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Press Conference on the 2007 Budget February 6, 2006

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CHARLIE JOHNSON: My name's Charlie Johnson, I'm a new face to most of you and you will acknowledge Kerry Weims [misspelled?]. Kerry Weims has been at this podium in the past and I'd like to thank him, he started this whole process with this year's budget. I was selected to finish. Delighted to be with you today. I also would like to thank my staff who spent an enormous amount of time with this budget. Many of them are not in this room are not in this room, they're watching by close circuit and I'd like to just wave and thank them for their services.

I'm one that believes in a little bit of efficiency and so we're going to structure this a little bit differently. The Secretary will give remarks and he will answer three or four questions and then he will leave. And as much as a lot of questions center around Medicare and Medicaid, Dr. Mark McClellan will then come up and answer that series of questions. At that point then I will ask the rest of our agency heads who are seated in front of me to join me at the podium and we will field all the rest of your questions and we'll take it to that point. So, Mr. Secretary, Michael O. Leavitt [applause].

MICHAEL LEAVITT: Good afternoon and thank you for coming to discuss the President's budget for the Department of Health and Human Services for the fiscal year of 2007. I'd

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like to express the appreciation I have to Charlie and to all of those who have worked to prepare this budget. It's a fine team and a fine budget. Over the past five years this administration has worked to make America healthier and to make it safer. Today we're looking forward to be building on that record of accomplishment. This budget represents a hopeful agenda for the upcoming fiscal year, one that strengthens against potential threats. It heeds the call of compassion that we all feel and it follows the wise fiscal stewardship that's necessary to advance our nation's health. To support these goals, President Budget has proposed a budget that is nearly \$700,000,000,000.00 for the Department of Health and Human Services. This represents an increase of some \$58,000,000,000.00 over the 2006 budget which comprises of a 9.1% increase.

I want to tell you upfront that this budget includes some reductions. There are of course two parts to our budget; those that are entitlements and those that are part of the discretionary budget. To meet the president's goal of cutting the deficit in half by 2009, discretionary spending will decline by about 1.5 billion dollars over the fiscal year. We had to make hard choices, hard choices about very well intentioned programs. I want to acknowledge that every program is important to someone. I want to recognize that that's true, that's the way they got it into the budget in the first place.

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If these weren't programs of value they wouldn't be there, but hard choices had to be made and this budget reflects our effort to make those in the wisest way. Reasonable people always disagree on the conclusions about what programs are essential and which programs are not and that's been true in every budget I've ever been involved in and it is, of course, true today.

This budget reflects the areas that have, in our collective judgement, the highest potential payoff. I'd like to take you through the principals that we used to determine where the funds should be committed. I want to also acknowledge that there are initiatives in this budget that are new, such as expanding the Health Information Technology Budget or our Domestic HIV/AIDS Program, the testing and treatment program I'll speak briefly of later. We're also continuing to fund many of the commitments that the president previously has made, such as expanding dramatically the community health centers, access to recovery, bioterrorism, and funding a pandemic flu preparation. We're also protecting programs in the budget that are in high time or budgets that have proven to be highly effective; Head Start is an example, NIH the Indian Health Service are good examples of budgets that we have protected in significant ways. We propose to pay for many of the priorities that I listed by reducing or eliminating funding from programs whose purposes are addressed in multiple agencies and by continuing the insistence that we have that budgets are

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based on performance. And some of the programs that you'll see eliminated are programs we identified in a previous budget that were not, but we have continued to believe that are less than optimal in their performance.

I want to characterize this budget as a responsible budget. You will see laced through it a series of themes that characterize our intent. One theme is the need for us to protect the health of Americans against the threat of bioterrorism and pandemics. The need to provide care for those who need it. The budget protects life, it protects family, it protects human dignity. It enhances the long term health of our citizens and it improves the human condition throughout the world. Now as we look at budgets we must never forget that we are a nation at war. We have seen the harm that can come from a single anthrax laced letter. We have to be prepared to respond to that. We have to not only be able to respond to something that we have already experienced, but something new and even worse, so the president's budget calls for a 4% increase in bioterrorism spending for the fiscal year 2007, that will bring the total to 4.4 billion dollars, and it's an increase of \$178,000,000.00 over last year's level. The funds that will increase the medicines and supplies that are available in the strategic national stockpile. It will promote the advancement of bio-counter measures that are being developed at the National Institutes of Health. It will

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support the transformation of the commissioned corps in to a fully equipped force that can meet any public health emergency.

We must also continue to prepare against a possible pandemic. This budget funds the goals that the president put forward, including the ability to provide pandemic influenza vaccine to every man, woman, and child within the United States within six months of detection of a human to human transmission of a pandemic virus. It also includes the necessary stockpiling of [inaudible] such as antivirals for 25% or supply sufficient to supply 25% of the entire population should a pandemic strike. It enhances the domestic and the international disease monitoring that's necessary for our preparedness.

The president's budget also includes initiative to fight HIV/AIDS, \$188,000,000.00 will be found in the budget. The funds go to a number of very important and noble goals including the testing of some 3,000,000,000 additional Americans for HIV/AIDS and the treatment of those people who are currently on state waiting lists for AIDS medicine. There are obviously others who need care in our society. We look to promote the independence and the choice for individuals through vouchers and through increased access to substance abuse treatment.

In the area of entitlements I'd like to begin by noting that congress successfully enacted many needed reforms last

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week by passing the Deficit Reduction Act. The act brings us to achieving sustainable growth rates in important programs such as Medicare and Medicaid. It also strengthens child support enforcement and increases funding for child care. The Deficit Reduction Act also achieves a notable accomplishment in reauthorizing the temporary assistance for needy families, prior to that reauthorization it had been continued through a series of short term extensions, ten of them in fact, and so to have that now continued on a permanent basis or reauthorized is a significant step in our ability to care for those who are in need.

It also continued important reforms that will make Medicaid more sustainable and this budget will build on those important reforms. Along with the sustainability of Medicaid, our budget will take steps to improve the long term fiscal health of Medicare. We're proposing a number of adjustments that will produce substantial savings, for instance the budget will allow Medicare to continue to grow but at a slower rate. Now I may I just say this is a subject that has been dealt with in previous administrations but we must do our share as a generation and this administration chooses to do so. One need only look at the facts, Medicare today represents 3.4% of the entire gross domestic product of this nation. Allowed to continue in the same rate by 2004, it would be 8.1% of the entire gross domestic product, of our entire economic output as

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a nation. By 2070 it would be 14%. No nation can sustain that level of growth and maintain economic vibrance, economic vibrance that is absolutely necessary to produce the dollars required to care for those for whom we provide care. This is a necessity for us to maintain its sustainability. We also have seen significant savings in Medicare because of market mechanisms. I raise in point the recent news last week that the new prescription drug benefit, Part D, has seen substantial reductions over what was originally projected. It started out at \$37.00 a month, it's down under \$25.00 for prescription drugs per month, that's a very good example of the way an organized market will begin to drive prices down. For the first time in decades we're seeing a prescription drug cost fall in that fashion. The budget includes a package of Medicare legislative proposals that are designed to strengthen its long term viability.

The proposals build on a long series of administration priorities that are not new but are very important to restate. One is the need to improve and prevent our efforts in medical errors, fewer medical errors means less suffering, it means lower cost. Encouraging efficient and appropriate payment for services, fostering the kind of competition that I've just spoken of, promoting beneficiary involvement in health care decisions. As I've mentioned the reforms that we're speaking of build on a series of reforms that have taken place in the

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first Bush administration, George Bush 41, also President Clinton, also the Regan administration, and now this administration. They will amount to reducing our growth rate by less than 1.5%. Under the current pattern we would see spending at 8.1% over the next five years, under this proposal it would fall to 7.7%. As it currently constituted Medicare would continue to grow over the next ten years at 7.8%, under this proposal it would continue to grow, but at 7.6%. Medicare will continue to grow, but at a slower rate.

The payment reforms that I'll refer to in just a moment reflect the recommendation of a bipartisan Medicare Payment Advisory Commission. The commission very clearly believes and has put forward in a bipartisan way that the rates that are currently being paid are higher than necessary for access to quality. Now there are several initiatives that will be referred to in more detail later. In addition to those related to Medicare, there are initiatives that protect life, and family, and human dignity. They include a new healthy marriage state grant program [inaudible]. They include state grants to allow people with chronic illness to secure health insurance. The initiatives include grants that are aimed at delaying or preventing the need for seniors to enter long term nursing facilities.

The last theme that I'd like to highlight in today's preview is that these increases are increases in funding that

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are focused very directly on assuring quality of health care that Americans receive to years to come. A good example is one I've already spoken of, and that is the initiative on Health Information Technology. It increases the funding by some \$60,000,000.00. By the end of this year the American health information community will be producing real results that will fundamentally change the way health care is delivered with consumers. This is a momentum that we have moving, it's a moment that needs to be kept and one that is by this budget. The president's budget also increases funds for programs that we've initiated that will transform the way health care is delivered to individuals. Programs that will make medicine more personalized, make it more predictive, it will make the way we practice medicine more preemptive. Let me just give you three examples, the Genes and Environment Initiative being conducted at the National Institutes of Health is designed to identify the most common genetic factors of diseases of substantial public health impact. I'm talking about disease like heart disease, diabetes, and cancer. Later this week we will further demonstrate our commitment to this effort with the announcement of a new private public partnership that's being formed to jump start the identification process. A second example is the drug safety initiative that's conducted at the FDA. It's designed to provide emerging information about the risk and the benefits of medicine to health providers and to patients. The drug

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safety and oversight board is one of the cornerstones of that system. It is enabling the FDA to insure that drugs are safe and that they're effective, a treasure to the American public. A third example I'll cite is what we call the critical path to personalized medicine. This is an effort that spans many agencies here at HHS and it's being directed by the Food and Drug Administration. It is a collaboration and a vision among all of the divisions here at HHS that are involved in research and evaluation, approval or the delivery of drugs. In the future we'll see people like you and people like me who will have access to drug therapies that are preemptive, that are preventative, and that in fact help us personalize in a very direct way, the type of treatment that we receive. It's a very exciting frontier, it is the new frontier of medicine and one in which this budget focuses very heavily on.

Those are just highlights of the budget. Before I take a few questions let me just say in closing, I'm an optimist. The President of the United States is an optimist. We're confident that we can continue to help Americans become healthier, help them to live longer, and to live better lives. Budgets are investments in the future, this is a responsible, forward looking budget that reflects our hopeful outlook and it sets on a path to get there. And now I'd be very happy to take a few questions and then I'll ask my colleague Charlie Johnson to conduct the balance of the business.

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MALE SPEAKER: [Off mic] calls for automatic cuts in Medicare [inaudible] that was reached?

MICHAEL LEAVITT: The details obviously will still need to be fleshed in a cooperative way with the congress, but it operates on a very clear principle, and that is that we establish an acknowledgment that Medicare will in part be funded by tax payer funds and part by those who contributed, by participants or beneficiaries. We see that in Part B of Medicare for example. In 2007 for the first time we will begin to see Medicare contributed to more by those who are making in excess of 80,000 as individual or 160,000 as a couple. This recognizes that in order to keep that balance, that if it goes above 45% that it will trigger a series of actions that would keep it at 45% and would at that point then have to be acknowledged with a series of actions, either by congress or in other ways. Now the details of it will be fleshed out and detailed in a future time, but that's how the basic mechanism works.

MALE SPEAKER: Is that going to be triggered any time soon or are we looking for 2007?

MICHAEL LEAVITT: As you know there is what's referred to sometimes as a soft trigger in the 2003 Medicare Modernization Act which requires the administration to make a recommendation should it exceed 45%, that is to say if taxpayer funds would exceed 45%. This would harden that requirement and

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would create a level discipline, as I said I believe the details will come forward in future days. Yes.

MALE SPEAKER: If I read this properly these savings in Medicare and in the administrative [inaudible] may be half of the savings for entitlements overall. Can you take about what the other major categories are in cost reductions.

MICHAEL LEAVITT: I believe that they are detailed, if you go through and you'll see that the Medicare as I recall to, I think, 2.8 billion dollars this year and under 39 billion—

MALE SPEAKER: 36 over five years.

MICHAEL LEAVITT: 36 over five years and then you can look at the balance and you can see that it's spread among a lot of other programs. I will tell you that a 700 billion dollar budget is a large budget and it has lots of detail through it. When I sat down with our team to say, "On the discretionary side we need to reduce this by a billion and a half dollars." We established a set of principles what were followed through all of the operating divisions. Basically I told them I want to give emphasis to those programs that are targeted and not just general reductions. I want to favor programs that are preventative and not simply treatment after people are ill. I want to focus on prevention because it's a far more efficient and humane way of approaching our human service efforts. Third, I wanted to focus on a tight budget year on offering treatment and not just building

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infrastructure. Fourth, I told them I believe that the market is a better determinant than government and we can find places where markets are making decisions, those are more efficient and I want to concentrate on those programs. I also believe that it's true that consumers make better choice almost always than government. We ought to be investing in new technologies, not just technologies that have run their course. And I also wanted to emphasize programs that there was a broad department wide effort as opposed to those that are run in silos. And the most basic measure can we demonstrate those that are having a positive impact? If we can, let's continue to fund them. If they're clearly positive let's continue to fund them but if we can't demonstrate those then I don't think we should continue to fund them. I'll give you one example that I believe will prominent in your questions. A lot of the block grants that go to states, now I've just come off of 11 years of being a governor, as Chairman of the National Governors Association on many different occasions I would come to congress particularly during the 2001-2002 period when state budgets were so dramatically effected by economic cut down after 9/11. The congress was very generous in being able to appropriate to states various block grants, and frankly governors really like those dollars because they're highly flexible. There are two problems; one is that there is no way to demonstrate how effective they are. We don't know how effective they are and

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during a period of substantial deficit reduction, those have to be visited. They may be important during a period when we have the capacity to do it and the states are struggling, but I can tell you that my former colleagues as governors are in far better times right now. Most states are experiencing substantial increases in their revenues, now there are exceptions to it and those can be dealt with as exception, particularly places like Louisiana and Mississippi because of the impact of Katrina but we can respond to those. But as a general matter you will see that many of the reductions come in places where frankly, we are just are not in a position to help the states as much as were before and gratefully they're in a position to be more helpful to themselves because their tax revenue collections are substantially better. Yes sir?

CHARLIE JOHNSON: We'll take one more.

MICHAEL LEAVITT: My independence is going to show, I was going to take two more.

CHARLIE JOHNSON: Okay two more. That's what I was going to suggest.

MICHAEL LEAVITT: Yeah I thought that's what you might say.

MALE SPEAKER: Mr. Secretary on page 56 you talk about expanding pay for performance on Medicare and I wondered if that has any savings or spending associated with it and connected with that, I guess is the physician update for 2006.

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It sums up on page 55 that the 4.4% uptake that was just rescinded. What's in store for 2007 in that regard? Thank you.

MICHAEL LEAVITT: I'll invite you to get a lot of detail on this from Dr. McClellan but let me just acknowledge the fact that I believe this is a very important long term initiative because it is the means by which we continue to pay physicians and providers that which they need in order to make their practice run at the same time, they're able to increase the quality and get what we pay for and have the right treatment the first time. At the heart of pay for performance, however, is the need to measure it and measure it well and at the heart of being able to measure it is health information technology. That is a theme that continues to come up, a need to be able to gather information in a highly efficient way that allows us to measure quality and begin to pay on the basis of value added as opposed to just the number of procedures. This goes back to a fundamental theme that you will see through this entire budget. Healthcare must be viewed as a means of keeping people well, not simply treating them after they're sick. Yes.

FEMALE SPEAKER: I have a question about the NIH budget, as you know this administration oversaw of the completion of the five year doubling of NIH's budget. When you take in to account biomedical inflation that there's now been four years of cut and this year is the flat budget. What is

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the rationale for doubling an agency's budget over five years and then cutting it in subsequent years?

MICHAEL LEAVITT: That doubling took place as an important national commitment and it has been completed and we need to continue to enhance it. What you'll see in this budget is the fact that we are at a time when we are working to reduce our deficit. We're not in a position to do as much as any of us would like to do this year. However we have targeted very carefully and began to put into place some very important principles, and that is the need for collaborative work among the institutes at NIH. Dr. Zerhouni has been brilliant in my judgement of the way he's been able to put forward the road map which begins to take some basic technological and scientific research that is common to all of the institutes. He's put forward a process by which we can bring all of the institutes together to select scientific priorities. When you have 27 institutes, each with an agenda, it's important to have that kind of leadership. You will see represented in our research budget efforts to assure, I mentioned the effort on genes and environment. Every one of the institutes will benefit from that. We're focusing on the ten diseases that have the most substantial impact on public health, the entire institute, the entire nation, will in fact benefit from that effort. You'll begin to see us focus on those that are most preventative, those sciences that will allow us not only to be preventative

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but also to be very personal and to reinvent the way we use science in the treatment. It goes back again to the concept of let's change the way we view healthcare from how we keep people well—rather, change it from just treating them after they're sick. Mr. Johnson I turn the podium to your able hand. Thank you.

CHARLIE JOHNSON: Thank you Mr. Secretary. Those were obviously good questions and we're delighted that you could get the secretary's response. As I indicated at the outset we'd like Dr. McClellan now to come before you and speak to the, in more detail, Medicare and Medicaid Issues.

MARK MCCLELLAN, M.D., Ph.D.: Thanks, Charlie. Thanks to all of you for coming this afternoon. And just to give you an update on where you can get some more information about numbers and technical details on the Medicare and Medicaid and SCHIP budgets, we're going to have a follow up briefing in my conference room, the [inaudible] Administrator's conference room at 2:00 so any specific questions, technical questions, I'll be there as well as some of our senior technical staff. But if there are any important issues right now, I'll be happy to address them.

FEMALE SPEAKER: The secretary talked about better care for bioterrorism and for a flu pandemic and a lot of the nation's emergency rooms already say they're under siege, hospitals say they're under siege. How can they be better

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prepared for those and other crises if they receive less money out of this budget than they currently get?

MARK MCCLELLAN, M.D., Ph.D.: Well they are going to be getting a lot more money under this budget. As the secretary mentioned, Medicare spending is projected to increase and under the President's budget it will still increase, it will increase slightly less, rather than 8.1% per year for the next five years, 7.7% per year. And the changes in payments are in areas where the Medicare payment assessment commission and other independent expert groups have identified ways in which Medicare payments are not right. They're not at the appropriate levels for providing access to quality care. So we are following along those recommendations for hospitals in many cases. At the same time, as you know, there have been recent legislation like the Deficit Reduction Act that takes another big step forward towards enabling to pay more for better care rather than more services. We have recent results from our performance based payment demonstration with the premiere hospital group for example that shows that when you add in money for payments based on quality, you get better quality, fewer complications, and lower costs, freeing up more resources for hospitals to use to do what their professionals want to do and that's deliver high quality care that gets it right the first time. So those kinds of steps will be incorporated in

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the budget as we build on the recommendations of expert groups.
Yeah, Robert.

ROBERT: Could you tell us what is the first year that the trigger could reduce provider payments under the long term-

MARK MCCLELLAN, M.D., Ph.D.: Well as you know there is a soft trigger under current law and in the actuaries trustee's report, actuaries analysis for the Medicare Trustee's Report last spring, they forecasted in 2012 would be the first year in which the 45% so called trigger. With the proposals in the president's budget, that date is pushed back significantly, back to 2017 and that's the point of the approach that we're taking in this budget. If we start taking incremental steps now, important steps, but incremental steps we can make Medicare more sustainable while continuing to support high quality care, probably even better support for high quality care and moving Medicare into a position where it can finance the needs of baby boomers for the long run. What we'd like to do is take these steps now, pushes that date back 4 years just with the steps that we would take here and then continue to build on those steps with further proposals that would come from the bipartisan commission that the president announced and continued close and ongoing attention to making sure Medicare will be there for the people who are counting it with up to date benefits and high quality care.

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MALE SPEAKER: The 1% reduction applies, not to the first year [inaudible] but the year in which the 45-

MARK MCCLELLAN, M.D., Ph.D.: The trigger actually applies, that's right, so it would be 2017 with the presidents budget proposals enacted would be the first year that would happen. And again if we take steps like we're proposing in our budget now we can keep pushing that back and back just like we're doing in this year's budget. Other questions? Okay. Thank you all very much.

MALE SPEAKER: Got one more.

MARK MCCLELLAN, M.D., Ph.D.: Sorry, I didn't see.

FEMALE SPEAKER: Hi, sorry. Can you talk a little bit about the justification for the change in the high income beneficiary cost sharing? I guess you're taking the indexing off. Aren't you sort of creating another alternative minimum tax situation?

MARK MCCLELLAN, M.D., Ph.D.: Well we're developing a proposal that would gradually increase the amount that wealthy beneficiaries would pay for their Medicare services and the income related premium as its enacted in the law now applies to only a small fraction of Medicare beneficiaries who have substantial incomes, \$80,000.00 for an individual, \$160,000.00 for a couple. By not indexing this proposal it will apply gradually to additional people but only very slowly, so even by 2016 fewer than 8% of Medicare beneficiaries would be paying

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the additional premium. And even for these beneficiaries, this is very important, they are still getting large subsidies for their Medicare benefits. They get the full Part A subsidy, they get the full Part D, drug benefit, subsidy and they get continued subsidies for a large part of their Part B expenses. So they are continuing to get large and growing support from the Medicare program but we are limiting the growth in those subsidies at the very high end. That's one more step to make Medicare sustainable for the long term. Yes, John.

JOHN: A question on the bipartisan commission. What are your hopes as to when this would actually begin and when it would actually begin making recommendations?

MARK MCCLELLAN, M.D., Ph.D: That's hoping that we hope to start talking with the congress about as soon as possible, that's why the president mentioned it in his State of the Union report and that's why we are proposing some steps in the interim that can get Medicare on a path towards more sustainability and the bipartisan commission can add to that. Again, if we take incremental steps now, steady steps now, we can make the program sustainable without having to go to drastic changes in taxes or drastic changes in benefits or other steps. And that's something that we think there should be strong bipartisan support for doing so we're hoping the commission can get going soon. Last one, yes ma'am?

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FEMALE SPEAKER: With the Health Savings Accounts proposals, that looks like over the 10 years it's 87 or 89 billion cost, when would you expect those proposals to actually start saving money. You said that across the health care system Health Savings Accounts would eventually drive down costs.

MARK MCCLELLAN, M.D., Ph.D.: Well those are new subsidies for Health Savings Accounts, that's not a measure of what their impact is on the overall cost of the health care system. And what we're seeing already among the more than 3,000,000 Americans who have signed up on their own for a Health Savings Account is that they're saving money, they're getting the health insurance that they need at a lower cost, they are in many case using less health care because they're getting help in identifying ways to get the care they need at a lower cost and so that's already contributing to a slow down in medical expenditure growth. This past year, for example, we've seen the lowest growth rate in prescription drugs in more than a decade as more people are switching to the more widely available generic drugs and finding other ways to save on their drug costs while still getting the prescriptions they need. So that's going to continue happening on out into the future especially as more and more people go into HAS type proposals and that's what the Administration's initiative would do. And just from a Medicare and Medicaid standpoint I want to

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highlight that one of the main concerns that people who have had HSAs have raised is that it can be difficult to get the kind of information they'd like, relevant information, on the quality of care and cost of care for the options that available to them, for different providers, different choices of drugs, or other medical treatments. We're going to be doing a lot more work in CMS and throughout the administration in the coming year to make better and more useful information on quality and cost available. For example, in CMS we're working to make information on patient satisfaction with hospital care available, information on hospital outcomes after surgery, so that people can make very informed decisions about getting the care that they need at a lower cost so those savings are going to start right away and we're going to push them along further by the fact that more and more people are going to be joining plans and making use of information that can help the care they need at a lower cost. Thank you all and again we'll have more technical briefing opportunities available at 2:00.

CHARLIE JOHNSON: Thank you, Mark. I'm going to ask those on the front row to join me on the podium. While I'm doing that let me say Mark had indicated, Dr. McClellan indicated that you will have access at 2:00 to the rest of the CMS budget group. I would like to say that all of the operative division heads that are joining me now on stage will also remain here and be available to you to the extent you

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don't get your questions asked or answered during this session. So with that I would like to open it up to general questions. On the end of here and let's make sure we get the microphones.

MALE SPEAKER: [Inaudible] this morning first the president's initiative to encourage to use or substitute block grants for the HER program and also it says to look for new opportunities to expand choice and other [inaudible] activities. My questions are won't using the block grant for more ATR programs take away from other necessary programs? And you can elaborate on what other new opportunities perhaps there are to expand choice in treatment programs?

MALE SPEAKER: Very good. The premise behind the use of ATR as an incentive to encourage states to consider using block grant dollars for vouchers is based on one, the principle of volunteerism. In other words states will voluntarily come forward if they're interested in using more of their block grant dollars for vouchers. There are states who have used block grant dollars for vouchers and nothing precludes that. We do not see it as taking away from treatment capacity issues but it would be a different financing mechanism and the way it would work is we're looking to have \$70,000,000.00 out of the Access to Recovery dollars to be available for states to apply. They will receive points for the percentage of the block grant that they would consider vouchering. On the other hand a state can apply and not put any of the block grant up for vouchering,

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the exception would be the current ATR states. There would be an eligibility criteria that they would need to put 20% of their dollars, or 20,000,000, whatever is less up in order to be eligible to apply for further grant dollars. One, it's voluntary. Two, states who want to utilize choice and empower consumer decisions can step forward and will receive credit and recognition for that and three we see that in fact enhancing [inaudible] capacity. You're second part of your question?

MALE SPEAKER: Other areas for—

MALE SPEAKER: I think the current budget pretty well describes those areas and that's access to recovery and the opportunity to give incentive to states to utilize the block grant where they would see fit.

CHARLIE JOHNSON: We might want to mention the aging program, gives other people the independence. Josephina, would you respond to that question?

JOSEPHINA: Part of the FY07 President's budget and the aging line item includes a very new and exciting program initiative called Choices for Independence, in which it accelerates the ability to target systems changes to allow people to remain independent longer in the community by including our by science out of our Institutes of Health and putting that at the community level in the area of prevention. That means improving the outcomes of the prevention techniques use at the community level. It also accelerates long term care

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systems to give people the choice, broader choices, to remain at home in the community and away from nursing homes. And it also informs people earlier on choices that they might need to do the plan ahead for their long term care needs, housing health care and other supportive activities.

CHARLIE JOHNSON: Let's keep the microphone in the back at this point right in the middle.

FEMALE SPEAKER: A question for Dr. Zerhouni, if you could just clear up on thing about the genes, environment, and health segment of the budget which is calling for an increase in 49,000,000 but the secretary alluded to new programs being announced later this week. So how much of the 49,000,000 is going to those new programs and then how much is simply funding the existing genes, environment, and health programs through NHCI. Then the second question is about the bioterrorism allocation in your office for Project Bio-Shield. Part of that is for a third generation anthrax vaccine and I wonder if you could talk about the rationale for a third generation anthrax vaccine when there are a lot of infectious diseases for which there is no available vaccine. Thanks.

ELIAS A. ZERHOUNI, M.D.: I'll address the genes and environment initiative. As you know the haplotype map was completed in October of 2005 and one of the opportunities that has emerged through that research is the possibility of using many of the cohorts of patients that we've studied over the

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years and rapidly screen for the most common conditions, what genetic linkages can be found which will usher an new era of investigations. We've had an example this year with age related macular degeneration, by using this strategy we found a completely unexpected gene that explains 50% of the cases of one of the common causes of blindness in our seniors. So this is what we're trying to expand, so all the funds are going to be directed at two things; one, genome wide association studies and two because measures of environmental exposures need to be performed at the individual level, we're going to have a program, we're going to develop completely novel ways of measuring exposures at the individual level. A little bit in line with what the secretary is saying, we really believe we're at the edge of a transformation where medicine is going to be predictive, personalized, and preemptive. And as a stepping stone to that we needed to do this on an accelerated basis.

In terms of the bioterrorism effort, remember that the dollars that are there are really for advanced product development. What is happening structurally is that you make discoveries in the laboratory and then to really implement that and scale them up to a production level where they can compete for bio shields funds for procurement, you really have a gap between the two and that gap needs to be managed extremely actively we believe and needs to be looked at depending upon what we call our threat matrix and understanding what the

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dangers out there based on analysis that are performed not just at HHS but the Department of Homeland Security and other agencies. And to be responsive to it we really need to bring the know-how that comes from R&D to the intermediate phase which is the scaling up and validation of an approach. The anthrax issue that you're raising, I'm not familiar with the details, but at 3:00 we'll have a session at NIH and we'll be certainly happy to comment on specifics like that.

CHARLIE JOHNSON: That's 3:00 this afternoon, is that correct.

ELIAS A. ZERHOUNI, M.D.: 3:00 this afternoon.

CHARLIE JOHNSON: Okay. We had two or three hands here. Yes, correct thank you.

MALE SPEAKER: Dr. Zerhouni, back to you. The secretary described a focus on preventing diseases and on the most common diseases that effect Americans. Can you help us understand that initiative in the context of a \$40,000,000.00 cut and National Cancer Institute cut for diabetes research, those are two that come to my eyes immediately. And second question, help us understand more broadly what your office is going to do with \$140,000,000.00 increase?

ELIAS A. ZERHOUNI, M.D.: For biodefense you mean?

MALE SPEAKER: Office of the director.

ELIAS A. ZERHOUNI, M.D.: I think it's very clear that what you call cuts if you will is really what we have to

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recognize and that is that you have to do prioritization and I think the secretary said it well. We want to make platform investments that apply to all of the institutes, for example new investigator programs are important so we have a new investigator's initiative that will fund 150 to 200 new scientist who are coming to the field and in fact when you have level of funding like this, one of the dangers that we identified at NIH and we've been preparing for is the possibility that new entrance to the scientific field will get discouraged. So there is that program. The second is a continuation of our investments in discovery the fundamental bases, the genetic basis and environmental factors that drive the development of many conditions, not just cancer or heart disease and that's the reason why you have that investment. When you say \$140,000,000.00 in the office of the director I think you can refer to two things. Is this dollar amount that relates to advanced product development, which needs to be managed separately because it needs to be tied in both in R&D that's done across the institutes and when you look at that it's nuclear, radiological, [inaudible] threats as well as neurological threats that have research in the institutes. You need to tie it to then the next step which is bio shield procurement. That needs to be done and managed in a way that I think is responsive to that next step. In terms of the other dollars in the budget, as you know we've planned a road map for

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the entire NIH over several years, in 2003 we announced that and therefore there is component of the budget which is in the office of the director of about \$111,000,000.00 and the other component is \$332,000,000.00 that is in the institutes and that's a common fund if you will that we have all managed jointly to sort of identify the most important areas of research that will be forgotten sometimes if you have tight budgets what tends to happen is strategy gets forgotten for tactics and this is not something that we want to do. We want to continue the momentum that we've accomplished through the doubling, through these sort of strategies that essentially focus on enabling research that enables progress across the board.

FEMALE SPEAKER: I have a question for Dr. Gerberding. It looks to me that you're getting about a \$367,000,000.00 cut this year and if memory serves CDC's proposed budget was reduced \$500,000,000.00 in the administration proposal last year. Why is CDC getting cut year after year? Where are these going to come from?

JULIE LOUISE GERBERDING, M.D., M.P.H.: Let me clarify the actual projected decrease in CDC's budget in FY07 is \$179,000,000.00 you're looking at the appropriated dollars but some of those are offset by increases in other budget lines, for example the vaccine for children program is actually going to increase. So for example the best estimate of our change in

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budget is the \$179,000,000.00. They're doing the same thing that everyone is doing right now. We have to look at our programs and figure out where are the priorities for the agency? Where are the opportunities for us to invest our resources to have the best possible impact on protecting people's health and then we've got to look at some programs that have been around for a long time that may not be performing as well as they should or that were never funded to a level where they could possibly to achieve an impact and those programs need to be eliminated and that is the genesis of some of the reductions in our budget. So we're really going through the same process of trying responsible about emphasizing the new things, the flu budget, the AIDS budget, the things that we know we need more investments in and finding resources from other parts of CDC as well as business efficiencies to try to offset some of these changes.

FEMALE SPEAKER: What are a couple of the \$179,000,000.00 worth that you're eliminating?

JULIE LOUISE GERBERDING, M.D., M.P.H.: One of the major components of that is our buildings and facilities master plan. In the past we've had about \$250,000,000.00 a year to support the development of CDC's buildings which were in a complete state of ruin over time. That's a ten year plan and we've made a lot of progress on it. We won't have the appropriation to support the escalated transition to our new

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buildings, but we are still on track with our master plan and we will be able to open two more buildings next year.

FEMALE SPEAKER: Hi. Can you talk about some of the health care provider quality monitoring and publicizing efforts that are specifically funded in this budget?

CHARLIE JOHNSON: Health care provider quality issues. Dr. Clancy [misspelled?].

CAROLYN CLANCY, M.D.: I think you can see, and it would probably be wise to get more technical detail when CMS has their briefing at 2:00, the Deficit Reduction Act specifically calls for the continuation of the linking public reporting of hospital performance, although to a larger set of measures. The NMA actually gave hospitals the opportunity to volunteer, if they didn't volunteer they didn't get their .4% market update and just about all hospitals did choose to volunteer for 10 measures. The Deficit Reduction Act actually allows funding but is going to require 16 different measures. There's not exclusive funding. There's some funding that isn't supported if it's in the QIO budget but I would refer you to CMS.

CHARLIE JOHNSON: In the rear?

FEMALE SPEAKER: Can you talk about some of the changes in the canon of welfare [inaudible] as compared to last year. And also the practical effect of changing or updating the case load reductions from 1995 to 2005.

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CHARLIE JOHNSON: Dr. Horn [misspelled?] would you please come forward?

DR. HORN: As you are aware TANF was reauthorized in the Deficit Reduction Act. There were two major provisions in that, the first was an updating of the Caseload Reduction Credit to 3005 which is effective come October 1st, 2006. What that effectively does is that puts back into effect the meaningful work participation rate of requirement for the states, because of the caseload reduction credit prior to TANF reauthorization the median work participation rate requirement upon states was zero, which meant that a state had to put 0% of their caseload into work in order to satisfy the federal requirements. So what this does is it updates it and it says that there shall be a 50% work participation rate requirement, except that you will continue to get a credit, but not against a 1996 baseline but against a 2005 baseline. So if a state reduces its caseload over the course of this year, '06, by 10% then they wouldn't have a 50% work participation rate requirement but a 40%. Also in the TANF reauthorization there was included \$150,000,000.00 for health marriage and responsible fatherhood programs. At least up to \$50,000,000.00 of that can be used for responsible fatherhood programs and most of the rest is used for health marriage initiatives. The difference in the '07 budget is there's a competitive state program of a \$100,000,000.00 as well. The \$100,000,000.00

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that's in the deficit reduction action for healthy marriage activities is a direct federal grantee program that's left to the secretary's discretion in terms of who gets that money. Eligible recipients include faith based, community based organizations as well as state and local governments. The competitive state grant program would be open only to states and would require a dollar for dollar match in order to draw down those funds. Both of those components were included in the original president's TANF reauthorization proposal and this is simply asking in the '07 budget for the other piece of that.

FEMALE SPEAKER: [Inaudible] I was wondering how FDA plans to use the additional [off mic] that's in question for [inaudible] preventiveness, I think this money is going to improve the [inaudible] pandemic flu vaccine, I was wondering how you plan to use that money, \$50,000,000.00

ANDREW C. VON ESCHENBACH, M.D.: Yes, in this budget there's a \$30,000,000.00 allocation that we intend to apply to a pandemic flu preparedness and to do that in a very comprehensive that moves across the continuum, not only of vaccine development and the need to be responsive and accelerating that process in a facilitating way but also with regard to the challenges in antivirals as well as diagnostic devices and including also a response to the animal issues and the veterinary medicine issues that would be potentially involved in a pandemic crisis. So it's a comprehensive

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program, we are particularly engaged in the facilitating of the vaccine development initiative that the secretary alluded to and in collaboration with both NIH and CDC working across that entire continuum in multiple places in FDA's regulatory function must go hand in hand with the development function. So it's comprehensive and it intends to really be responsive to the full continuum.

MALE SPEAKER: This question is for Dr. Zerhouni. You mentioned briefly encouraging new investigators and so far university researchers have been a little disappointed that NIH funding has stayed flat over the years and I was wondering if you could talk a little bit about any changes in the number of competitive grants as especially as it bears to universities, graduate student researchers, and encouraging new investigators from universities.

ELIAS A. ZERHOUNI, M.D.: Can you repeat what it is that universities were disappointed with?

MALE SPEAKER: That the funding stayed flat after doubling and that some have been anticipating a decrease in the number of competitive grants this year.

ELIAS A. ZERHOUNI, M.D.: This is actually I think what the secretary said. I mean this is a deficit reduction budget you have to balanced priorities but one of the top priorities have announced across NIH and directors and I have met last January already was the forecasted impact on new investigators

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and our ability to maintain not only a vibrant research capacity but also remember that we're entering new areas of science that we didn't really have to cover many years ago, computational biology being one, genomics you just heard. So our strategy has to be proactive in making sure that the number of competing grant pools does not get damaged. That's why this year we have asked for 2.35% cut across all noncompeting grants. If you remember that was our guidance a couple months ago and the reason we're doing this is because we want to maintain a decent success rate and portfolio if you will that will allow us to maintain absolute numbers, as much as possible the number of grants that we can offer to new investigators, to competing investigators and in that I really want to make as much effort as possible in maintaining the likelihood of having new investigators enter the field with new ideas and go to a percentage where in the competing pool, at least 25% over time would be new investigators so that we maintain the vibrancy of that. So yes, our intent is to maintain the number of grants to the largest extent possible and that's how we've made some choices in this budget to make sure that that happens.

CHARLIE JOHNSON: We have agreed that this session would at 2:00 in time for those who want to go to the Medicare Medicaid briefing that they could meet over here and they'd be escorted up. But we do have time for one more question if

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someone has a question otherwise our agency heads will be available to you for individual meetings. One last question? One last?

FEMALE SPEAKER: Stockpiled antivirals for pandemic flu, I'm not sure which official too, but what, I mean Roche has been saying that there may be problems with delivering the supply and there's a big line up of countries needing the drugs. What do we know about their ability to deliver the drugs if we're able to purchase actually enough to cover 25% of Americans.

JULIE LOUISE GERBERDING, M.D., M.P.H.: This is the expectation, that we will purchase enough drugs to cover 25% of the population. The intent is to be able to support the development of that capacity domestically so that we're not dependent on drugs made elsewhere or raw materials being imported from elsewhere to support that supply chain. It takes time to convert to that but the manufacturer has represented that they're willing to take those steps and the appropriate that we just received in the supplemental plus the additional flu resources that we expect to support us in the future will really help set the stage for that to happen. I can assure you that we're buying Tamiflu as fast as it comes out of the manufacturer and we've already been able to continue to expand the supply that we have on hand and we'll continue to do that as the drug becomes available.

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CHARLIE JOHNSON: Thank you all for coming there will be many of us remaining here for as long as you have questions. Thanks again

[END RECORDING]