about the role government should play in health care. One is a Washington-run, government-owned plan, where government makes the choices, sets the prices, and then taxes people to pay the bill.

The other, supported by the Administration, is a private market where consumers choose, where insurance plans compete, and where innovation drives the quality of health care up and may drive the cost down.

The Administration believes every American needs access to health insurance at an affordable cost. In addition to its proposed tax reforms and health insurance market-based initiatives, the Administration believes the current health care system could operate more efficiently, without increasing federal spending on health care, if some portion of indirect public subsidies were redirected to make health insurance affordable for individuals with poor health or limited incomes. The federal government would maintain its commitment to the neediest and most vulnerable populations, while giving the States, which are best situated to craft innovative solutions, the opportunity to move people into affordable insurance.

Before leaving Medicare, I want to make one more point.

I spoke earlier about the cherry blossom syndrome of entitlement warnings. Many may look at this budget and see the same old cherry blossom story – X billion of reductions here and Y billion there. But, as a Trustee of the Medicare Trust Fund, I ask that you concentrate on the condition of the Medicare Trust Fund. It is a story that needs to be told, and told, and told.

I have admired and appreciated David Walker, the Director of the Government Accountability Office (GAO) traveling the country sounding the warning. If my remarks today, describing the Department's budget, don't focus attention on this problem, then read his speech. Call the government actuary, or your favorite economist.

We are approaching an emergency. Real change in Medicare as a system is required, and soon. If you are 54 years old, and if Medicare is left on autopilot, when you turn 65 years old, Medicare will not be able to provide all the hospital insurance benefits promised under current law. We need a change in philosophy not just a change in the budget.

Now, on to other matters.

State Children's Insurance Program (SCHIP)

The President proposes to increase funding to states by $19.7 billion through 2013, with $450 million in outreach grants. Our proposal is consistent with the Administration's philosophy that SCHIP should be focused on uninsured, targeted, low income children first. It is also consistent with the position the President and the Administration articulated last fall. Our legislative proposal calls on Congress to address the issue of "crowd-out." It outlines State responsibilities when they expand SCHIP above 200 percent of the Federal Poverty Level, proposes enforcement mechanisms, and clarifies SCHIP eligibility by clearly defining income.

Medicaid

We are continuing our successful transformation of the Medicaid program. This budget request includes a series of proposed legislative and administrative changes. We propose legislative savings of more than $17 billion and assume administrative savings of approximately $800 million over the next five years while keeping Medicaid up-to-date and sustainable.

Food Protection

We have a good system of food protection in the United States, but as the global market matures, our systems have to change. Last year, we unveiled a new Food Protection Plan and proposed significant improvements in how we deal with imported products.

The President's budget increases funding for food safety by 7 percent, and the overall FDA budget by 5.7 percent. Eighty percent of the FDA budget pays for people. In two years, we will have added more than a thousand people at FDA. I mention that as an indication of how seriously we take the need to prepare aggressively for the future.

Biomedical Research

We have proposed increases for each Institute and Center at NIH. The overall budget will support 38,000 research project grants, including more than 9,700 new and competing awards. Overall, the budget will be the same as FY 2008.

Emergency Preparedness

Our nation remains at risk of terrorist attack and war. HHS is responsible to prevent and detect attacks, and respond to mass casualty events. Our budget proposes $4.3 billion to:

- Increase bioterrorism readiness
- Double advanced development of medical countermeasures
- Establish new international quarantine stations
- Expand and train medical emergency teams

We are seeking the funds necessary to complete our Pandemic preparedness.

One rather interesting part of our preparedness budget deals with ventilators. In many emergencies, especially terrorist attacks or pandemics, ventilators are needed to help victims breathe. Currently, ventilators cost $8,000 to $10,000 each. They also require specially trained teams to operate them. The combination of those two factors makes having an adequate supply nearly impossible.

We are requesting $25 million to develop the next generation of ventilators that are portable, up to 90 percent less expensive and do not require special training to operate.

Global Health

You will see a series of health diplomacy initiatives. Because threats to human health have become just as mobile as we are, our leadership in health around the world benefits Americans directly.

In addition to our work on HIV/AIDS, Malaria and Tuberculosis, we help other nations with disease monitoring and preparedness.

Conclusion

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, and all our other partners to carry out the initiatives President Bush is proposing to build a healthier, safer and more compassionate America.

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