STATEMENT

BEFORE THE

U.S. SENATE
COMMITTEE ON FINANCE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Good morning, Mr. Chairman and members of the committee. I am pleased to present to you the President's FY 2005 budget for the Department of Health and Human Services (HHS). I am confident you will find our budget to be an equitable proposal to improve the health and well-being of our Nation's citizens.

This year's budget proposal builds upon HHS accomplishments in meeting several of the health and safety goals established at the beginning of the current Administration. This year, Congress passed the comprehensive Medicare reform legislation, adding prescription drug coverage for seniors and modernizing the Medicare program.

- Since 2001, with the support Congress, the Administration has funded 614 new and expanded health centers that target low-income individuals, effectively increasing access to health care for an additional three (3) million people, a 2.9 percent increase.
- The Department established the Access to Recovery State Vouchers program, providing 50,000 individuals with needed treatment and recovery services.
- To support the President's faith-based initiative, HHS has created the Compassion Capital Fund for public/private partnerships to support charitable groups in expanding model social services programs. We awarded 81 new and continuing grants in 2003.
- HHS initiated a new Mentoring Children of Prisoners program to provide one-to-one mentoring for over 30,000 children with an incarcerated parent in FY 2004. The Department also created education and training vouchers for foster care youth, providing $5,000 vouchers to 17,400 eligible youth.
- In August 2001, the President and I invited States to participate in the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative. States use HIFA demonstrations to expand health care coverage. As of January 2004, HIFA demonstrations had expanded coverage to 175,000 people, and another 646,000 were approved for enrollment.

I could go on listing our achievements to you and the Committee, Mr. Chairman, but instead I have chosen to highlight a few that we are most proud of.

For FY 2005, the President proposes an HHS budget of $580 billion to enable the Department to continue working with our State and local government partners, as well as with the private and volunteer sectors, to ensure the health, well-being, and safety of our Nation. Through the programs and services presented in the budget plan of HHS, Americans will receive new health benefits and services, be protected from the threat of bioterrorism, benefit from enhanced disease detection and prevention, have greater access to health care, and will see improved social services through the work of faith- and community-based organizations and a focus on healthy family development. This proposal is a $32 billion increase over the comparable FY 2004 budget, or an increase of about 5.9 percent. The discretionary portion of the HHS budget totals $67 billion in budget authority, a 1.2 percent increase.

Your committee, Mr. Chairman, has jurisdiction over much of this budget. I am grateful for the hard work and achievements we have made together. Allow me to draw your attention to several key factors of the HHS budget so that we may continue to work together to address the needs of our Nation.

Medicare and Medicaid Reform/Modernization

I am proud to have worked closely with so many members of this Committee on the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which President Bush signed into law December 8, 2003. I would like to particularly thank Senators Grassley, Baucus, Frist, Breaux, Nickles, Kyl, and Hatch for their tireless efforts. With the implementation of MMA, the Department faces many challenges in the coming fiscal year. As the most significant reform of Medicare since its inception in 1965, the law expands health plan choices for

beneficiaries and adds a prescription drug benefit. MMA will strengthen and improve the Medicare program, while providing beneficiaries with new benefits and the option of retaining their traditional coverage. The HHS FY 2005 budget request includes about $482 billion in net outlays to finance Medicare, Medicaid, the State's Children's Health Insurance Program, the Health Care Fraud and Abuse Control Program, State insurance enforcement, and the Agency's operating costs.

Drug Discount Card

MMA establishes a new, exciting Medicare approved prescription drug discount card program, providing immediate relief to those beneficiaries who have been burdened by their drug costs. From June 2004 through 2005, all Medicare beneficiaries, except those with Medicaid drug coverage, will have the choice of enrolling in a Medicare-endorsed drug discount card program. With the discount card, beneficiaries will save an estimated 10 to 15 percent on their drug costs. For some, savings may reach up to 25 percent on individual prescriptions. A typical senior with $1,285 in yearly drug expenses could save as much as $300 annually. To enroll, beneficiaries will pay no more than $30 annually. Those with low incomes will qualify for a $600 per year subsidy to purchase drugs. Medicare also will cover the enrollment fees for low-income seniors.

Voluntary Prescription Drug Benefit

Responding to President Bush's pledge to add meaningful drug coverage to Medicare, MMA establishes a new voluntary prescription drug benefit under a new Medicare Part D. Starting in 2006, Medicare beneficiaries who are entitled to Part A, or enrolled in Part B, can choose prescription drug coverage under the new Part D. Under Part D, beneficiaries can choose to

enroll in stand-alone, prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA-PDs), and will be able to choose between at least two plans to receive their benefit. The law contains important beneficiary protections. For example, while the plans are permitted to use formularies, they must include drugs within each therapeutic category and class of covered Part D drugs, allowing beneficiaries to have a choice of drugs. In instances in which a drug is not covered, beneficiaries can appeal to have the drug included in the formulary. To reduce the number of prescribing errors that occur each year, HHS will develop an electronic prescription program for Part D covered drugs.

Medicare Advantage

MMA replaces the Medicare+Choice program with a new program called Medicare Advantage, which will operate under Part C of Medicare. Starting in 2004, the new law changes how private plans will be paid. In response to the increasing costs of caring for Medicare beneficiaries, the law increases payments to managed care plans by $14.2 billion over 10 years. These enhanced payments will allow private plans to provide more generous coverage, including benefits that traditional Medicare may not offer. Specifically in 2004, plans must use these funds to provide additional benefits, to lower premiums and/or cost-sharing, or to improve provider access in their network. This increased compensation will also encourage more private plans to enter the Medicare market, improving beneficiaries' overall access to care.

Under Medicare Advantage, local managed care plans will continue to operate on a county-by-county basis. Beginning in 2006, Medicare Advantage also will offer regional plans, which will cover both in-network and out-of-network services in a model very similar to what we in the

Federal Government enjoy through the Federal Employee Health Benefits Program. There will be at least 10 regions, but no more than 50. The regional plans must use a unified deductible and offer catastrophic protection, such as capping out-of-pocket expenses.

The changes in the Medicare advantage program will provide seniors with more choices, improved benefits, and provide beneficiaries a choice for integrated care – combining medical and prescription drug coverage. We project that 32 percent of Medicare beneficiaries will enroll in Medicare Advantage plans by 2010.

Providers and Rural Health

Recognizing geographic disparities in Medicare payments, MMA provides much needed relief to rural providers by equalizing the standardized amounts paid to both urban and rural hospitals. Of course, I don't need to tell this Committee how important these rural health investments are, and I congratulate Chairman Grassley, Senator Baucus, Senator Conrad, and others for ensuring that the programs were included in the final bill. Along with standardizing the base payment amounts to both urban and rural hospitals, MMA reduces the labor share of the standardized payment amount. In addition, Mr. Chairman, MMA increases payments for Disproportionate Share Hospitals (DSH) and provides greater flexibility to Graduate Medical Education (GME) residencies. The new law also increases flexibility for hospitals seeking Sole Community Hospital (SCH) status and reduces the requirements for achieving Critical Access Hospital (CAH) status. Critical Access Hospital status will receive increased payments under MMA, as the payment rate will be increased to 101 percent of allowable costs.

Providers will see increased reimbursements under MMA. Physicians practicing in defined shortage areas will receive an additional 5 percent payment bonus. Home Health Agencies in rural areas also will receive a 5 percent bonus. In a change for rural hospice providers, more freedom will be given to utilize nurse practitioners. The law also creates an Office of Rural Health Policy Improvements and requires demonstration projects involving telehealth, frontier services, rural hospitals, and safe harbors.

Preventive Benefits

MMA expands the number of preventive benefits covered by Medicare beginning in 2005. Through a particularly important provision, an initial preventive physical examination will be offered within six months of enrollment for those beneficiaries whose Medicare Part B coverage begins January 1, 2005 or later. The examination, as appropriate, will include an electrocardiogram and education, counseling, and referral for screenings and preventive services already covered by Medicare, such as pneumococcal, influenza and hepatitis B vaccines; prostate, colorectal, breast, and cervical cancers; in addition to screening for glaucoma and diabetes. Diabetes and cardiovascular screening blood tests do not have any deductible or co-payments, as Medicare pays for 100 percent of these clinical laboratory tests.

Regulatory Reform/Contracting Reform

MMA includes a number of administrative and operational reforms, as well. For example, regulatory reform provisions require the establishment of overpayment recovery plans in case of hardship; prohibit contractors from using extrapolation to determine overpayment amounts except under specific circumstances; describe the rights of providers when under audit by

Medicare contractors; require the establishment of standard methodology to use when selecting a probe sample of claims for review; and prohibit a supplier or provider from paying a penalty resulting from adherence to guidelines. In addition, MMA allows physicians to reassign payment for Medicare services to entities with which the physicians have an independent contractor arrangement. Under the new law, final regulations are to be published within three years, and all measures of a regulation are to be published as a proposed rule before final publication.

Also under the law, as Secretary, I will be permitted to introduce greater competitiveness and flexibility to the Medicare contracting process by removing the distinction between Part A and Part B contractors, allowing the renewal of contracts annually for up to five years, limiting contractor liability, and providing incentive payments to improve contractor performance. These changes will enhance HHS efficiency and effectiveness in program operations.

Regarding Medicare appeals, MMA changes the process for fee-for-service Medicare by requiring the Social Security Administration and HHS to develop and implement a plan for shifting the appeals function from SSA to HHS by October 1, 2005. MMA also changes the requirements for the presentation of evidence. This also will enhance the efficiency and effectiveness of the operation of the Medicare program.

Medicare and Medicaid Estimates

Historically, HHS and the Congressional Budget Office (CBO) have provided differing estimates of Medicare and Medicaid spending. It is not uncommon for different assumptions underlying

the respective estimates to produce differences in cost projections. This year's new estimates include the changes resulting from enactment of MMA.

When Congress considered this act, Mr. Chairman, CBO estimated the cost of the bill at $395 billion from 2004 to 2013. The HHS actuaries have recently estimated the cost of the law as $534 billion from 2004 to 2013. Last week, the CBO Director told the House and Senate Budget Committees that CBO has not changed its estimate and that they continue to believe that the cost of the bill is $395 billion. Because the Medicare legislation makes far-reaching changes to a complex entitlement program with many new private-sector elements, there is even larger uncertainty in these estimates than usual.

The two sets of estimates provide a reasonable range of possible future cost scenarios for Medicare spending. The tremendous uncertainty surrounding estimates of the newly-enacted Medicare law has resulted in a plausible range of estimates of future cost scenarios for Medicare spending, from the $395 billion estimate from CBO to the $534 billion estimate from the Medicare actuaries. It should be noted that this difference of $139 billion is approximately two (2) percent of the projected $7 trillion in total Federal Medicare and Medicaid spending over the same period, as projected by HHS.

Additional MMA Changes

MMA addresses other issues facing the Medicare program including the program's long-term, financial security. To contain costs in the Medicare program, the law requires the Medicare Trustees, beginning in the 2005 annual report, to assess whether Medicare's "excess general

revenue funding" exceeds 45 percent. As defined in the law, excess general revenue funding is equal to Medicare's total outlays minus dedicated revenues. The Medicare Trustees shall issue a "warning" if general revenues are projected to exceed 45 percent of Medicare spending in a year within the next seven years. If the Trustees issue such a warning in two consecutive years, the law provides special legislative conditions for the consideration of proposed legislation submitted by the President to address the excess general revenue funding.

In addition to implementing MMA, the HHS budget request includes provisions for the State Children's Health Insurance Program, the New Freedom Initiative, and Medicaid.

State Children's Health Insurance Program (SCHIP)

As you know, Mr. Chairman, SCHIP was created with a funding mechanism that required states to spend their allotments within a three-year window, after which any unused funds would be redistributed among states that had spent all of their allotted funds. These redistributed funds would be available for one additional year, after which any unused funds would be returned to the Treasury.

On August 15, 2003, President Bush signed Public Law 108-74. The law restores $1.2 billion in FY 1998 and FY 1999 SCHIP funds, and makes them available to states until September 30, 2004. The law also extends $2.2 billion in FYs 2000 and 2001 SCHIP funds, and revises the rule for the redistribution of the unspent funds from these allotments. For FYs 2000 and 2001 allotments, the law allows states that do not spend their entire allotment within the three-year period to keep half of those respective year's unspent amounts. The other half would be

redistributed to states that have spent their entire amount of the respective year's allotments. The law also extends the availability of funds from the FY 2000 allotments through September 30, 2004, and the availability of FY 2001 allotment through September 30, 2005. The law gives some relief to states that expanded their Medicaid programs to cover additional low-income children prior to the enactment of SCHIP.

New Freedom Initiative

The Administration is committed to ensuring that people with disabilities and/or the long-term care needs receive the supports necessary to remain in (or return to) the community as opposed to remaining in an institutional setting. One of the Administration's priorities is relying more on home- and community-based care, rather than costly and confining institutional care, for the elderly and people with disabilities. The New Freedom Initiative signifies the President's commitment to promoting at-home and community-based care. There are several components to this initiative, Mr. Chairman, which I would like to bring to your attention.

Under the "Money Follows the Individual Re-Balancing Demonstration" states could participate in a five-year demonstration that finances services for individuals who transition from institutions to the community. Federal grant funds would pay for the home- and community-based waiver services of an individual for one year at an enhanced Federal match rate of 100 percent. As a condition of receiving the enhanced match, the participating State would agree to continue care at the regular Medicaid matching rate after the end of the one-year period and to reduce institutional long-term care spending.

The New Freedom Initiative is very important to me and to the President, and we would like to work closely with this Committee to secure its passage this year. The Administration recognizes the success of consumer directed programs that give people the opportunity to manage their own long-term care, as delineated by the development of its Independence Plus Waivers. Thus, we propose allowing individuals who self-direct all of their community-based, long-term care services to accumulate savings and still retain eligibility for Medicaid and Supplemental Security Income. Under current law, beneficiaries are discouraged from accumulating savings because it could jeopardize their eligibility for Medicaid and SSI. Under the Living with Independence, Freedom, and Equality (LIFE) Accounts Program, individuals who self-direct all of their Medicaid, community-based, long term supports will be able to retain up to 50 percent of savings from their self-directed Medicaid community-based service budget at year end, contribute savings from employment, and accept limited contributions from others. Ultimately, LIFE Accounts would enable individuals to save money to reach long-term goals (for example, to purchase expensive equipment or attain higher education) and to obtain greater independence.

The Administration looks forward to working with Congress to pass legislation authorizing me, as Secretary, to administer demonstrations to assist caregivers and children with serious emotional disturbances. Two demonstrations will provide respite services to caregivers of adults with disabilities and to children with severe disabilities. A third demonstration will offer home and community-based services for children currently residing in psychiatric facilities. The fourth demonstration will address shortages of community, direct-care workers by providing grants to States to identify best practices and develop models. Direct-care workers play an important role

in providing care to individuals living with disabilities in the community and this demonstration should help address these workforce challenges.

Medicaid and SCHIP Modernization

This Committee is well aware that Medicaid spending continues to rise each year. Total Medicaid spending for 2004 is projected to be $304 billion, nearly a tripling in spending over 10 years. Medicaid -- not Medicare -- is currently the largest government health program in the United States. Since Medicaid expenditures are a large and growing proportion of most state budgets, the Medicaid program is an area to which states turn to reduce costs including dropping optional Medicaid benefits or limiting optional groups from enrolling.

These concerns have fostered a dialogue between the Federal government and the states regarding ways to improve and modernize Medicaid and SCHIP. Building on this dialogue, the Administration will continue to work with Congress and other stakeholders to seek new ways to strengthen and improve the Medicaid and SCHIP programs.

In addition to structural reform, improving the fiscal integrity of the Medicaid program will continue to be a priority for the Administration and HHS. Among these efforts, the Administration proposes capping the reimbursement level to individual state and local government providers to no more than the cost of providing services to Medicaid recipients and restricts the use of certain types of intergovernmental transfers. The proposal would deem as "unallowable" certain Medicaid expenditures that result in Federal Medicaid and disproportionate share hospital (DSH) payments returned by a government provider to the state.

The proposal would not affect legitimate intergovernmental transfers that are used to help raise funds for the state share of Medicaid costs. Rather, this proposal would only apply to intergovernmental transfers that are used to recycle Medicaid payments through government providers.

Other Medicaid Legislation

Extension of the Qualified Individual (QI) Program

The Administration is committed to helping low-income seniors afford not only prescription drugs, but also health coverage through Medicare. Under current law, as authorized by MMA, Medicaid programs will pay Medicare Part B Premiums for qualifying individuals (QIs) through September 30, 2004. QIs are defined as Medicare beneficiaries with incomes of 120% to 135% of the Federal Poverty Level and minimal assets. The HHS budget would continue this premium assistance for one additional year.

Extension of Transitional Medical Assistance

As families make the transition from welfare to work, health coverage is an important component to ensure their success in contributing to, and remaining in, the work place. Transitional medical assistance (TMA) was created to provide health coverage for former welfare recipients after they entered the workforce. TMA extends up to one year of health coverage to families who lose eligibility for Medicaid due to earnings from employment. This provision will expire March 31, 2004. The Administration proposes a five-year extension of TMA with statutory modifications to simplify administration of the program for states. States would have the option to eliminate TMA reporting requirements; provide twelve months of

continuous eligibility; and to request a waiver from providing the mandatory TMA program in their Medicaid program if their eligibility income level for families is set at 185 percent of the Federal Poverty Level or higher.

Partnership for Long-Term Care

The budget request, Mr. Chairman, includes a proposal to eliminate the legislative prohibition on developing more partnership programs for long-term care (LTC). The partnership for LTC was formulated to explore alternatives to current LTC financing by blending public and private insurance. Four states currently have these partnerships in which private insurance is used to cover the initial cost of LTC. Consumers who purchase partnership-approved insurance policies can become eligible for Medicaid services after their private insurance is utilized, without divesting all their assets as is typically required to meet Medicaid eligibility criteria.

Refugee Exemption Extension

Under current law, most legal immigrants who entered the country on or after August 22, 1996, and some who entered prior to that date, are not eligible for SSI until they have obtained citizenship. Refugees and asylees are currently exempted from this ban on SSI for the first seven years they reside in the United States. To ensure refugees and asylees have ample time to complete the citizenship process, the President's budget proposes extending the current seven-year exemption to eight years.

Special Enrollment Period in the Group Market for Medicaid/SCHIP Eligible

This legislative proposal would make it easier for Medicaid and SCHIP beneficiaries to enroll in private health insurance by making eligibility for Medicaid and SCHIP a trigger for private

health insurance enrollment outside of the plan's open season. This proposal will help states implement premium assistance programs in Medicaid and SCHIP.

Marriage and Healthy Family Development

This year, Mr. Chairman, the President is proposing a new marriage and healthy family development initiative. This Initiative is supported by funding increases in this Department's FY 2005 budget, encompasses a variety of new and existing programs, and impacts both mandatory and discretionary programs.

I am very grateful to this Committee for acting to advance Temporary Assistance to Needy Families (TANF) reauthorization last fall, and I look forward to working together as the bill is considered on the Senate Floor in weeks ahead. Building on the considerable success of welfare reform in this great Nation, the President's FY 2005 Budget maintains the framework of the Administration's welfare authorization proposal. Mr. Chairman, we are committed to working with the Congress in the coming months to ensure the legislation moves quickly and is consistent with the President's Budget. The President's proposal includes five years of funding for the TANF Block Grant to States and Tribes; Matching Grants to Territories; and Tribal Work Program. A new feature, intended to support the President's Marriage and Healthy Family Development Initiative, is a proposal for increased funding for two key provisions in our welfare reform package.

A cornerstone of the President's commitment to strengthen and empower America's families through welfare reform provides targeted resources to family formation and healthy marriage

strategies. Statistics tell us that children from two parent families are less likely to end up in poverty, drop out of school, become addicted to drugs, have a child out of wedlock, suffer abuse or become a violent criminal and end up in prison. Building and preserving families are not always possible. But it should always be our goal.

Beginning in FY 2005, the FY 2005 budget would provide an additional $20 million, a total of $120 million, under TANF to support research, demonstrations, and technical assistance primarily focused on family formation strategies and healthy marriages and an additional $20 million for matching grants to States, Territories, Tribes, and Tribal Organizations for innovative approaches to promoting healthy marriage and reducing out-of-wedlock births. A dollar-for-dollar match to participate in the grant program will be required, generating another $20 million in matching State and local funds. States can use Federal TANF funds to meet this matching requirement. In total, $360 million in Federal and State funding would be available in the FY 2005 Budget to broaden the Administration's efforts to support healthy marriages and promote effective family formation.

To reverse the rise in father absence and improve the well-being of our Nation's children, the budget includes a total of $50 million for grants for public entities; nonprofits, including faith-based; and community organizations to design demonstration service projects. These projects will test promising approaches to improve outcomes for children by encouraging the formation and stability of healthy marriages and responsible fatherhood, and to assist fathers in being more actively involved in the lives of their children.

As the Committee may remember, President Bush announced in his State of the Union address a new initiative to educate teens and parents about the health risks associated with early sexual activity and to provide the tools needed to help teens make responsible choices. To do this, the President proposes to double funding for abstinence education activities for a total of $273 million, including a request of $186 million, an increase of $112 million, for grants to develop and implement abstinence educations programs for adolescents aged 12 through 18 in communities across the country; the reauthorization of state abstinence education grants for five years at $50 million per year as part of the welfare reform reauthorization; another $26 million for abstinence activities within the Adolescent Family Life program; and a new public awareness campaign to help parents communicate with their children about the health risks associated with early sexual activity.

In addition, the budget provides for significant increases to two State child abuse programs reauthorized this past year as part of the Keeping Children and Families Safe Act of 2003. The increase for the Child Abuse Prevention and Treatment State Grants will enable State child protective service systems to shorten the time to the delivery of post-investigative services from 48 to 30 days. The Community-Based Child Abuse Prevention program will increase the availability of prevention services to an additional 55,000 children and their families.

Child Welfare

The Administration is proposing a nearly $5 billion budget for Foster Care. These funds will be used to support the President's child welfare program option, which provides states more flexibility in both the population served and allowable activities. The funds will be used to

provide payments for maintenance and administrative costs for more than 230,000 children in foster care each month, as well as payments for training and child welfare data systems. The HHS budget request reflects savings associated with a legislative proposal to clarify the definition of "home of removal" in the foster care program in response to a court decision. The President's FY 2005 budget also requests $140 million for the Independent Living Program and $60 million for the Independent Living Education and Training Vouchers program. Additionally, to support the Administration's commitment to helping families in crisis and to protecting children from abuse and neglect, the President's FY 2005 Budget requests $505 million, full funding, of the Promoting Safe and Stable Families program.

Child Support Enforcement

The President's FY 2005 budget, building on the high level of success achieved by the Child Support Enforcement Program, focuses on critical improvements in the arena of medical child support. Legislation will be proposed to enhance and improve state's efforts to collect medical support on behalf of children. These efforts include providing Child Support agencies with notifications of lost coverage (COBRA notices) so they can assist families in providing continuous health care coverage. Additionally, legislation would require states to consider both parents' access to health care coverage when establishing child support orders, with the option of enforcing medical support orders against both custodial and noncustodial parents. By assuring that IV-D agencies receive notice of a child's loss of health insurance coverage, and by seeking health insurance from either parent, more children will have access to continuous health coverage, which will result in healthier children and families.

These proposals build on the policies in the FY 2004 budget that increase resources for the Access and Visitation Program to support and facilitate non-custodial parents' access to visitation of their children, and various proposals to enhance and expand the existing automated enforcement infrastructure at the Federal and State level. When combined with the opportunities to increase child support outlined in the President's FY 2003 budget, such as expanded passport denial, the offset of certain Social Security benefits, and the optional pass through of child support to families on TANF, these proposals offer an impressive $8.1 billion in increased child support payments to families over 10 years.

Compassion and Faith Based Agenda

Compassion Capital Fund

The FY 05 budget requests $100 million for the Compassion Capital Fund, which creates public/private partnerships that support charitable organizations in expanding or emulating model social service programs.

Samaritan Initiative

The President's budget also continues and strengthens the Administration's commitment to end chronic homelessness by proposing $70 million for the Samaritan Initiative, a new competitive grant program jointly administered by the Departments of Housing and Urban Development, Health and Human Services, and Veterans Affairs that supports the Administration's efforts to end chronic homelessness by 2012. These grants will support the most promising local strategies to move chronically homeless persons from the streets to safe permanent housing with

supportive services. Of the $70 million for the program, we are requesting $10 million at HHS for supportive services.

Domestic and Global Health Improvements

I would like to take a moment to share with the Committee a few other priorities that strengthen our efforts for a healthier U.S. Building on the accomplishment of the five-year doubling of the National Institutes of Health (NIH) budget, this year's budget proposal includes $28.6 billion for NIH. These funds will continue to support the long-term stability of the biomedical research enterprise and ensure continued productivity in all areas of research at NIH. To bring medical research and advances to those who need it, $1.8 billion of the HHS budget proposal provides health care services to 15 million individuals through the Health Center program and an increase for the National Health Service Corps to initiate recruitment of nurses and physicians.

The President's budget proposal for FY 2005 also strives to meet the needs of our vulnerable populations. To protect our children from preventable illness, the budget proposes improvements to the Vaccines for Children (VFC) program to increase access to needed vaccines for underinsured children. In an effort to ensure we have enough vaccines when they are needed, the HHS budget request calls for a six-month stockpile of all regularly recommended vaccines for children, as well as for a stockpile of influenza vaccine for next winter. In addition to our Nation's children, we must not forget those struggling yet who are ready to help themselves out of the cycle of addiction and dependency. For FY 2005, the President proposes to double the Access to Recovery State Voucher program, for a total of $200 million, to provide vouchers to approximately 100,000 individuals seeking substance abuse treatment services.

Our Nation's health, Mr. Chairman, is not dependent solely on access to care and treatment, but also on the security of our health in a global context. Our Nation faces threats from bioterrorism, disease outbreaks in other countries, and food-borne diseases and illnesses. The HHS budget targets $373 million of investments to accelerate the detection of and response to potential disease outbreaks of any kind, regardless of whether the pathogen is naturally occurring or intentionally released. The Food and Drug Administration (FDA) has already expanded its work dramatically to prevent intentionally contaminated foods from entering the U.S. The President's FY 2005 budget takes the next step by making the needed investments in FDA to expand substantially the laboratory capacity of its State partners, and to find faster and better ways to detect contamination, particularly at ports, processing plants, and other food facilities.

Management Improvements

Finally, I would like to update the committee on the Department's efforts to use our resources in the most efficient manner. To this end, HHS remains committed to setting measurable performance goals for all HHS programs and holding managers accountable for achieving results. I am pleased to report that HHS is making steady progress. We have made strides to streamline and make performance reporting more relevant to decision makers and citizens. As a result, the Department is better able to use performance results to manage and to improve programs. By raising our standards of success, we improve our efficiency and increase our capability to improve the health of every American citizen.

Improving the Health, Safety, and Well-being of Our Nation

Mr. Chairman and members of the Committee, the budget I bring before you contains many different elements of a single proposal. The common thread running through these policies is the desire to improve the lives of the American people. Our FY 2005 HHS budget proposal builds upon our past successes to improve the Nation's health; to focus on improved health outcomes for those most in need; to promote the economic and social well-being of children, youth, families, and communities; and to protect us against biologic and other threats through preparedness at both the domestic and global levels. It is with the single, simple goal of ensuring a safe and healthy America that I have presented the President's FY 2005 budget today. I know this is a goal we all share, and with your support, we at the Department of Health and Human Services are committed to achieving it.