S. HRG. 99-494

NOMINATION OF DR. OTIS R. BOWEN

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

ON

NOMINATION OF

DR. OTIS R. BOWEN TO BE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

DECEMBER 10, 1985

Printed for the use of the Committee on Finance

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NOMINATION OF OTIS R. BOWEN, M.D., TO BE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

TUESDAY, DECEMBER 10, 1985

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The committee met, pursuant to notice, at 10:32 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Bob Packwood (chairman) presiding.

Present: Senators Packwood, Chafee, Heinz, Grassley, Long, Bentsen, Moynihan, Baucus, Boren, Bradley, and Mitchell.

[The press release announcing the hearing and the opening statements of Senators Bob Dole, David Boren, and George Mitchell follow:]

[Press Release No. 85-092]

PRESS RELEASE

(For Immediate Release, Wednesday, December 4, 1985)

NOMINATION HEARING FOR GOVERNOR BOWEN SCHEDULED DECEMBER 10

The nomination of Governor Otis R. Bowen, M.D., as Secretary of the Department of Health and Human Services will be reviewed by the Committee on Finance at a hearing scheduled December 10, Chairman Bob Packwood (R-Oregon) announced today.

Senator Packwood said the Committee would convene at 9:30 a.m., Tuesday, December 10, 1985, in Room SD-215 of the Dirksen Senate Office Building.

President Ronald Reagan today submitted to the Senate the nomination of Governor Bowen to be Secretary of HHS. Governor Bowen will succeed Margaret Heckler, who will be nominated as Ambassador to Ireland.

Governor Bowen currently is the Lester D. Bibler Professor of Family Medicine and Director of Undergraduate Family Practice Education at the Indiana University School of Medicine, in Indianapolis. He is 67 and a native of Richland Center, Indiana.

The Secretary-designate served two terms as Governor of Indiana, 1973-1981. He was Chairman of the President's Advisory Council on Social Security, August 1982 to December 1984.

After completing three years of service with the U.S. Army Medical Corps in the Pacific Theatre during World War II, Governor Bowen served in the Indiana legislature for fourteen years and practiced family medicine from 1946 to 1973.

STATEMENT OF SENATOR BOB DOLE

CONFIRMATION HEARING

OTIS R. BOWEN

MR. CHAIRMAN. IT IS NOT UNCOMMON FOR NOMINEES TO BE WELL SUITED FOR THE POSITIONS THEY WILL ULTIMATELY HOLD. BUT RARELY IS THERE A PERSON SO EMINENTLY QUALIFIED AS OTIS BOWEN IS TO BE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

BECAUSE HHS IS ONE OF THE LARGEST FEDERAL DEPARTMENTS, AND HAS THE BIGGEST BUDGET, THE PERSON WHO HEADS THE DEPARTMENT MUST BE AN EXCEPTIONAL MANAGER. I CAN THINK OF NO BETTER PREPARATION FOR RUNNING HHS THAN BEING THE CHIEF EXECUTIVE OF A LARGE AND DIVERSE STATE. AND AS GOVERNOR OF INDIANA, A JOB HE HELD FOR EIGHT YEARS, OTIS BOWEN PROVED HIMSELF TIME AND AGAIN A COMPETENT AND EFFECTIVE ADMINISTRATOR.

OTIS BOWEN HAS CONTINUED HIS PUBLIC SERVICE, SERVING AS CHAIRMAN OF THE 1982 ADVISORY COUNCIL ON SOCIAL SECURITY AND A MEMBER OF THE PRESIDENT'S ADVISORY COMMITTEE ON FEDERALISM. HE NOW SERVES ON SENATOR LUGAR'S FEDERAL JUDICIARY APPOINTMENTS COMMISSION.

ENHANCING HIS EXPERTISE IN RUNNING A LARGE AND COMPLEX BUREAUCRACY, IS DR. BOWEN'S EXPERIENCE AS BOTH A PRACTITIONER AND A TEACHER OF FAMILY MEDICINE. THE DEPARTMENT OF HEALTH AND HUMAN SERVICES SETS FEDERAL GOVERNMENT POLICY ON ALL MATTERS CONCERNING HEALTH CARE. IT IS ONE OF THE CHIEF MISSIONS OF THE DEPARTMENT, ONE OF GREATEST CONCERN TO ALL AMERICANS. AND TO HAVE SOMEONE AT THE HELM OF THE DEPARTMENT, WHO HAS HAD PERSONAL EXPERIENCE AS A PHYSICIAN AND A PROFESSOR OF MEDICINE WILL PROVIDE THE ADMINISTRATION WITH CRITICAL KNOWLEDGE IN DEVELOPING HEALTH POLICY AND INCREASE THE AMERICAN PUBLIC'S FAITH IN THE ADMINISTRATION'S HEALTH AGENDA.

MR. CHAIRMAN, I WISH THAT ALL NOMINEES WHO CAME BEFORE THE SENATE COULD PRESENT THE KIND OF CREDENTIALS DR. BROWN WILL BRING TO THIS JOB.

AS WE ALL KNOW, HHS WILL BE FACING REAL CHALLENGES IN THE MONTHS AHEAD AS THE DEPARTMENT CONFRONTS SEVERE BUDGET CONSTRAINTS. SO, MR. CHAIRMAN, I HOPE AND TRUST THAT THIS COMMITTEE AND THE FULL SENATE WILL QUICKLY CONFIRM DR. BOWEN, SO HE CAN BE IN PLACE AT HHS AS THE NEW YEAR CYCLE BEGINS.

Statement of Sen. David Boren

I am very pleased that the President has nominated Dr. Otis Bowen for the position of Secretary of Health and Human Services. I have known Dr. Bowen for many years, having worked with him during the period in which we both served as governors of our respective states.

As a physician and former governor, Dr. Bowen is extremely well qualified to serve as Secretary of HHS. He has a special appreciation for the problems and frustrations that state officials often experience in trying to administer federal programs. His nomination should be a source of encouragement for those at the state level who all too often feel there is a lack of understanding within the federal bureaucracy for the difficulties states encounter in the federal-state partnership.

I can think of no one who is more qualified than Otis Bowen to take on the difficult task of managing the federal government's largest department. I look forward to working with him, and I applaud the President for this outstanding nomination.

Statement of Senator George J. Mitchell
Committee on Finance
Hearing to Consider the Nomination of
Otis R. Bowen to be Secretary of
The Department of Health and Human Services
December 10, 1985

Mr. Chairman, I commend you for promptly scheduling this hearing to consider the nomination of Otis R. Bowen as Secretary of the Department of Health and Human Services.

I want to join with my colleagues on the Finance Committee in welcoming Governor Bowen here today. I had the pleasure of meeting with Governor Bowen several weeks ago and found him to be a person with an impressive background in a number of areas relative to the position for which he is nominated.

The Department of Health and Human Services is one of the largest and most complex agencies in the Federal Government. This Agency is the caretaker of the nation's most vulnerable citizens, including children, the elderly and the poor. The person chosen to lead this department must be a skillful administrator who can balance the need to control the enormous costs of the agency with genuine concern and compassion for those who rely upon its programs.

In recent months we have become aware of serious problems with a number of important programs administered by the Department of Health and Human Services. Several weeks ago the Subcommittee on Social Security held a hearing to address the recent divestiture of social security bonds by the Department of the Treasury. Clearly, issues such as this one need to be addressed by both the Congress and the Executive Agencies in question.

I believe that Governor Bowen will contribute much valuable expertise in the field of health care, as well as many years of experience in both the Legislative and Executive branches of state government, to the position of Secretary of Health and Human Services.

Governor Bowen has also served on several Advisory Committees at the request of Presidents Nixon, Ford and Reagan. His position as Chairman of the Advisory Council on Social Security from 1982 to 1984 will be valuable experience as he takes on the enormous task of administering the Department of Health and Human Services. ~~which includes the Social Security Administration.~~

I look forward to working with Governor Bowen in the coming months, and hope that this committee will have an opportunity to continue to review and improve the programs at the Department of Health and Human Services within its jurisdiction.

The CHAIRMAN. The hearing will come to order, please.

We are here this morning to consider the nomination of Gov. Otis Bowen to be the Secretary of Health and Human Services, and I would also like to welcome the Governor's wife, Rose. Rose, we are glad to have you with us.

It has been a real pleasure. I have met Governor Bowen three or four times over the years and was impressed with him then. I have been most impressed with him since he was nominated by the President. His FBI check, his résumé, everything about the man's background is exemplary, and I indicated to the administration that I wish all of the other nominees that they sent to us were as qualified as this man.

I can think of no one that we have had before this committee for years who is better suited for this position and that is clearly seconded by every accolade that I have found in his record.

The man does not have a blemish nor apparently an enemy, which is very unusual for somebody who has been in politics as long as he has been there. I know that we have both of the Senators from Indiana, and we have also Congressman Andy Jacobs here to introduce the Senator.

Senator Moynihan, do you have a statement?

Senator MOYNIHAN. Mr. Chairman, I had not intended to make a statement, but I will, just to clear up a matter that the press might note and that even Dr. Bowen might note and whom I welcome.

The chairman said that Dr. Bowen does not have an enemy. Evidently, he does. We have before us here on the committee, and I presume the press has it also, a statement from something purported to be the National Democratic Policy Committee, which states that the National Democratic Policy Committee has absolutely denounced the appointment of Otis Brown to be Secretary of Health and Human Services.

May I say several things? First of all, the National Democratic Policy Committee is neither national nor is it democratic nor is it a committee. It is a wholly owned operation of Mr. Lyndon LaRouche, of whom the less said the better. [Laughter.]

And I had some very difficult questions to address to you, but now that I see that Mr. LaRouche has absolutely denounced your appointment, you have my absolute support. [Laughter.]

The CHAIRMAN. Senator Bentsen.

Senator BENTSEN. Thank you, Mr. Chairman. I have a number of questions. I am not going to let him get by that easily, but I would like to ask if we have had opening statements already.

The CHAIRMAN. We have just started.

Senator BENTSEN. Are we ready for questions?

The CHAIRMAN. No.

Senator BENTSEN. All right, then. I will work on him later. [Laughter.]

The CHAIRMAN. Senator Chafee, do you have an opening statement?

Senator CHAFEE. No, I don't, Mr. Chairman. I just want to welcome Dr. Bowen here and say that I think his chances of confirmation are excellent. [Laughter.]

The CHAIRMAN. Senator Lugar.

STATEMENT OF HON. RICHARD G. LUGAR, U.S. SENATOR FROM THE STATE OF INDIANA

Senator LUGAR. Thank you very much, Mr. Chairman and members of the committee. It is an honor and a privilege today to introduce to this distinguished committee Otis R. Bowen, M.D., nominee for Secretary of the Department of Health and Human Services.

I am a long-time personal friend of Doc Bowen, and I have been impressed by his public career of extraordinary compassionate service and achievements. Doc Bowen's expertise in the health and human services arena is nationally recognized. He was Chairman of the Advisory Council on Social Security which published Medicare benefits and financing.

He has had extensive experience in dealing with health professionals, both as Governor of Indiana and as a practicing physician. Moreover, he has kept abreast of the rapid changes in health care as professor of family medicine at Indiana University School of Medicine.

Governor Bowen is one of Indiana's most respected and influential public leaders. He served in the Indiana House of Representatives for 14 years and was speaker of the house for 6 years. Doc Bowen served 8 years as Governor of Indiana, the first Indiana Governor to be elected to two terms in office. Doc Bowen established a record of fiscal conservatism in the office of Governor that had administration of 28,000 employees and a biannual budget of $12 million. He instituted a comprehensive property tax relief program, which brought about many favorable economic changes in Indiana. During his governorship, he was Chairman of the National Governors Conference, the Republican Governors Conference, and the Midwest Governors Conference.

Until this Presidential nomination, he has served as Chairman of the Indiana Merit Selection Panel on Federal Judicial Appointments.

Mr. Chairman, Doc Bowen's professional accomplishments speak for themselves. He is held in the highest esteem by his professional colleagues, his constituents, and his friends and has demonstrated an outstanding record of administrative ability and fiscal integrity.

It is a privilege to introduce him to this committee and to urge your support for his confirmation.

The CHAIRMAN. Thank you very much. Senator Quayle.

STATEMENT OF HON. DAN QUAYLE, U.S. SENATOR FROM THE STATE OF INDIANA

Senator QUAYLE. Thank you, Mr. Chairman; after listening to Senator Moynihan's statement, I guess we ought to also thank Mr. LaRouche. Be that as it may, I join with my senior colleague in bringing to this committee an outstanding nominee for Secretary of HHS.

I can tell you with firsthand knowledge that Doc Bowen was not one who was seeking the job; we sought it for him. As a matter of fact, over the course of time we have been trying to convince him that we are doing him a favor by letting him come out and bring a great deal of efficiency and respect to HHS, and he has yet to be convinced of that. However, when he gets over there and takes

charge of a very very difficult job, I think that you will soon learn what we learned in Indiana, and that is that this gentleman brings a tremendous amount of respect and credibility to a Government policy position.

The White House has described him as a "triple crown" nominee. Now, that has a lot of different connotations to different people, but what they were saying is that he has tremendous administrative capabilities, is an experienced physician, and has a great deal of political sensitivity and ability.

I can only tell you about his outstanding service as speaker of the house of representatives in Indiana, his outstanding service as a physician in the small town of Bremen, IN—that will now be on the map forever, at least in the annals of HHS—and his outstanding service as Governor of the State of Indiana. You know, this man practices a very quiet type of medicine, not only in his practice with his patients over the years, but also in the medicine that he delivered to 5.5 million Hoosiers for 8 years as Governor of our State.

Being a recipient of that medicine, we sort of enjoyed it: he brought a lot of economic growth and jobs and opportunities to that State.

I am sure that this committee will ask good policy-oriented questions, and he will give you the answers straight from the shoulder. I can tell you one thing: Doc Bowen does not have a hidden agenda. He will tell it like it is. He has told that to us in the State of Indiana over the years.

It is just with a great deal of gratitude that I join my senior colleague in supporting Doc Bowen's nomination. I am glad to see Congressman Jacobs and Congressman Hillis here joining in this effort. We wish the Governor well. We believe that he is, as Senator Chafee pointed out, an outstanding appointment and one with an excellent chance for confirmation. I hope that it is one without dissent because that is certainly the way that I feel about this. I certainly wish the Governor and his wife, Rose, very well in what will be a very, very tough job. It is a tough job, but a tough job going to a person who has done it before, and who will certainly do it again.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you very much. Congressman Jacobs.

[The prepared written statement of Senator Quayle follows:]

STATEMENT OF U.S. SENATOR DAN QUAYLE (R-IN)
BEFORE THE SENATE COMMITTEE ON FINANCE
ON THE NOMINATION OF FORMER INDIANA GOVERNOR OTIS R. BOWEN, M.D.,
TO BE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DECEMBER 10, 1985

It is with a great deal of personal pleasure and pride that I appear before this Committee today to introduce one of Indiana's favorite sons, former Indiana Governor Otis R. "Doc" Bowen, M.D., who has been nominated by President Reagan to be the Secretary of the U.S. Department of Health and Human Services.

When the White House announced his nomination, Doc Bowen was described as a "triple crown" nominee. I could not agree more. Governor Bowen is uniquely qualified for this demanding post by virtue of his political experience, his demonstrated administrative competence and his expertise as a physician.

I am confident that Doc Bowen will be able to meet successfully the rigorous challenges presented by this position. The administrative problems and politically sensitive issues that the Secretary of Health and Human Services must face on a daily basis are awesome, and I am convinced that Governor Bowen is one of the very few individuals capable of taking on a task of such magnitude.

[MORE]

Doc Bowen has shown great skill as both a political leader and administrator throughout his career, which has included 14 years in the Indiana General Assembly, where he was Speaker of the House for six years, and two distinguished terms as Governor of Indiana. By virtue of his record as chief executive of the Hoosier State over an eight-year period, Governor Bowen remains today one of the most popular public servants in the history of Indiana.

Doc Bowen has been a practicing physician for 44 years, including 26 years as a family doctor in his home town of Bremen. He has regularly contributed articles to medical journals, and most recently he has been Lester D. Bibler Professor of Family Medicine and Director of Family Practice Education at the Indiana University School of Medicine in Indianapolis. As Chairman of President Reagan's Advisory Council on Social Security, he demonstrated his knowledge of the problems confronting the federal Medicare and Medicaid programs, which he will be charged with administering as Secretary of Health and Human Services.' In addition, Governor Bowen showed his ability to devise innovative and successful solutions to the problem of health-care inflation when he worked with the Indiana General Assembly in 1975 to enact a law to curb medical malpractice costs that has been used as a model by a number of States.

[MORE]

When confirmed, Doc Bowen will become the first physician to head the federal agency that has such enormous influence over health policy in this country. I believe that his medical background and his reputation in the medical community make him ideally suited to lead the Department of Health and Human Services during a time that is one of the most turbulent the health care industry has ever known in our country.

I believe President Reagan chose Doc Bowen because he is the best person for the job. It's that simple. There is no doubt in my mind that time will prove that the President was right. I urge my colleagues to support the President's nominee.

STATEMENT OF HON. ANDREW JACOBS, JR., U.S. REPRESENTATIVE FROM THE STATE OF INDIANA

Congressman JACOBS. Thank you, Mr. Chairman. I don't think the U.S. Senate would ever regret confirming this appointment. You wouldn't have to go very far to do worse; and you would have to go a long, long way to do better, I think.

Dr. Bowen is competent, he is honest, and he is a nice guy. He not only has executive experience; he also has extensive legislative experience; and I predict before he finishes this job, he will have a lot more legal, judicial experience. [Laughter.]

Doc Bowen reminds me of that old ad about Sara Lee cakes: Where I come from, nobody doesn't like Dr. Bowen. Actually, from what Senator Quayle said, you might infer that we are thrusting Dr. Bowen into this nearly impossible task. With friends like us, Doc, you really don't need any enemies. [Laughter.]

If Dr. Bowen has an enemy at all, it is probably the common cold germ; so I hope that the U.S. Senate will speedily confirm this nomination, so that the United States can commence to benefit from this wonderful, wonderful, wonderful man.

The CHAIRMAN. Thank you. Congressman Hillis.

STATEMENT OF HON. ELWOOD HILLIS, U.S. REPRESENTATIVE FROM THE STATE OF INDIANA

Congressman HILLIS. Thank you. It is certainly a pleasure and a privilege to be here this morning on behalf of my good friend, Dr. Bowen. I am not going to go back over all of the accomplishments that have been stated. You have them there in the record, and they are all accurate and true.

I had the good fortune to serve as his colleague in the house of representatives in the State of Indiana. I first got to know Dr. Bowen and learned to like him and love him there. I think that I recall in my service and in his public service is that he had a motto when he was Governor that "he hears you," and he has always had

that air about him. And I am sure that when the confirmation is completed and he is sworn in and takes this high office that he will not only do it well, but he will carry that motto into practice there of being one public servant and Government official who hears the people out there; and in his administration of that office, he will do what he can to see that it is administered very fairly and efficiently.

I am happy to be here in his support.

The CHAIRMAN. Congressman, thank you very much.

Governor, do you have a statement?

Dr. BOWEN. Yes, sir, I do.

The CHAIRMAN. The Members of Congress may be excused, if they would like. You are welcome to stay.

Congressman JACOBS. I have a prepared statement that I would like to have included in the record.

The CHAIRMAN. Without objection.

STATEMENT OF OTIS R. BOWEN, M.D., SECRETARY-DESIGNATE OF HEALTH AND HUMAN SERVICES

Dr. BOWEN. Before they leave, I might say that, after hearing all of their comments, I am a little embarrassed; but I am grateful to them and want to thank Senator Lugar and Senator Quayle and Congressman Jacobs and Congressman Hillis for being here. Thank you very much.

Mr. Chairman and members of the committee, I am deeply honored to appear before you as President Reagan's nominee to be Secretary of the Department of Health and Human Services.

My visits with the members of this committee have convinced me that the job as head of the largest and most complex Department of the Federal Government will be challenging. I pledge to you that I will immediately recruit the most able and qualified individuals to fill the many key vacancies at HHS. I will seek your guidance and cooperation as I set out to manage the Department and guide its policies.

The real significance of the Department is its impact on the lives of all Americans. The enormous programs of the Health Care Financing Administration, the Social Security Administration, and the far-reaching programs of the Public Health Service, and the Office of Human Development Services must continually be considered in terms of their effectiveness and the Federal budget deficit. Creative thinking needs to be instilled into the structure, management, and operation of these programs.

Important progress has been made by the Reagan administration and the Congress in improving the efficiency of health care delivery. I hope to be able to contribute to the refinements so essential to move to a more competitive health system.

With my background, you can be sure that I will not allow the quality of health care in this country to be sacrificed. In addition, you can be sure that I am deeply interested in fostering efforts to strengthen families and promote individual self-reliance. Our crucial challenge is to be sensitive to the needs of beneficiaries, providers, and taxpayers. In a larger sense, we must balance these needs while retaining quality and restraining costs. Once that balance

has been struck, with unity of purpose and honesty of communication, we will most effectively ensure that Americans will have access to the services that we provide.

And I welcome, with God's help, this challenge.

Mr. Chairman, I will be happy to respond to questions.

[The prepared written statement and resume of Dr. Otis R. Bowen, and a letter from the Office of Government Ethics follow:]

STATEMENT OF GOVERNOR OTIS R. BOWEN, M.D.

SECRETARY-DESIGNATE OF HEALTH AND HUMAN SERVICES

BEFORE THE COMMITTEE ON FINANCE

UNITED STATES SENATE

DECEMBER 10, 1985

STATEMENT OF GOVERNOR OTIS R. BOWEN, M.D.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE I AM DEEPLY HONORED TO APPEAR BEFORE YOU AS PRESIDENT REAGAN'S NOMINEE TO BE SECRETARY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

MY VISITS WITH THE MEMBERS OF THIS COMMITTEE HAVE CONVINCED ME THAT THE JOB AS HEAD OF THE LARGEST AND MOST COMPLEX DEPARTMENT OF THE FEDERAL GOVERNMENT WILL BE CHALLENGING. I PLEDGE TO YOU THAT I WILL IMMEDIATELY RECRUIT THE MOST ABLE AND QUALIFIED INDIVIDUALS TO FILL THE MANY KEY VACANCIES AT HHS. I WILL SEEK YOUR GUIDANCE AND CO-OPERATION AS I SET OUT TO MANAGE THE DEPARTMENT AND GUIDE ITS POLICIES.

THE REAL SIGNIFICANCE OF THE DEPARTMENT IS ITS IMPACT ON THE LIVES OF ALL AMERICANS. THE ENORMOUS PROGRAMS OF THE HEALTH CARE FINANCING ADMINISTRATION, AND THE SOCIAL SECURITY ADMINISTRATION, AND FAR-REACHING PROGRAMS OF THE PUBLIC HEALTH SERVICE AND THE OFFICE OF HUMAN DEVELOPMENT SERVICES MUST CONTINUALLY BE CONSIDERED IN TERMS OF THEIR EFFECTIVENESS AND THE FEDERAL BUDGET DEFICIT. CREATIVE THINKING NEEDS TO BE INSTILLED INTO THE STRUCTURE, MANAGEMENT AND OPERATION OF THESE PROGRAMS.

IMPORTANT PROGRESS HAS BEEN MADE BY THE REAGAN ADMINISTRATION AND CONGRESS IN IMPROVING THE EFFICIENCY OF HEALTH CARE DELIVERY. I HOPE TO BE ABLE TO CONTRIBUTE TO THE REFINEMENTS SO ESSENTIAL TO MOVE TO A MORE COMPETITIVE HEALTH SYSTEM. WITH MY BACKGROUND YOU CAN BE SURE THAT I WILL NOT ALLOW

THE QUALITY OF HEALTH CARE IN THIS COUNTRY TO BE SACRIFICED! IN ADDITION YOU CAN BE SURE THAT I AM DEEPLY INTERESTED IN FOSTERING EFFORTS TO STRENGTHEN FAMILIES AND PROMOTE INDIVIDUAL SELF-RELIANCE.

OUR CRUCIAL CHALLENGE IS TO BE SENSITIVE TO THE NEEDS OF BENEFICIARIES, PROVIDERS AND TAXPAYERS. IN A LARGER SENSE, WE MUST BALANCE THESE NEEDS WHILE RETAINING QUALITY AND RESTRAINING COST. ONCE THAT BALANCE HAS BEEN STRUCK, WITH UNITY OF PURPOSE AND HONESTY OF COMMUNICATION, WE WILL MOST EFFECTIVELY ENSURE THAT AMERICANS WILL HAVE ACCESS TO THE SERVICES THAT WE PROVIDE.

I WELCOME THIS CHALLENGE.

MR. CHAIRMAN, I AM HAPPY TO RESPOND TO YOUR QUESTIONS.

CURRICULUM VITAE
OTIS R. BOWEN, M.D.

CURRENT POSITION	Lester D. Bibler Professor of Family Medicine and Director, Undergraduate Family Practice Education
BUSINESS ADDRESS	Department of Family Medicine Indiana University School of Medicine 1100 West Michigan Street Indianapolis, IN. 46223 (317) 264-4971
DATE OF BIRTH	February 26, 1918
PLACE OF BIRTH	Richland Center, Indiana
MARITAL STATUS	Married, February 25, 1939 formerly Elizabeth Ann Steinmann (deceased 1/1/81) Children: Richard H. Bowen, Judith I. McGrew, Timothy R. Bowen, and Robert O. Bowen Married, September 26, 1981 formerly Rose May Hochstetler
RELIGION	Lutheran (St. Paul's Lutheran Church, Bremen, In. and Pleasant View Lutheran Church, Indianapolis, In.
EDUCATION	Indiana University, Bloomington, Indiana A.B. Degree in Chemistry - 1939. Indiana University School of Medicine, Indianapolis, IN. M.D. Degree - 1942. Rotating Internship, Memorial Hospital South Bend, Indiana, 1942 - 1943.
ARMED SERVICE	United States Army Medical Corps, Pacific Theatre, World War II, 1943 - 1946.
POLITICAL, GOVERNMENTAL POSITIONS	Coroner, Marshall County, Indiana, 1952 - 1956. Indiana House of Representatives, Republican Member, 1957, 1958, 1961 - 1972; Minority Leader, 1965 - 1966; Speaker (three terms), 1967 - 1972. Legislative Council; Indiana General Assembly: Vice Chairman, 1967 - 1968; 1969 and 1971; Chairman, 1970 and 1972. Delegate, Republican National Convention, 1972 and 1976. Governor, State of Indiana, (two terms) 1973 - 1981.

GOVERNMENTAL AFFILIATIONS

Past

Chairman, Advisory Council on Social Security 8/1982 to 12/1984. (President Ronald Reagan).
Member, Advisory Council, United Student Aid Fund.
Member, Two Year Study of Nursing and Nursing Education, Institute of Medicine, National Academy of Sciences, 2/1981 to 2/1983.
Member, Presidential Advisory Committee on Federalism, 4/1981 to 12/1982 (President Ronald Reagan).
Republican Governor's Association, Member, 1973-1981; Chairman, 1978-1979.
Chairman, Midwest Governor's Conference, 1973-1979.
Education Commission of the States, Member, 1973-1981; Chairman, 1977-1978.
Executive Committee, Council of State Governments, Member, 1973-1981.
National Governor's Association, Member, 1973-1981; Committee Member, 1972-1978; Chairman, 1978-1979.
Midwest Governor's Great Lakes Caucus, Member, 1973-1981.
Advisory Commission on Intergovernmental Relations, Member, 1977-1979, (President Gerald R. Ford).
Interstate Mining Compact Commission, Chairman, 1978.
National Governor's Association, Committee on Crime Reduction and Public Safety, Chairman, 1973-1978.
President's Committee on Science and Technology, Member, 1976-1977, (President Gerald R. Ford).
Commission on Federal Paperwork, Member, 1975-1977, (President Gerald R. Ford).

Present

Member, Senator Lugar's Federal Judicial Appointments Commission, 1981 to present.
Board of Directors and Subscribing Member, Hoosier Celebration '88, Inc. (with Governor Robert D. Orr and former Governor Matthew E. Welsh). An Indiana not-for-profit corporation organized for the purpose of promoting Indiana, to increase community pride and to engage in constructive planning for economic opportunities for Indiana and its residents.

GOVERNING ROLES: EDUCATIONAL, CIVIC AND PRIVATE INSTITUTIONS

Past

Member, Board of Trustees, Valparaiso University, 1978 to 10/1984.
Member, Board of Directors, Indiana Science Education Fund, to 11/1984.
Member, Advisory Committee, Vincennes University.
Member, Board of Directors, Center for Public Service, Anderson College (Honorary).
Member, Board of Trustees, Ancilla College, 1970 to 1976.
Member, Board of Directors, Greater Indianapolis Council on Alcoholism, Inc./NCA, 9/1982 to 10/1984. (on non-active status).
Member, Advisory Board, Indianapolis Chapter, Fellowship of Christian Athletes.
Member, Board of Directors, United States Track and Field Hall of Fame, Inc. to 5/1984.
1982 Christmas Gift Chairman, Mental Health Association of Indiana Inc.
Chairman, Cancer Crusade, American Cancer Society, Indiana Division, 1981-1982.
Honorary Chairman, American Red Cross, Indianapolis Area Chapter, African Relief Campaign, 12/1984 to 5/1985.
Member, Board of Visitors, School of Public and Environmental Affairs, Indiana University, 8/1982 to 6/1985.
Member, Board of Directors, BetaMED Pharmaceuticals, Inc., 10/1982 to 2/1985.
Member, Board of Directors, Hook Drugs, Inc., 2/1981 to 5/1985.
Member, Board of Directors, On Farm Computing, Inc., 11/1981 to 6/1985.
Member, Indiana State Medical Association, Committee on Medical Malpractice, 3/1982 to 12/1984.
Member, Board of Directors, Fairbanks Hospital Inc., Indianapolis, In. 8/1983 to 3/1984.

Present

Member, Board of Directors, Ivy Tech Foundation.
Chairman, Advisory Council, BACCHUS, 1979 to present.
Member and Past Chairman, Board of Governors, Woodburn Guild, Indiana University Alumni Association, 8/1981 to present.

GOVERNING ROLES:
continued

Present

Member, Board of Governors, Riley Memorial Association, 2/1981 to present.
Member, Board of Directors, Indiana Neuromuscular Research Laboratory, 3/1981 to present.
Member, Advisory Council, Indiana Cardinal Society, 1980 to present.
Member, Board of Directors (ex-officio), Family Support Center, Inc. 6/1981 to present.
Member, Advisory Council, Chemical Independent Children, Inc., 1982 to present.
Honorary Member, Board of Governors, Associated Colleges of Indiana, current.
Member, Board of Trustees, Leukemia Society, Indiana Chapter, 7/1981 to present.
Member, Board of Directors, Indiana State Chamber of Commerce, 1981 to present.
Member of the Cabinet, Campaign for Indiana, Indiana University, Bloomington, 6/1984 to present.
Chairman, Indiana Future Farmers of America Foundation Sponsoring Committee, 5/1984 to present.
Member, Advisory Board - Indianapolis, Campaign for Indiana, Indiana University, 7/1985 to present.

Member, Board of Directors and Executive Committee, Lilly Endowment, 2/1981 to present.
Member, Board of Directors, First Source Bank of Bremen, 2/1981 to present.
Member, Board of Directors, Indiana National Bank, 2/1981 to present.
Member, Board of Directors, Blue Shield of Indiana, 1981 to present.
Member, Board of Directors, Meridian Mutual Life Insurance Company, 1981 to present.
Member, Board of Directors, U.S. Care Corporation, 6/1982 to present.
Member, Board of Directors, Public Service Indiana, Plainfield, In. 6/1983 to present.
Member, Board of Directors, Indiana Bell Telephone Company, 12/1983 to present.
Member, Board of Directors, Health and Hospital Corporation, Indianapolis, In. 7/1985 to present.
Editor: Lifewise Report, 1985. (A weekly report on health matters for employees; owner is Harley Bierce, 2935 North Meridian St., Indianapolis, In.
Consultant, Dalton Founderies, Warsaw, In., 1985.

DIPLOMAS, FELLOWSHIPS AND HONORARY DOCTORATES

Diplomas: Divine Heart Seminary, 1971; Kewanna High School, 1980.
Fellowship: St. Joseph College, 1979.
Doctorates: Vincennes University, 1973; Valparaiso University, 1973; Butler University, 1973; Anderson College, 1973; Indiana University, 1976; Calumet College, 1976; Tri-State University, 1976; University of Evansville, 1977; Indiana State University, 1977; Rose Hulman Institute of Technology, 1977; Ball State University, 1978; University of Notre Dame, 1978; St. Mary's College, 1978; Manchester College, 1979; Hanover College, 1981; St. Joseph College, 1981; Marian College, 1982; Purdue University, 1982; Bethel College, 1982.

HONORS AND AWARDS

"Merit Award," Indiana Public Health Association, (Highest honor bestowed on an individual for outstanding achievement in public health), 1971.
"Alumnus of the Year" Award, Indiana University School of Medicine, Alumni Association, 1971.
First recipient of AMA's "Benjamin Rush" Award for outstanding contribution by a physician in citizenship and public service, 1973.
Medal of Honor, University of Evansville, 1975.
Medal of Honor, Valparaiso University, 1976.
Valparaiso University, eight Otis R. and Elizabeth A. Bowen Scholarships established on a permanent basis, 1981.
Indiana University - School for Public and Environmental Affairs, established a Beth Bowen Scholarship, 1981.
Ancilla College, Beth and Otis Bowen Scholarship Fund, established 1981.
Bethel College, Mishawaka, Indiana, built and on March 23, 1984 dedicated the Otis R. and Elizabeth A. Bowen Library.

United States of America
Office of Government Ethics

Office of Personnel Management
P.O. Box 14108
Washington, D.C. 20044

DEC 9 1985

Honorable Robert Packwood
Chairman, Committee on Finance
United States Senate
Washington, D.C. 20510

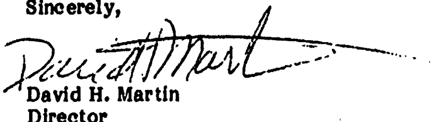
Dear Mr. Chairman:

In accordance with the Ethics in Government Act of 1978, I enclose a copy of the financial disclosure report filed by Otis R. Bowen, who has been nominated by President Reagan for the position of Secretary, Department of Health and Human Services (HHS).

We have reviewed the report and have also obtained advice from the Department of Health and Human Services concerning any possible conflict in light of the Department's functions and the nominee's proposed duties. According to HHS's transmittal letter of December 4, 1985, Dr. Bowen has agreed to divest himself of certain stock holdings and to resign from all organizations in which he is serving as an officer, director, trustee or consultant upon his confirmation by the Senate.

Based upon the foregoing information, we believe that Dr. Bowen is in compliance with applicable laws and regulations governing conflicts of interest.

Sincerely,



David H. Martin
Director

Enclosure

OGN 132-64-0
March 1985

The CHAIRMAN. Governor, as you are aware, not only have I had a longstanding interest in family planning and related issues, but at the moment, it has become in addition a very hot political topic. If you wouldn't mind, I would like to ask you a few questions in that area.

One, do you believe in family planning, and do you believe that Government expenditures to assist low- and moderate-income people in this area are proper and that they are a wise use of Government funds?

Dr. BOWEN. Yes; I do believe in family planning, Mr. Chairman. I believe Government expenditures to assist the low and moderate income people in this area are proper and that they are a wise use of Government funds.

The CHAIRMAN. Your predecessor, Secretary Heckler, has testified before congressional committees for 2 years that she accepts the finding of the GAO and the HHS auditors that title X family planning clinics do not use their Federal funds for abortion. She has further stated that she sees no need for further law or regulation in that area. Do you agree?

Dr. BOWEN. Mr. Chairman, I am not really familiar with the GAO and the HHS auditors' findings. I will need to review the reports and, in the meantime therefore, will certainly defer to Secretary Heckler's assessment. As I see the situation now, without having reviewed the reports, I would see no reason to alter her assessment.

The CHAIRMAN. Do you favor proposals that seek to require Federally funded family planning clinics to notify the parents of teenagers who receive family planning services?

Dr. BOWEN. As a father, personally, I would like to know. As a practical physician, I believe that unwanted pregnancies can be prevented by sexually active teenagers obtaining family planning services, if necessary without parental consent; and I will follow the law.

The CHAIRMAN. As you are aware, the issue of parental notification leads directly to the issue of the obligation of the executive branch to follow the law that is duly enacted by Congress and signed by the President. Two U.S. courts of appeals have ruled that the Department of Health and Human Services went far beyond and around congressional intent when it proposed parental notification regulations for title X in 1982. Do you agree that HHS went beyond the intent of the law, and can you give me some assurance that under your leadership HHS will be more responsive to congressional intent in the future?

Dr. BOWEN. As a potential member of the executive branch of the Government, I would deem it to be my responsibility to administer the laws as enacted by Congress and as signed by the President. It is the courts' responsibility to interpret the law, and I certainly will comply with the judicial decisions. So, yes, I shall comply with congressional intent as I understand it and to the best of my ability.

The CHAIRMAN. Governor, one of the things you are going to find that will frustrate you perpetually when you testify is that we get interrupted; we have a vote. I wonder if I might ask a couple of the members of the committee to go and vote now. It is a Hatfield

motion to table the Proxmire amendment. I do not know the subject of the amendment; but I will stay here until somebody can come back, and then I will go and vote.

Governor, Congress passed the Family Violence and Prevention and Services Act in October 1984, despite the formal opposition of the Secretary of Health and Human Services. In August 1985, Congress provided $6 million in the fiscal year 1985 supplemental appropriations bill and $2.5 million in fiscal year 1986 in the Labor-HHS-Education and related agencies appropriation bill for this purpose.

Now, my question is this: It is my understanding that HHS has not yet drafted the regulations necessary to implement the Family Violence and Prevention and Services Act. This program provides funds to victims of family violence, meaning any act or threatened act of violence which results or threatens to result in physical injury and is committed by a person related by blood or marriage or living together against another individual, including an elderly person.

Since August 16, 1985, $6 million has been available under this program. As I said, another $2.5 million is expected to be added to the pot when the Labor-HHS appropriation bill is signed into law; and I think it will be. Because no regulations have been drafted, let alone issued, no money can be disbursed to the States according to the law; and 85 percent of the funds appropriated for the program must be disbursed to the States. It concerns me that the Department appears to have let the ball drop with this program because it is not a priority with the administration.

What can you tell me to assure me and my colleagues that the program will not be ignored and that the funds will be disbursed to the States?

Dr. BOWEN. Mr. Chairman, I do find your question both enlightening and alarming, because this is an area that I personally regard as deserving immediate attention. Family violence, especially as it relates to teenagers, is one of my priorities. Suicides, homicides, and accidents are death by violent means and result in more teenage deaths than any other causes; but any family violence, to include spouse, child, and elder abuse, is very unacceptable to me. I would like to go on record with you now that, if I am confirmed, the regulations in question will be issued within the next 90 days.

The CHAIRMAN. Governor, that is very assuring, and I appreciate it. Senator Bentsen.

Senator BENTSEN. Mr. Chairman, I certainly am in accord with the members of this committee, I think the President has made an absolutely superb choice for Secretary; and I am looking forward to working with him after his confirmation.

Dr. Bowen, as the incoming Secretary, one of your responsibilities is going to be that of overseeing the Social Security Administration that employs over 80,000 people, and pays out over $200 billion a year to more than 50 million recipients. The agency has had an Acting Administrator for over 2 years in Martha McStein. I have listened to some very laudatory things about you today, and I think they are well deserved; but you know, I hear some of the same things about her from Republicans, Democrats, conservatives and liberals. She is a very able administrator.

Earlier this year, I asked the Secretary when the administration was going to proceed to fill that position with a confirmed appointee. It seems to me that, after 2 years, certainly action should be expedited in that particular agency; and that the Social Security Administration certainly deserves such attention. Would you care to respond?

Dr. BOWEN. Yes; obviously one of my first priorities would be to get a team in place—and by "team," I mean the highest qualified individuals in all of the vacancies, not only in the one that you are talking about—and then expect them to do their job.

Senator BENTSEN. Let me say to you, Doctor, that I certainly recommend for your very positive consideration Martha McStein, who serves in that position at the present time, as permanent administrator of the Social Security Programs.

Now, in looking at your qualifications, I am particularly impressed by the professional expertise that you have in the health arena. The Medicare Program is now undergoing a major transition to prospective payments using DRG's; and I think we will be well served by having a Secretary of HHS with your expertise and knowledge. But, I would like to talk to you about a situation that has developed with implementation of PPS. DRG-based payments use the average cost of a given service or a procedure to establish Medicare payment rates. In some instances, those average rates are simply insufficient to cover the cost of new or developing techniques. A case in point involves the Methodist Hospital of Houston, where Dr. Stanley Crawford has been developing a very complicated graft procedure to deal with aortic aneurysms. Approximately 250 procedures are performed each year at the Methodist Hospital, which amounts to 80 percent of all such procedures in the United States. Now, the doctor's patients fall into four DRG's—104, 105, 110, and 111. Two of those, 104 and 105, pay a higher rate because valve procedures are involved. However, a majority of cases don't require that procedure, so the reimbursement to the hospital is on the basis of DRG's 110 and 111. They are equally resource-intensive, but paid at the lower rate. In a nutshell, that means an annual loss to that hospital of $2.4 million, and that is substantial. But more importantly, are we going to encourage Methodist and other hospitals to turn away Medicare patients needing that procedure simply because you can't work out an appropriate coding? I would like to hear your views on that.

Dr. BOWEN. I think that the DRG system has accomplished a very good purpose, but it is still a relatively young program. It is one that continually will need some fine tuning. I am not truly familiar with all of the facets of the Methodist Hospital problem, but I can give you assurance that it will get my attention.

Senator BENTSEN. Early?

Dr. BOWEN. Early, yes. [Laughter.]

And I will want to consult on it with as many knowledgeable people as I can. I would be interested in hearing more of your specific views on it.

Senator BENTSEN. Doctor, I get more impressed with you all the time. [Laughter.]

Now, my final question. I know we share some views on trying to do something about catastrophic illness. Despite Medicare cover-

age, the elderly currently pay for more than half of their medical costs. Since 1965, over 100,000 individuals have absolutely exhausted their Medicare benefits. What I would like to hear are your comments on how we might finance a catastrophic benefit in the absence of mandatory copayments for the early days of a hospital stay? Would you be willing to support the development of a catastrophic component for the Medicare Program?

I would recommend you look at my bill, S. 569.

Dr. BOWEN. The number again?

Senator BENTSEN. S. 569. [Laughter.]

Dr. BOWEN. All right.

Senator, I presume, you are also aware that this is one of my main priorities, that is I believe we should make an attempt to ease the burden on our senior citizens in the areas of both acute catastrophic care and also long-term care for the people with Alzheimer's and this type of disease. I coauthored a paper which was just published, and I am sure that many of you have seen it. Although it was just published, it was written long before I was even approached for this particular position. Simply, the paper states that we can solve the problem of funding for acute catastrophic care by adding an actuarially sound premium to part B of Medicare.

Now, when the paper was written, the figures we used indicated that for about $12 a month added to the premium, you could get an unlimited number of hospital inpatient days. I can't verify if the figures have changed since that time. The individual would not be at risk for any coinsurance. However, the individual would still have to pay two deductibles for the first day of each admission, for example, if they should happen to be admitted two times in 1 year. Part B out-of-pocket expenses would have an upper limit of $350 per year. The need for the expensive medigap insurance would be greatly reduced. This would also eliminate the need for the 12.5-percent coinsurance for skilled nursing home care.

About 70 percent of all the patients do have medigap insurance, and the medigap insurance is usually considerably more than the $12 a month this additional premium would be. The reason that this could be done at such a low price, relatively, is that the cost of the catastrophic care would be spread across the 28 or 30 million people who are enrolled in the Medicare Program.

Senator BENTSEN. Doctor, I appreciate that. I see that our time to vote is running out. I would also like to say that Senator Pryor will want to submit some questions in writing, and he will be pleased to receive your answers.

Dr. BOWEN. Thank you.

The CHAIRMAN. Dr. Bowen, we are going to have to take about a 3- or 4-minute recess until somebody comes back to preside. We will go and vote, and we will be right back.

Dr. BOWEN. Thank you.

[Whereupon, at 11 a.m., the hearing was recessed.]

AFTER RECESS

Senator MOYNIHAN. The hearing will come to order, please. We apologize for having to leave the hearing to go and vote, but we do

want to ask questions of you; and if you will be patient with us, we are accustomed to ourselves and our own behavior. I have a number of matters to raise with you, and you will find as you go along that we pay special heed to those subcommittees on which we sit and legislation we carry on the floor, whose issues we follow.

In my case, I am the ranking member on this side on the Subcommittee on Social Security and Income Maintenance, and I think it would be the case that by far the largest portion of the budget as such of the Department of Health and Human Services is that occasioned by the outlays from the Social Security Administration. I guess that was a question.

Dr. BOWEN. Yes, I am aware that that is so, Senator.

Senator MOYNIHAN. We have had a number of concerns, of which the most symptomatic is our feeling that because of the organizational difficulties of managing such a different enterprise from the context of a policymaking Cabinet department, the Social Security Administration has not had anything like the share of administrative attention or executive energy that it ought to have. You could look at its present roster, sir, it acts as though the administration wished it to go out of business and, in fact, had planned for it to do. Of the five major officials in the Social Security Administration, all but one is an acting official. The Commissioner of Social Security has been acting since 1983. The Deputy Commissioner for Programs and Policy has been acting since 1983. The Deputy Commissioner for Management and Assessment has been acting since 1983. The Deputy Commissioner for Systems has been acting since 1984. The Associate Commissioner for Central Operations, the Regional Commissioner for Seattle is acting. I could go down through the list; it sounds more like Broadway than Baltimore.

There have been no permanent officials appointed. I mean, it is literally as if you were phasing this agency out and didn't want to plan on its being there in 5 years; and this is how you would do it. May I ask: Are you aware of this, and has anybody discussed this with you in the course of your preparation for this hearing?

Dr. BOWEN. Senator, I have refrained from even talking about personnel because I thought it might be presumptuous; but I have thought a lot about it. Obviously, the key to success in any administration is to get good people in the top spots and then expect them to do their job. That would be my goal, and I want to do it as rapidly as we possibly can.

Senator MOYNIHAN. You won't mind my saying, sir, that that is somewhat the equivalent of saying take two aspirins and get a good night's sleep? [Laughter.]

I mean, the simple fact is that the administration has chosen not to give permanent positions to anybody in the Social Security Administration. The second fact is that there are $31 billion of bonds missing from the trust funds. Are you aware of that?

Dr. BOWEN. Yes; I am aware of that.

Senator MOYNIHAN. My use of the term "missing" is obviously meant to be provocative. They aren't missing; they were cashed in. No one has run off to South America with them. We realize that; but they were cashed in.

Dr. BOWEN. It is my understanding, sir, that it was done as a result of the need to resolve the debt ceiling, and that it was done

for the timely payment of Social Security checks. There would be no question that I would prefer to see the fund made whole with the interest that should have come into it. Also, I would hope that communication between the Congress and the trust fund trustees might be such that each would know what the other was thinking.

Senator MOYNIHAN. Well, that anticipates my last question. I will just take the liberty to ask it. You do know, as you obviously stated, that this practice first occurred in 1984, and then started this time around in September. The Congress was never notified. It was only when we got someone from Treasury up here and under very harsh questioning did they admit to something that you would have thought would be a very open public matter, and that the public trustees, who were appointed in 1983, were not notified.

Could I ask, just as a general principle, while you are the head of HHS, if the Social Security administration remains within your department, could we just assume that as a matter of principle you would insist that if anything like this happened—it never happened before in 6 years—that the public trustees would be informed and that the Committee on Finance would be informed?

Dr. BOWEN. Senator, I was not aware that it had occurred in that manner.

Senator MOYNIHAN. Nor were we, sir.

Dr. BOWEN. I didn't know about it previously. Let me assure you that, since I have had a considerable number of years of service in the legislative branch and then as Governor for 8 more, I do recognize the importance of good communication between the legislative and executive branches, and I will do my best to see that that communication occurs.

Senator MOYNIHAN. Thank you, sir. I have more questions for a later round.

Senator CHAFEE. We will have another round. Senator Mitchell?

Senator MITCHELL. Thank you, Mr. Chairman. Governor Bowen, welcome; I look forward to working with you over the coming months on this committee. I would like to ask you about the Disability Review Program. As you will recall, we discussed this briefly during our private meeting a few days ago. As a result of the Disability Benefits Reform Act of 1984, the continuing disability review process has been revised to provide a medical improvement standard for review of continuing eligibility. At the same time, the evaluation process for cases of mental impairment has gone through a review and reform.

It has been brought to my attention that the delay in promulgation of regulations for determination of Social Security disability for mental impairment cases has resulted in many persons being in a category defined as just on hold for as long as since last April. In my own State of Maine, one of the smallest States in terms of population, more than 1,300 cases have been denied, and those persons have not been able to appeal their cases since April. I have a letter here from the director of a coalition for the psychiatrically labeled in Maine talking about this problem, and I would like to provide a copy to you. It is my understanding that final regulations determining mental impairment cases were published on November 26, but these guidelines cannot be administered until State Social Se-

curity personnel are trained. I have a couple of questions on this subject.

The first question is: When can we expect that the States will be able to process all of the mental impairment cases so that people will be able to know their status and, if appropriate, begin to receive benefits? Second, this leads into a broader question: The delay in promulgating these regulations is one example of hardships caused by consistent continuing delays on the part of the Department of Health and Human Services in publishing regulations on virtually every issue before it. Why, if you know, has this been the case? What can you do to improve it? Can you and will you do that?

Dr. BOWEN. Senator, I am not aware of why. By nature, I am a punctual individual, and I like to see things get out on time; and the only reason they wouldn't would be if there were a good reason why we couldn't do it. And again, this is an instance in which communication with Congress would be important. All I can do now is pledge that we will be as prompt as we possibly can in getting the rules and regulations out because we certainly do not want to create a hardship for any of those individuals who may be affected by this particular situation. I do realize that this has been very controversial in the last 2 or 3 years. I know that there has been great effort to improve the medical standards by which these cases will be judged and that there will be face-to-face meetings with those in question so that undoubtedly there will be many fewer errors made than were ever made before.

Whenever anyone is taken off a roll, I am sure there will be complaints, and we need to have absolute reasons for our actions.

Senator MITCHELL. I would like to ask you to look into that and provide me and the other committee members with a written report, specifically on the mental impairment case situation, which is a very serious one. I will give you a copy of this letter also. I would like to have you take a look at it after the hearing.

Dr. BOWEN. All right.

[The written prepared letter from the Portland Coalition for the Psychiatrically Labeled, furnished by Senator Mitchell follows:]

PORTLAND COALITION
For the Psychiatrically Labeled

'112-...

Attn: Christine Williams

November 25, 1985

Senator George Mitchell
151 Forest Ave.
Portland, Maine 04101

Honorable Senator Mitchell,

I am writing on behalf of the Portland Coalition to request your assistance in the resolution of a problem faced by many residents of the State of Maine. Specifically, the Social Security Administration has implemented a policy whereby the processing of claims of mental health consumers eligible for Social Security benefits has been administratively delayed until SSA staff completes training in the application of new eligibility guidelines.

The Social Security Administration states that it has adopted this policy in order to accomplish a transition from the "old" to the "new" regulatory guidelines. As a consequence, individuals who are 1) entitled to administrative reviews, 2) have filed initial claims, 3) are appealing a denied claim, or 4) who have cases in court are all left without benefits until administrative training is completed. This poses a severe and undue hardship upon eligible Social Security recipients, who are the victims of a decision by the administrators of the Social Security System that is designed to solve their institutional difficulties at the expense of thousands of mental health consumers.

We became aware of this problem when it happened to a Portland Coalition member. She applied for Social Security benefits last April and has been on "hold" ever since. She has absolutely no income and has had to resort to begging for city welfare for housing, food, medication, etc., for the past eight months. This is only one example of a nationwide problem brought about by the administrators of the Social Security Administration.

Further, this policy decision, as articulated in the SSA's "Legislative Implementation Update" of November 1985, has been intentionally kept from the public. We believe that public policy decisions must be accountable to the public at large, and we deplore the SSA's intentional stonewalling of this issue.

We will appreciate any assistance you may be able to provide in this matter, and we will be watching the developments concerning this issue with great interest.

Sincerely,

Dianne C. Côté

Dianne C. Côté
Executive Director

P.O. Box 4138, Station A Portland, Maine 04101

Senator MITCHELL. I would like to ask about another subject, and that is the peer review organization process. As you know, this was designed as a system of review of the newly implemented prospective payment system under Medicare when that was adopted. In Maine, a serious problem has arisen between the organization that received the contract, which is an organization from another State, and the physicians within the State. I had a lengthy go-around with Dr. Davis over this at previous hearings. I would like to ask you a couple of questions. If you can, respond now; and if not, provide me with a written response.

First, how does the Department, and more specifically the Health Care Financing Administration, review the PRO contractors to determine whether or not they are successful in carrying out provisions of their contract? What is the method? What are the standards? What is the mechanism for conducting that kind of review? Second, does the agency intend to hold open bidding for the next round of PRO contracts when this current 2-year contract period ends?

Third, will the agency revise its criteria, selecting a PRO contractor to include rates for a contract submitted by an organization within the same peer review? As you recall, Doctor, we talked about this. Of course, you are a practicing physician and were for many years in Indiana; and how would you feel if a doctor from Nebraska or from Colorado or Maine were selected to review the practices which you pursued in the practice of medicine in Indiana?

Dr. BOWEN. Senator, I will not be able to answer the questions you asked about the exact process, but I will make myself familiar with it.

[NOTE: A written response for the record is provided at the end of this transcript.]

Dr. BOWEN. I have become acquainted with the problem you addressed about Maine physicians being reviewed by a PRO in another State that is not even contiguous with Maine. If I were a physician in Maine, I would not like it.

Senator MITCHELL. Right. Not only not contiguous, but separated by two other States.

Dr. BOWEN. All right. So, it will get my attention, and we will hope that it can come out with a satisfactory solution.

Senator MITCHELL. Thank you very much. My time is up, so I want to just conclude by saying that I want to make clear that this is a problem that is nationwide. In other words, the whole concept of peer review organization, what its objectives are, how the selections were made, whether or not this was in fact principally a review mechanism or principally a budget reduction mechanism under the guise of review, all the questions that have to be answered, we will know when we get the answer to this. I just want to make clear that my interest is more than merely limited to my own State's situation. It is very much with the entire nationwide situation.

Dr. BOWEN. Yes, sir.

Senator MITCHELL. Thank you very much, Dr. Bowen.

Senator CHAFEE. Dr. Bowen, I am particularly interested in the long-term care of both the disabled and the elderly; and it is no

secret that we are having an ever-increasing percentage of our population that are elderly because the elderly are living much longer. I have statistics that indicate that the number of people over 80 will double in this country by the end of this century—in other words, in some 13 more years or 15 more years.

I am interested in what you think the approach should be toward the long-term care services for the elderly. In other words, should it be strictly through public resources, or should it be through private resources, or some mixture of both? Have you given much thought to that? As you know, the current system is Medicare, and then they exhaust their resources and go into Medicaid. It seems to me there ought to be a better way somehow involving the private insurance sector. Have you given much thought to that?

Dr. BOWEN. I have given some thought, in fact considerable thought, to not only the acute catastrophic illness problem but also to the long-term care question; that is a devastating problem to those who have illnesses such as Alzheimer's or other illnesses that are prolonged. This is essentially where your question is?

Senator CHAFEE. That is right. Yes.

Dr. BOWEN. I don't know that anyone has the proper answer. One solution I would like to see is the establishment of some system whereby there could be a voluntary individual medical account comparable to the individual retirement account.

Now I realize that this is a long-term solution, but you have to start sometime. Incidentally, this has not been costed out or actuarially tested, but it is an idea I think that should be examined. For example, at the onset of perhaps age 35 to 45, the money could be paid in during the highest earning years to a "health bank" either administered by the Federal Government or by the private sector. The money would be sheltered from taxes, and the person's estate would then remain safe irrespective of the outcome of the individual's health. And if death should occur before the age of 65 or should occur suddenly without the funds being used, then the amount plus a small amount of interest could be returned to the estate. I think the tax revenue loss would be minimal, but again, that would have to be tested.

This would also have the great potential of removing a lot of the need for the States' Medicaid programs, and it would not generate adverse selection because the individual would select the program when he or she was working and presumably was in a healthy condition. If an IMA account were insufficient to take care of certain individuals, perhaps this could be helped out with the accumulated interest in the health bank. It is just one idea for a long-term care solution.

Again, it would have to be almost in the next generation, but as I have said, we have to start some time. I don't know what an immediate action would be, perhaps, other than improvement and refinement of the programs that we have.

Senator CHAFEE. Thank you. I think that it is good that you are thinking along those lines because this situation is going to be with us in an increasing fashion in the years ahead. I would also like to talk to you about the Medicare waivers that now can be used for deinstitutionalization of the developmentally disabled, principally the retarded. In many sections of the country, they have had great

success in the community-based programs, and I would like to see increased thrust in that direction, particularly through the Medicaid waiver or making it permanent. I do have legislation dealing with that: The Community and Family Living Amendments of 1985, which is S. 873. I wonder what your reaction to that is—with the thrust toward the community-based living facilities for the, let's say, retarded, as opposed to the institutions. Did you do much of that in Indiana?

Dr. BOWEN. Yes, we did have that. Our statement was simply that we wanted to have the people housed in the least restrictive environment. We felt that that was a more humane method of handling it; and I agree that if the States can do it at equal or lesser cost, then the waivers ought to be given. I think many of the States do have waivers to accomplish that now.

Senator CHAFEE. That is right, but the trouble is that the waivers always keep you on pins and needles. You don't know whether the waiver is going to be withdrawn. I don't see why we don't get into a permanent situation, rather than doing all this by waiver. Have the Federal Government say that this is an acceptable method of using Medicaid funds.

Dr. BOWEN. The less red tape there is and the less pins and needles you have to sit on, the better I will like it. So, I would say that we would certainly look into that, and please keep us informed of your thoughts on it.

Senator CHAFEE. All right. Now, the last bell has just started. I think we will hold evervthing in abeyance here. Have you introduced your family? I would be interested in seeing your family.

Dr. BOWEN. Senator, the only family I have with me today is my wife, Rose. Maybe she could stand.

Senator CHAFEE. I am very glad to see you.

Dr. Bowen, and you have quite a few children, but they are not here?

Dr. BOWEN. Yes, we have 8 children between us and 20 grandchildren. I would mention that Rose already has the Christmas presents all wrapped and labeled and sent. [Laughter.]

Senator CHAFEE. I would say that is a bit of efficiency that is not too apparent in my household, I think. [Laughter.]

Fine. We will be in recess. I will go over and vote now, and the others will be back shortly.

Dr. BOWEN. Thank you.

[Whereupon, at 11:25 a.m., the hearing was recessed.]

AFTER RECESS

The CHAIRMAN. Governor, we apologize. Senator Boren has arrived and has questions, and I believe Senator Bradley does also. Senator Boren.

Senator BOREN. Thank you very much, Mr. Chairman. I apologize for being detained at another meeting and not being able to be here in the very beginning when my good friend, Governor Bowen, was first introduced. We had the privilege of serving together as Governors. He was known as a man of good judgment and of integrity, and I was pleased and gratified when I heard that the President had decided to name him for this post. That is a view held, I

would say unanimously, by all of us who served with him as Governors.

So, I am pleased to be able to at least get here before the questioning is over and to say this word of greeting on behalf of all of us to Governor Bowen.

Let me ask you about this, Governor. We have had some difficulties in our State recently with the regional office, and this happens from time to time. All of us as Governors experienced these problems—regional losses of Federal agencies. And it would appear to some of us that some regions are more aggressive than others; they don't exactly follow uniformly the same sorts of policies. I wonder what actions you would feel should be taken to make sure that all the regions are acting in an even-handed way, that policy is not being set at the regional level, but is being set here in Washington and implemented only at the regional level. And also, what do you feel would be the appropriate manner if a State or if a Governor, for example, were having trouble resolving something at the regional level? Would you be open to trying to resolve that at the Federal level here in Washington? And what procedures do you think should be followed?

Dr. BOWEN. Senator, thank you first for your kind comments, and it is good to see you again. The regional offices, in my judgment, would have to be considered as simply an arm of the office here, and certainly the policies should be the same; if they are not, then we need to make efforts to make sure that the policies are the same.

The answer to your other question is that my motto as Governor, as was mentioned by Representative Hillis, was: "He hears you." And that would be my aim in Washington, as well. I understand that there are a few million people who want me to hear them, and I will do my best to be as responsive as I possibly can to their problems.

Senator BOREN. Right. So, it would be your feeling that, for example, if a governor or a State Government could not get a problem resolved at the regional level, that within the bounds of reason and your schedule you would attempt to at least give them a hearing at the Secretarial level to try to resolve those difficulties?

Dr. BOWEN. I will do my very best.

Senator BOREN. I appreciate that answer. Mr. Chairman, I will have to say in all candor my mind is already made up about this nominee. I am going to enthusiastically vote for his confirmation, so I don't want to take time away from the other members of the committee.

The CHAIRMAN. Senator Bradley, then Senator Baucus, and then Senator Heinz.

Senator BRADLEY. Thank you very much, Mr. Chairman.

Governor, if you could, I would like you to share with us a little bit your attitude toward long-term health care for the elderly. I know of your support and record on catastrophic coverage; and yet, when we see the increasing longevity of elderly, it raises the issue of long-term health care. What is your general attitude toward the Federal role in helping to provide for long-term health care? As you know, our present policy gives Medicare coverage only for acute care hospital coverage and some nursing home care and

leaves the long-term question largely open from the Federal perspective. I am curious as to where you see our interests lying there.

Dr. BOWEN. Senator, this probably is one of the biggest problems that the country is going to face in the next 25 to 30 years. Indeed, it is on us now, the reason being that between the years of 1980 and 2030, it is estimated there is going to be an 80-percent increase in the number of individuals between the ages of 65 and 74, a 220-percent increase in those between the ages of 75 and 84, but a whopping 280 percent increase in those above the age of 85. I think the statistics show that it costs 1.5 times as much to take care of someone above the age of 85 as it does someone at the age of 65. So, this gives a dimension of the problem in the future.

I also would have you know that I am faced with this situation because my mother has been in a nursing home for over a year now, and I realize the catastrophic type of expense that this can be. The short-term solution to it, I think, will have to be worked out between the Department and Members of the Senate and Congress as a whole. The long-term solution, I think, could be handled with the establishment of an individual medical account, like an IRA; the IRA could be either with the Government or private enterprise. While the loss of taxes to the Government certainly would have to be considered, I think that the contributions to the individual IMA should be tax-sheltered to help encourage the use of it. So, this type of program would be for the future. Obviously, it would be almost a generation before it would be very effective, but you have to start some time.

Senator BRADLEY. Do you see any connection between the desire to put people to work who are now receiving welfare and the need for senior citizens to have someone to care for them in a home setting? Are you aware of the demonstration programs that are now in progress around the country where, in some States, you have seen a drop in the cost of welfare and an increase in the provision of services for senior citizens in a home setting? Is that the kind of thing that you will be looking at?

Dr. BOWEN. I am interested in keeping disabled people, whether senior citizens or otherwise, in the least restrictive type of environment. Certainly, home would be that; and I think it would be an innovative way of utilizing those who could participate.

Yes, I favor people who are receiving subsistence of any type from the Government really putting out some work for it.

Senator BRADLEY. It will cost money if you do an IMA, in terms of lost revenues to the Government, just as it would cost money if you spent the dollars directly.

Dr. BOWEN. Yes.

Senator BRADLEY. On this alternative suggestion that I made, it might end up saving Federal dollars. Is that the kind of thing that you would be attracted to?

Dr. BOWEN. I mentioned the IMA to another Senator a little while ago, and I did say that we had not costed it out at all. I feel it is an idea we should think about, but it should be costed out before we can make up our minds on it.

Yes, I realize that there would be costs to it.

Senator BRADLEY. Thank you.

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Dr. Bowen, as we work toward taking a whack at the budget deficit, and given some of the problems in the rural communities with respect to health care, anyway, what can you say to rural America, as doctors tend to leave, as the Department proposes a capitation approach to part B Medicare which applies only where there is an HMO or where there is an insurance company that is going to be willing to provide the service? In rural areas where there are no HMO's, and in rural areas where health care is already very sparse, what hope can you give with respect to long-term health care financing?

Dr. BOWEN. Senator, I practiced in a town of 3,500, so I am from a rural area. I am acquainted with the problem. I think the problem of reimbursement to rural hospitals and to the rural physicians, who are predominantly primary care physicians, are related—because there is a disparity of the payments to physicians in different areas of the country and in different specialties.

As far as the rural hospitals go, I think the new wage index will be of some help, although. I don't think it has been in place long enough yet to judge it totally. The rural hospitals, I believe, are known to have more part-time help so that this does make a difference, and the rural hospitals that are especially close to the city boundaries probably are being affected a little bit more than those others.

There is a study going on at the present time to determine whether or not there needs to be a classification of rural versus urban, and I do not know what that report will say, but I certainly want to look into it. And perhaps the whole DRG system needs some refining as far as the problem of rural versus urban. Of course, the city hospitals also have some complaints about increases——

Senator BAUCUS. As you know, obligations to the National Health Service Corps are dropping off in part because there are fewer Federal dollars to the corps. Most rural areas look toward the National Health Service Corps as the potential source of doctors. I am wondering what you can say to rural America, the small towns, that look to that source for physicians; and second, whether you are going to take any specific initiatives to address the disproportionate problems facing health care in rural America.

Dr. BOWEN. I think that we can be a little more hopeful for the rural areas than we could, say, 10 years ago, simply because the numbers problem for physicians is essentially solved; but there still remains a distribution problem and that is what I think you are talking about here.

I think we should make every encouragement to get physicians to settle in the rural areas. I have no specific plan for that now. I do know that once physicians go to rural areas, they tend to like it and tend to remain. The National Health Service Corps still does keep a roster of the places of need and tries to fit Corps physicians to those particular areas. I think that it is working fairly well, but I am aware there still are some vacancies, one of which is in your State. So, we will try to get that figured out very shortly.

Senator BAUCUS. As you well know, if the President signs Gramm-Rudman, it is going to have an effect on all health care in this country. The budget of about $350 billion which is under your

jurisdiction—95 percent of that is entitlements and, even though Social Security is off limits under the present Gramm-Rudman, still other entitlements—Medicare and other discretionary programs—will be greatly affected by Gramm-Rudman. What is your best guess as to where the cuts will be made if Gramm-Rudman is put into effect?

Dr. BOWEN. Senator, as I understand it, there are some 300 programs administered in HHS and I can't tell you where they would be made now; but I can assure you we would give careful consideration to all of them so to be as fair as we possibly can to the taxpayer, the provider, and the recipient. That is all the information I can provide now, but I will be glad to discuss it with you later. Gramm-Rudman will require some innovative and creative types of decisions, though, to prevent any disservice to the people.

Senator BAUCUS. Thank you, Doctor. I see my time is up, Mr. Chairman. I have some more questions for a later round. Thank you.

The CHAIRMAN. Senator Heinz is next, but let me tell you what I am going to ask the members. If we have another vote, if they don't object, we have markup tomorrow; and I hope to send Governor Bowen out, along with some other bills.

If we have another vote, I would hope the members might be willing to submit their questions in writing because we are going to be going back and forth and back and forth and back and forth; and I hate to keep the Governor waiting and keep us running when I think his confirmation is assured.

Dr. BOWEN. I will be glad to answer questions in writing if you so desire.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you. Governor, first let me welcome you to the Finance Committee. I am sure this will be the first of many illustrous appearances by you. I have no doubt, and I share the chairman's conviction, that you will be confirmed very strongly by the committee and by the Senate. And I also know, from having had the chance to talk with you, that you share the concern that many of us have over the quality of health care under Medicare's new prospective payment system, DRG's.

My greatest concern is not per se that patients are being discharged sicker and sicker; that was anticipated. My concern is with those patients, who require heavy followup care, care which in theory can and should be available to them, in practice have no place to go to get it. The posthospital care programs, home health care agencies, for example, and nursing homes, are being strained by these new demands. At the same time, we have had testimony before this and other committees that HHS is restricting reimbursement to such vital programs as nursing homes and home health agencies.

My question to you is this: Would you agree that, while we are going through and working the bugs out of the DRG system, that we should avoid cutbacks that finance these posthospital care programs?

Dr. BOWEN. The home health care—that is what you are talking about?

Senator HEINZ. Yes.

Dr. BOWEN. Incidentally, it is the fastest growing program in the whole Medicare system; and that I have no objection to. It is a good followup to hospitalization, and it probably is much less expensive than additional days in the hospital. I think there is the potential abuse of overutilization and that needs to be monitored and controlled; but, in general, home health care has the great potential of improving the quality of care and especially the followup care. It just needs careful monitoring as to quality and utilization.

Senator HEINZ. Isn't it not just inevitable but appropriate that, if we are saving—as we hope to and indeed as we appear to be, literally billions of dollars a year through prospective payment for hospital care—that we should expect to transfer a portion of those savings to post-acute-hospital-care scenarios? Is that not logical and proper?

Dr. BOWEN. It seems logical and reasonable, and it seems to be something that we should consider very carefully.

Senator HEINZ. Can you tell the committee at this point whether you are prepared to go on record that you will guard against the kinds of reductions that would jeopardize people's health and safety and well-being where home health care is concerned?

Dr. BOWEN. In my opening remarks, I did state that, because of my background and my intense interest in it, I would do everything I could to protect the quality of health care in all phases; and of course, this would be one in which I would have interest. Yes, sir.

Senator HEINZ. Another issue is the amount of geriatric manpower or womanpower that is available. We have 120 medical schools in this country. They are affiliated with something over 400 teaching hospitals; yet there is a grand total of only 12 teaching nursing homes, as just one example of the minimal—in fact, I think totally inadequate—amount of attention we pay to the training of professional care givers for the aging population.

What do you intend to advocate or initiate in the way of preparing for the senior citizen boom and the blossoming of the 85 and older generation by way of improving our production of trained people power?

Dr. BOWEN. I hesitate to say that a medical school should be mandated to teach various things because, I think, most of them are aware of the needs that exist, especially the great numbers of senior citizens that are coming along. I feel that encouraging the schools of nursing and the schools of medicine to emphasize gerontology or geriatrics would be adequate; but if it weren't adequate, then we might have to take some other measures.

Senator HEINZ. My time has expired. Thank you very much.

Dr. BOWEN. Thank you.

The CHAIRMAN. Senator Moynihan.

Senator MOYNIHAN. Doctor, I am sure that you are aware that the Department just recently issued a public report of the Secretary's task force on black and minority health. Secretary Heckler, in response to it, announced that she would propose to establish an office of minority health under the Assistant Secretary for Health, at an estimated cost of about $300 million a year. Could I ask if you are generally aware of and supportive of that proposal?

Dr. BOWEN. I am aware that the report was made, and I read about it with great interest because it is very important. I do know of the difference in infants survival rates. We know that the difference exists, but we don't know exactly why. So, I think that the why has to be found out, followed then with what to do about it; and I am intensely interested in following that up.

Senator MOYNIHAN. You will give close consideration to the proposal of establishing an office where the why might be concentrated on?

Dr. BOWEN. Let me say that I will give every consideration to doing whatever we can to find out why; and if that requires an office, then I would have to see how it could fit into the budget.

Senator MOYNIHAN. Sir, the Subcommittee on Income Maintenance and Social Security is going to hold a hearing early next year on the proposal, S. 17, which I have introduced, and there is one in the House also, in progressing to establish an independent Social Security Administration, or to reestablish since that was the original mode.

Could we hope that you might appear before our committee? Will you give it favorable consideration? And the answer is,"why not?" [Laughter.]

Dr. BOWEN. To make Social Security a separate agency, was that your question?

Senator MOYNIHAN. Yes.

Dr. BOWEN. The answer is "yes"; if you want me to appear before your committee, I will appear before it.

Senator MOYNIHAN. I wish we had heard more answers like that from more members of the Administration—that is not meant to be a political remark. Sir, last year in considering the issues of disability criteria, one of the matters we couldn't settle was that of pain as a disabling condition when there was no medical condition that could be established as the basis for it; and we couldn't get ourselves to agree on that. We established a commission, which is sometimes a very good idea—Dr. Foley of New York is head of it. Could I just report to you, sir, that the legislation requires that their report be ready by December 31. It is not going to be. They have finished their work; it will be mid to late January before we actually get a document. I am just saying that for the record and for the chairman to hear it; we obviously aren't going to turn down the report because they are 2 weeks late. I understand that a genuine concensus emerged among the doctors. I am sure you will be interested, as well, in the proposition that clearly there are situations in which pain can be disabling for reasons that doctors don't know; but they didn't know what appendicitis was for a long time either. I just wanted to put you on notice that that is coming as an issue.

Dr. BOWEN. Yes, I am aware that the commission has studied the problem of pain; and pain is a subjective thing, and it is most difficult to judge whether one is disabled or not. I agree that it can occur and that attention should be given to it.

Senator MOYNIHAN. We will be pressing that. They are going to be proposing a 2-year pilot project which I think you will find interesting, and this Senator does as well.

Dr. BOWEN. We will find it very interesting, too.

Senator MOYNIHAN. Could I submit to you, sir, some questions with respect to the prospective attention to the problem of AIDS and the cost of AIDS care to municipalities. As the Veterans' Administration finds, care of an AIDS patient may cost up to $1,000 a day in the VA hospitals. AIDS has an epidemic proportion that seems to be something that you obviously will have to address, and I would like to submit my questions to you in writing.

Dr. BOWEN. Yes, but those are ones that I know a little more about; and I would be more prone to answer those in person. [Laughter.]

Senator MOYNIHAN. My time has expired. Thank you very much.

Dr. BOWEN. Yes, I will be glad to answer those.

Senator MOYNIHAN. Finally, Doctor, Senator Gore would like to submit some questions in writing to you. He is not a member of this committee, but this is a privilege that I know the chairman would extend; and if you would have the goodness to answer them, we would appreciate it.

Dr. BOWEN. We will be glad to.

With all of the questions, I don't know what the deadline will be, but we will try to reply promptly.

Senator MOYNIHAN. Friday at noon will be fine. [Laughter.]

Dr. BOWEN. Which Friday?

Senator MOYNIHAN. If you get your answers in by the time we pass your budget, you will have all the time you need. [Laughter.]

The CHAIRMAN. Senator Baucus.

Senator BAUCUS. Thank you, Mr. Chairman. Dr. Bowen, as you well know, there is a lot of tension in this town between Department heads and the Office of Management and Budget. I would like to ask you what you think your role is in setting health policy vis-a-vis OMB?

Dr. BOWEN. It is the duty of the Secretary of Health and Human Services to set policy and to recommend it. Obviously, I would have to be very mindful of the budgetary consequences, and certainly I would want the consent of the entire administration, but I assure you I will speak my piece and try to protect those that I think are very important to the health and welfare of the people.

Senator BAUCUS. Do you have any understanding in those instances where you do disagree with OMB that you will sit down and have meetings directly between yourself and the OMB Director?

Dr. BOWEN. That would be my intention.

Senator BAUCUS. Do you have any understandings with the administration that that will be easily arranged?

Dr. BOWEN. I have not talked specifically about it, but I would assume that there would be communication from Department head to Department head.

Senator BAUCUS. Do you have any understanding that you will be able to go directly to the President if you disagree with a position taken by OMB?

Dr. BOWEN. Yes. That is my understanding.

Senator BAUCUS. You do have that understanding?

Dr. BOWEN. Yes, I do.

Senator BAUCUS. That you can go directly to the President?

Dr. BOWEN. Yes. I may not get my way, but I will have the opportunity to speak out.

Senator BAUCUS. That is another matter, but it is comforting to hear that you have that understanding, sir, because there will be times, as we both know, where you will probably have to speak with the President. As we work to cut budget deficits and because this administration seems not to want to take other ways to cut budget deficits, other than cutting spending, you are probably going to have to talk to the President.

Dr. BOWEN. As I have mentioned, the quality of care still has to remain high on my priority list.

Senator BAUCUS. Dr. Bowen, when Secretary Schweiker was before this committee, he said his long-term goal as Secretary of the Department, was to put much more emphasis on preventive care. When Secretary Heckler was before this committee, she said her goal was to provide a catalyst to caring.

Dr. BOWEN. To provide what?

Senator BAUCUS. A catalyst for caring. That was Secretary Heckler's goal as Secretary. Could you tell us what goals you have? What marks do you want to leave on the Department? What initiative do you want to see accomplished as Secretary of HHS?

Dr. BOWEN. Obviously, my first priority would be to get a team in place—to fill the vacancies and to get as fine a team as I possibly can to do the job. Then I want to expedite the overdue reports and regulations, of which I am told there are several. Perhaps another would be to stress preventive efforts. I have a preference, as Senator Heinz knows, for home health rather than institutionalization. Of course, we also need to balance the interests of the recipients and the provider and the taxpayer. I have a whole long list of things I have put down in writing as problems I have perceived; it is a two-page list. I will be glad to go over all those if you want. I don't think you want to get into all of that.

Senator BAUCUS. I wish you a lot of luck. You have a great challenge ahead of you; and even though I didn't hear rural health care on that list——

Dr. BOWEN. It is on this list. [Laughter.]

Senator BAUCUS. Very good. I wish you all the luck and look forward to working with you. Thank you.

Dr. BOWEN. Thank you.

The CHAIRMAN. Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you. Governor-Doctor, I have two questions. One has to do with a subject which you were involved deeply with in 1984 and part of 1983. You chaired the Advisory Commission on Medicare Solvency. One of the issues we voted on last night was whether or not the part A deductible, currently $400—supposedly the cost of 1 day in the hospital—should rise to $492, a whopping 23 percent increase on January 1.

Most of us don't believe that hospital costs actually increased 23 percent in 1 year, but some increase in the part A deductible from $400 to something higher than that is probably necessary and proper and represents a reasonable burden of cost sharing to be shared by the beneficiary. However, we are astounded at what is clearly an accounting gimmick to bring about additional revenues

to hospitals because there is no way in 1 year that hospital costs could increase 23 percent.

Are we on the right track in making that statement? Isn't this just the allocation of overhead costs because the DRG's are cutting down the number of days per patient—the average per patient stay? Isn't this just fooling around with accounting when, if we wanted to be really billing beneficiaries for costs, we would see nothing like a $92 increase on January 1? Am I right or am I wrong? I am really not asking you to take a position yet on whether you want to do something about that increase; I might ask you a followup question in that regard.

Dr. BOWEN. Senator, I do not know the reasons that it went that high, but I would be thinking along the same lines that you were. There are fewer days of stay and fewer admissions, which probably—if you divide the right figures into all of that—would make it go up. Now, I don't think——

Senator HEINZ. It would make the allocated costs go up, not the real costs go up.

Dr. BOWEN. All right.

Senator HEINZ. Is that right?

Dr. BOWEN. That would be my impression of it. I am not an accountant, and I really haven't gone over those figures. I don't know.

Senator HEINZ. When you chaired the commission had you any indication or understanding that as a result of DRG's, we could expect this kind of very unpleasant surprise in the part A deductible? Had you any inkling that that compression of days was going to result in such an enormous increase?

Dr. BOWEN. No; we had no idea of that at the time, and DRG's then were just being thought of and were just going to be put in place, I believe, in October 1983. Our commission simply said that we thought the prospective payment system, DRG's, was the proper direction in which to move. But one must remember that at the time we were making that study, we were charged with finding methods for rescuing a financially ailing program.

Senator HEINZ. By all accounts you did a very good job. As a result of PPS the bankruptcy date for Medicare is now postponed well into the next decade and maybe beyond.

Dr. BOWEN. We are pleased that that happened.

Senator HEINZ. My last question has to do with the Social Security system, and whether or not it should be an independent agency. A number of people have advocated the independence of Social Security from not only the unified Federal budget, which has been affirmed now, by both the House and Senate in several different test votes and is law, effective 1991 or 1992; and that obviously raises a question of whether it should be handled as an independent agency as well. Some of the previous Commissioners, such as Bob Ball, and the former Chief Actuary of Social Security, Bob Myers, and others, believe that the system needs as much independence as it can get. As long as it is embroiled in OMB, congressional, Presidential, and other political budget wars, political support for Social Security will be undermined. Do you believe Social Security should be an independent agency?

Dr. BOWEN. One has to weigh the pros and cons which you have just stated, but I suspect I would oppose the separation simply because there are so many programs of the Social Security Administration that are linked to HHS that it just seems to make sense to keep them together. I think also that the elderly citizens need a Cabinet-level individual to speak for them.

Senator HEINZ. Thank you, Governor.

Dr. BOWEN. Thank you.

The CHAIRMAN. Senator Grassley.

Senator GRASSLEY. Thank you, Mr. Chairman. Dr. Bowen, you were—and this has probably been referred to—Chairman of the Social Security Advisory Council on Medicare. In that, you recommended the enactment of Federal "living will" legislation as one way to cut down on the cost of Medicare; and I hope I read that right. I believe the logic was that the largest part of Medicare expenditures is spent on caring for the patient in his or her final days of life.

I would like to have you discuss your position on living wills, and I would primarily like to have you relate that to what you think about the trend which considers nutrition and hydration as extraordinary care or as heroic methods.

Dr. BOWEN. Senator, the living will was not recommended as a means of reducing costs. It just sounds too inhumane to talk that way. It was put in the report simply because we felt that an individual should have a right to choose whether heroic measures are taken in the last few days of his or her life, knowing full well that they may not help. Now, those who have stated that I have a favorable view of euthanasia are just as wrong as they can possibly be.

About 28 percent, I believe, of all the Medicare costs are spent on those in the last year of their life. About 21 percent of all Medicare costs are spent on the last 6 months of life. About 8 percent are spent on the last 30 days of life, this is an area about which we felt the patient should have some concern.

Senator GRASSLEY. You don't in any way then associate yourself with the movement—if there is a movement, but at least it got considerable publicity when Governor Lamb of Colorado referred to it, you know, almost in the sense that older people ought to get out of the way for younger people.

Dr. BOWEN. No, absolutely not. When we discussed this in the Commission, there were, I believe, 14 States that had living wills. Now, I think there are about 35. I don't know what the exact number is.

In Indiana, my own State, last year they did enact this. I consulted with the authors of the bill, and I insisted that the bill include provisions that there would be fluid balance maintained, nutrition given, and adequate pain medication, so that it would be humane.

Incidentally, our bill stated that you could make the will state that you did not want all of these things done to you, but also that you did want them all done to you. So, it could be either way.

Senator GRASSLEY. All right. Again, referring to your chairmanship on the Advisory Council, there was also a recommendation on the elimination of Medicare's reimbursement for medical education. So, I would like to have you tell us, in your new position as

Secretary of HHS, how you might intend to approach reform of medical education reimbursement.

Dr. BOWEN. Senator, we did not recommend that it should be eliminated. We said that the funding was coming out of the wrong pocket; we felt that Medicare funds were not the appropriate source.

Senator GRASSLEY. Then, you wouldn't anticipate a need for reform or carrying out anything along that line as Secretary of HHS?

Dr. BOWEN. No. Medical education is a most important part of the program. The controversy is which "pocket" the funding should come from. You can't take away the residency training without causing tremendous hardship on the teaching hospitals. The residents do a lot of the work on the hospital floor; and if you remove them from the scene, somebody has to take their place, and that somebody would be the higher paid physicians who are already out of their training. So, you would actually be increasing the costs, rather than decreasing the costs, if you removed them from the scene.

Senator GRASSLEY. How about one short question?

The CHAIRMAN. All right.

Senator GRASSLEY. This is in regard to your own State's rather unique medical malpractice statute. Do you support the enactment of Federal legislation that would encourage States to adopt similar State laws?

Dr. BOWEN. Several years ago, I did not, and I don't know whether I do now or not; but I am leaning more toward it, simply because I think the problem has gotten worse, and not enough States have seen fit to enact legislation to stop the serious malpractice problem there is.

There is no question that defensive medicine has increased tremendously the cost of medical care. There is just no question. If you fell and bumped your head and said you felt dizzy or had a little knot, even though the doctor felt certain there would be no x ray findings, you are going to get your skull x rayed anyhow, just simply to protect yourself.

Senator MOYNIHAN. Could I ask, Doctor, by defensive medicine, what do you mean?

Dr. BOWEN. Doing things to prove that you did everything you could to be sure—really doing things to prevent getting sued. That is really what it is all about.

Senator MOYNIHAN. You are defending yourself as a doctor, rather than necessarily being concerned about the patient?

Dr. BOWEN. Yes.

The CHAIRMAN. Governor, I believe we are done. This has been very, very well done, and we hope to send out your nomination tomorrow.

Senator MOYNIHAN. We thank you very much.

Dr. BOWEN. Thank you, sir.

[The written prepared questions of Senators Moynihan, Mitchell, Pryor, and Gore follow:]

AIDS — Senator Moynihan

Q: In a speech before the United States Conference of Mayors in June 1984, Secretary Heckler said that Acquired Immune Deficiency Syndrome (AIDS) is the Nation's "number one health priority." With the number of AIDS cases expected to double next year, will AIDS remain your number one. health priority during your tenure as Secretary?

A: AIDS is a deadly disease, one that presents a major public health problem. While I am Secretary, the Department will continue to explore every lead until this dread disease is conquered. We will continue to regard AIDS as an urgent and high priority.

AIDS

Q: According to Mayor Edward Koch of New York City, the cost of treating AIDS patients at municipal and nonprofit hospitals is $800 per day, while Medicare reimbursement for this treatment averages $500 per day. Will you support a Federal role in lessening the burden of AIDS treatment costs on municipal governments?

A: The cost of AIDS is high for several reasons: It is a new disease with severe episodes of illness requiring intensive treatment. Nearly 76 percent of the more than 15,000 AIDS cases have occurred in just five States. This places a burden on the hospital system of States such as New York.

Costs differ from State to State and city to city. For example, the evidence we have from San Francisco suggest that alternative approaches to care significantly lower costs to AIDS patients. We have a study under way to better quantify the cost of AIDS, both hospitalization costs and costs to society. In addition, the FY 1986 Labor-HHS Appropriations Act calls for health care delivery service demonstration projects for victims of AIDS in those four standard metropolitan statistical areas having the highest incidence of the disease.

Senator Mitchell

MENTAL IMPAIRMENT REGULATION

QUESTION:

Governor Bowen, when can we expect that the States will be able to process all of the mental impairment cases so that people will be able to know their status and, if appropriate, begin to receive benefits?

ANSWER:

All the States should be processing their mental impairment cases by mid-January, 1986. New rules for evaluating these cases were published as final regulations on August 28, 1985. There has been a delay in processing mental impairment cases because the Social Security Administration (SSA) wanted to make sure that all disability adjudicators fully understand the new rules and apply them correctly and consistently.

MENTAL IMPAIRMENT REGULATION

QUESTION:

The delay in promulgating the mental impairment regulations is only one example of the hardships caused by consistent delay on the part of the Department of Health and Human Services in publishing regulations on almost every issue. Why has this been the case? Can you - will you correct this situation as Secretary of HHS?

ANSWER:

The 1984 disability legislation was highly complex and contained an unusually large number of relatively short deadlines. Twelve regulatory documents were due within six months of enactment of the legislation. While it is regrettable that, despite the best efforts of the Administration, it was not possible to meet every deadline, it was essential to lay a sound foundation to ensure a fair and consistently-administered disability program. I would also add that the two most significant disability regulations have now been published as final regulations: The new rules for evaluating mental impairment cases; and, the medical improvement standard of review. The Social Security Administration is now ready to resume the continuing disability review process.

As a general matter, I am a punctual person, and will expect regulations to be promulgated on a timely basis.

Senator Mitchell

HCFA REVIEW OF PRO CONTRACTS

Question: How does HHS, more specifically the Health Care Financing Administration (HCFA), review the PRO contracts to determine whether or not they are successful in carrying out the terms of their contracts?

Answer: Ongoing monitoring of PROs is performed by project officers and medical review teams from the regional offices through onsite visits, telephone conversations and correspondence. Reports of work activity and accomplishments are made by the PRO on a monthly and quarterly basis to HCFA regional offices and central office. These reports are monitored for compliance with contract requirements and adequacy of performance. A PRO Monitoring Protocol and Tracking System (PROMPTS) report must be completed by the regional office on each PRO. The PROMPTS covers all areas of responsibility for which PROs are accountable. In addition, HCFA has contracted with a firm called Systemetrics to act as a "SuperPRO". The SuperPRO will evaluate the medical appropriateness of determinations made by the several PROs. The SuperPRO will use nurses, medical records personnel and practicing physicians in all appropriate specialties to monitor the appropriateness of the medical review decisions made by PROs.

Where deficiencies are identified and not corrected expeditiously, HCFA, under the terms of the contract provisions, withholds payment until the PRO meets its requirements. If there is substantially nonperformance of contract obligations, then HCFA can terminate the contract. So far, HCFA has found it necessary to terminate three organizations who were not meeting their contract obligations.

We are now beginning to evaluate the performance of each PRO. The evaluation will consider the findings of PROMPTS, SuperPRO, Regional Project Officer Assessment and available national data to determine if the PRO has substantially met its contract requirements and therefore should be eligible for renewal for an additional 2-year period.

PRO REVIEWERS

Question: Are interested organizations, such as the state medical association and state hospital association, entitled to know the names of physicians who are participating as peer reviewers for a PRO within their State?

Answer: There is no statutory, regulatory, or contractual requirement that the PROs make available to the public a list of reviewers. The major reasons for this are: first, confidentiality of reviewers is critical to prevent unnecessary harassment of physicians who agree to serve as peer reviewers, and second, publication of such a list would implicitly identify specific reviewers in certain specialty areas where there may be only one or two physicians. However, in recognition of the statutory requirement that review be conducted only by physicians in the area, HCFA has an extensive contract enforcement program in place to ensure that this requirement is met.

PRO CONTRACTS

Senator Mitchell

Question: Does HCFA intend to hold open bidding for the next round of PRO contracts when this 2-year contract period ends?

Answer: The statute, in Sec. 1153(c)(3) of the Social Security Act, creates a strong presumption in favor of renewing PRO contracts. However, HCFA intends to carry out an "open," competitive bidding process in cases where the current PRO has demonstrated less than satisfactory performance of its current contract or where agreement on the terms of a contract renewal cannot be reached.

PRO CONTRACTS

Question: Will HCFA revise its criteria for selecting a PRO contract to include weight for a contract submitted by an organization within the State to be reviewed?

Answer: Modification of the criteria is not necessary: the current criteria and statute already give a preference to a physician sponsored organization within the PRO area. Furthermore, regardless of where the organization may be from, the bidder must demonstrate that it has available to it a sufficient number of physicians, with privileges in the State, to conduct review as required by the PRO contract.

ANSWERS TO QUESTIONS SUBMITTED BY MEMBERS OF THE

SENATE FINANCE COMMITTEE

Senator Pryor

SOCIAL SECURITY AS INDEPENDENT AGENCY

QUESTION:

As Secretary of the Department of Human Services, you will be responsible for a broad range of programs, including the retirement income security programs under the Social Security Administration. Originally these programs were administered by an independent agency, governed by a board structure. Both the 1981 Commission on Social Security and the 1983 Commission on Social Security Reform recommended an independent structure for the Social Security Administration. I have introduced legislation which would reestablish that structure for administering these income programs, and the House Ways and Means Subcommittee on Social Security has already approved a similar proposal. What are your views on this proposal?

ANSWER:

I oppose the establishment of the Social Security Administration (SSA) as an independent agency for at least three reasons. First, I favor keeping SSA under the HHS umbrella of related programs. Second, it is important for Social Security recipients to have a spokesman for the program with Cabinet rank, with the prestige and access to the President which Cabinet status confers. Third, creation of an independent board would tend to politicize administration of SSA and undermine public confidence in the system.

SOCIAL SECURITY COMMISSIONER

QUESTION:

I have been seriously concerned that for almost three years now (since the nomination of John Svahn in early 1983 for the post of Under Secretary of HHS) we have been waiting for a nomination for Commissioner, as well as a number of other key SSA positions. In addition, we in the Congress have become increasingly concerned in recent months over other extended vacancies within the Department of Health and Human Services. How soon do you expect to fill these positions?

ANSWER:

I will move swiftly to fill personnel vacancies within the Department, including a Commissioner for the Social Security Administration.

Senator Pryor

BACCHUS

QUESTION.

I note that you have served as the Chairman of the Advisory Council for the organization known as BACCHUS (Boost Alcohol Consciousness Concerning the Health of University Students). I have been very impressed with the activities of this group at a university in my state. I believe that BACCHUS goes a long way toward enabling students to become informed, aware and to exercise freedom of choice, as well as to be able to make informed, responsible decisions. Would you please comment on your work with BACCHUS and perhaps give some suggestions as to whether or not you would like to see more student-directed activities like this?

ANSWER:

From my work with BACCHUS and my familiarity with other organizations like it, such as Students Against Drunk Driving, I have become convinced that these are a critical component in preventing alcohol-related car accidents with resultant injuries and deaths among our Nation's young people. I would certainly support the establishment of more student-directed efforts and would expect that HHS would support these activities through technical assistance and our prevention activities.

Q. Let me begin by asking, whether in your judgment, liver and heart transplants are therapeutic medical procedures?

A. To the extent that death might be avoided as the result of receiving a transplanted heart or liver for some patients, those procedures are clearly palliative. Whether these treatments of last resort can be considered as therapeutic in the sense that the recipient is returned to normal functioning with a good probability that there will not be a recurrence of the end organ disease remains to be established. Liver transplantation for children suffering from biliary atresia is clearly a sound therapeutic medical procedure and is a treatment of choice as well as a treatment of last resort. While there is evidence of increasingly good survival for recipients of transplanted hearts and in some cases, for the recipients of liver transplants, a design to stimulate the availability of these procedures through reimbursement is at the present time premature.

Sen. Gore

ORGAN TRANSPLANTS

Q: The NIH consensus development conferences on heart transplants and on liver transplants both stressed the importance of "institution and patient selection criteria" in finding these procedures to be accepted medical practice. Their findings state over and over again that we must limit these procedures to designated centers that meet rigorous scientific standards, and that can do enough procedures each year to maintain the necessary skills.

Despite the importance the medical experts have placed on limiting transplants to designated centers, so far the Department has refused to follow these recommendations, causing a dangerous proliferation of transplant programs. I fear this will have tragic results.

What is your opinion of limiting complex medical technologies such as organ transplants to a limited number of designated, specialized centers that meet established medical criteria? What role should the Department of HHS play?

A: The Department has proceeded consistent with the recommendations of the consensus development conferences with respect to institutional and patient selection criteria. What the Department has not done is to stimulate proliferation of transplant programs by prematurely determining that they should be paid for under Medicare. The materials developed by the consensus development conference, together with other criteria which have been developed by the Department are available to the transplant community. A proliferation of transplants still occur in a small proportion of the transplant facilities. It is the expectation of Federal financing for these procedures, together with the interest of medical science and developing new approaches that have led to the increase in the number of surgical teams willing to attempt transplantation.

I believe that the Department should continue to work with the transplantation community to define the medically appropriate cirteria for patient selection and institutional participation in transplantation programs, while we are developing a data base which will permit the determination of the clinical efficacy of these procedures. We much establish which procedures are appropriate for which kinds of patients in a way that will optimize the likelihood of a satisfactory outcome for individual patients. That process must minimize the risks of individuals who are appropriate candidates, particularly in institutions which do not have the requisite experience not just for the transplant but for the postoperative management of transplant recipients.

Sen. Gore

MEDICAL TECHNOLOGIES

Q: Much of the difficulty and debate in deciding whether programs such as Medicare should cover a medical procedure such as transplants has focused on the question of "experimental" vs. "accepted medical therapy"--a question whose answer is based on our capability to assess medical technologies.

How do you rate our current ability to evaluate new medical technologies, and what do you believe is the proper role for government in the technology assessment process?

A: While there is always room for improvement, our ability to evaluate new medical technologies is quite satisfactory. But, there are two problems. First is the ability to make judgments of the relative clinical effectiveness of the variety of diagnostic and therapeutical interventions which biomedical research has made available. These involve not only the difficulty of making relative clinical judgments, but also the questions of cost benefit and cost effectiveness. These, of course, include making determinations of social value which are not questions which can be satisfactorily addressed solely on the basis of clinical evidence. A second problem is that proper evaluation of medical technology is time consuming and the public is not willing to tolerate the delays which are almost always necessary in order to establish an adequate empirical base for the scientific analysis.

ORGAN TRANSPLANTATION Senatore Gore

Q: Last year, in response to the problems posed by rapid advances in organ transplantation and the resulting shortage of donor organs, Congress rejected (in the House by a vote of 379-25) proposals supported by the Administration for prolonged study of the problems, and instead overwhelmingly passed (House: 369-6/Senate: unanimously) a comprehensive package (P.L. 98-507) of programs designed to dramatically increase the number of donor organs.

Unfortunately, as yet, the Department has only set up a task force, also required by law, and has all but ignored the other provisions of the law. I can say without any doubt that Congress considered these other provisions of the law the most important and most in need of immediate implementation.

Dr. Bowen, can I get your commitment that if approved as the new Secretary of HHS you will take immediate steps to promptly and fully implement all provisions of P.L. 98-507?

A: Senator Gore, you are quite correct in your observation that up until very recently, the Department has focused its efforts toward completing the statutorily mandated assignments of the Task Force on Organ Transplantation.

It is important that as we implement the law, we rely on the expertise of the Task Force. Many issues are still being debated by the Task Force and differences of opinion still exist. The final report will give us direction from a consensus of the organ transplant community as a whole. With this information, we will be better able to implement the law and have the impact on organ procurement and transplantation that was intended.

HEART TRANSPLANTS Senator Gore

Q. In 1980, NIH and the Public Health Service recommended that Medicare deem heart transplants safe and effective and reasonable and necessary. The Department requested further study on how best to cover this complicated medical technology. That Department received the study, the National Heart Transplantation Study in October 1984, and released it in publicly in a press conference in May 1985.

At that time Secretary Heckler promised to finally make a coverage decision by the end of the summer. We are still waiting for that decision. Each day we wait more lives are lost, and greater confusion permeates the transplant field (proliferation of programs).

Dr. Bowen, can you give me your assurance that you will do your utmost to see to it that a decision providing coverage will be made within the first month you become Secretary?

A. I will review the history and recommendations of this issue as soon as possible but I am not prepared at this time to give you my assurance that the outcome will be to provide reimbursement under Medicare.

Senator Gore

ORGAN TRANSPLANTS

Q. In October, the Task Force on Organ Transplantation established by P.L. 98-507 sent Congress and the Secretary of HHS a report on immunosuppressive therapies as required by P.L. 98-507. The report recommends "the establishment of a joint Health Care Financing Administration-Public Health Service program to provide immunosuppressive medications to transplant centers for distribution to financially needy Medicare eligible transplant patients."

On November 14, 1985, the Senate passed a sense of the Senate resolution asking the Secretary of HHS to "immediately reconsider the Medicare liver transplant coverage decision" and to remove the current restriction on liver transplants for those over 18 years of age.

Can you tell me what plans the Department has for implementing these two items?

A. We are currently reviewing the first report of the Task Force on Organ Transplantation.

When the decision was made to provide Medicare reimbursement for liver transplants in children suffering from biliary atresia, a process was initiated to collect data with respect to the potential clinical indications and outcomes for adults. The NIH has established a liver transplantation registry and is presently documenting patient outcomes. Because of the large number of diagnostic indications for which liver transplantation is being under taken, resulting in a relatively small number of patients in each category, it will require several years of data collection to create an adequate data base on which a decision can be based. If evidence becomes clear with respect to particular diagnoses where the outcomes are known to be favorable and where there is a low probability that the disease which originally lead to liver failure would reoccur, we will consider coverage on a diagnosis by diagnosis basis.

American Lung Association

TUBERCULOSIS

QUESTION:

The highest incidence of tuberculosis occurs among poor inner city blacks and in areas that have a large influx of refugees such as Miami. Because tuberculosis is concentrated in these areas, doesn't it make sense to target federal expertise and resources on these areas?

ANSWER:

In 1984, 22,255 cases of tuberculosis were reported to CDC, for a rate of 9.4 cases per 100,000 population. The U.S. 1984 case rate for whites was 5.8 per 100,000 population compared to a case rate of 29.9 for nonwhites. The case rate for persons living in 57 cities with populations of 250,000 or more was 19.3 per 100,000 - more than twice the national rate. Urban rates ranged from 49.9 per 100,000 in Miami, Florida, to 2.3 per 100,000 in Omaha, Nebraska. Eight cities had rates at least three times the national rate: Miami, Florida; Newark, New Jersey; Atlanta, Georgia; San Francisco, California; Tampa, Florida; Oakland, California; Honolulu, Hawaii; and Washington, D.C.

CDC's tuberculosis technical consultation and assistance are targeted primarily to health departments and other providers in areas of high disease incidence. Specifically, in each of Fiscal Years 1983, 1984, and 1985, CDC awarded $5 million in Cooperative Agreements to 48 State and city health departments with areas of high disease incidence. Cooperative Agreement funds have been used by the recipient health departments primarily to employ outreach workers in the high incidence areas for field followup and directly observed therapy of persons with tuberculosis who otherwise would not take their medication.

Although CDC and the Federal government play an important role in the prevention and control of tuberculosis, we believe that States and localities should have the primary responsibility for establishing effective control programs.

American Lung Association

TUBERCULOSIS

Q: When the American Lung Association, then known as the National Association for the Prevention of Tuberculosis, was founded in 1904, tuberculosis was the number one health menace in the United States, but 20,000 cases continue to be reported each year around the country, and globally tuberculosis remains an immense public health problem. How can the United States take the lead in the eradication of this age-old highly contagious disease?

A: Tuberculosis does remain a problem in the United States and throughout the world. Infection with the tubercle bacillus may be the most prevalent infection in the world. In many developing countries, more than half the population is infected by the time they reach adulthood.

The Public Health Service works closely with the American Lung Association (ALA) particularly with ALA's medical affiliate, the American Thoracic Society. We are pleased that this voluntary agency continues to work toward the eradication of tuberculosis, a disease which, in theory, is both curable and preventable.

From a worldwide perspective, CDC has maintained, and will continue to maintain, a close working relationship with the World Health Organization (WHO), the International Union Against Tuberculosis, and other groups concerned with the control of tuberculosis in the world. We are very supportive of WHO's new tuberculosis research program on immunology and have indicated our interest in serving as the WHO Coordinating Center for a proposed program on new drug development.

The United States can take the lead in the elimination of this age-old disease. In our report to the Senate Committee on Appropriations, we outlined the three steps necessary to hasten the elimination of tuberculosis from the United States. These steps included 1) more effective application of existing methods for prevention and control; 2) initiation of basic and applied research efforts using modern biotechnology to develop more effective, simpler, and less expensive control methods; and 3) rapid and effective transfer of new prevention and control methods into field operations.

American Lung Association

PPS AND CHRONIC DISEASES

Question: Under the PPS the utilization of hospital resources and the length of stay of patients with such chronic diseases as emphysema and chronic bronchitis are extremely variable and unpredictable. Do you see a risk in these patients being labeled as undesirable by hospitals and in a broader sense, as we foster competition among health insurance plans, how does the Federal government assure continued access to quality health care for patients affected with chronic diseases?

Answer: The fact that individual cases within a DRG may vary in the amount of resources consumed should not serve to make patients who fall within it undesirable. The variability produces both "winners" and "losers" and, as hospitals gain operating experience under PPS, the fear of various types of patients which your question anticipates should be dissipated. In the event that a DRG is identified as not being clinically coherent or as not embracing an appropriate resource range, HCFA can reclassify the cases into other DRGs in order to avoid inappropriate results. Thus, I do not believe that variability itself is necessarily a problem but, if it proves to be, I am prepared to make the changes necessary to correct it.

I believe that increased competition will increase access to care for individuals with chronic illnesses. In particular, I would note that various types of capitation arrangements create situations in which there is a prepayment in return for the guarantee of treatment. Thus, there is less opportunity for an organization providing care under such an arrangement to avoid individuals who become chronically ill.

SMOKING EDUCATION American Lung Association

Q: Smoking is the number one preventable cause of death in the United States. The Surgeon General has called for a smoke free society by the year 2000.

What additional steps can be taken to bring about a smoke-free society?

A. The problem of smoking and its effect on health is a national one and one which cannot be solved by government alone. If our efforts are to be successful, it will require a total effort of all society, including those of government, health care, the community, and the individual. We must have programs of information, education, and where applicable, regulation. We must increase our efforts to inform all our citizens about the dangers of smoking; to persuade children not to start the habit and convince adults who smoke they must quit. History has shown however, that we have achieved considerable success in reaching our goal. Over 34 million smokers have successfully quit and fewer and fewer children are now adopting the behavior. These changes are beginning to have a sizeable benefit on the health of this nation and will continue to do so in the future.

American Lung Association

HEALTH STATUS OF MINORITIES

QUESTION:

A recent report released by the Department of Health and Human Services brought to the fore some very disquieting facts about the health of minorities in the United States. What do you propose we do to narrow the gap between health care for minorities and the general population?

ANSWER:

The Task Force on Black and Minority Health acknowledged that the factors responsible for the health disparity are complex and that diversity within and among minorities necessitates activities, programs and data collection tailored to meet their health needs.

Recommendations included incorporating minority health initiatives into existing HHS program areas in order to address health conditions amenable to immediate improvement; achieving greater public and private involvement in a common effort to address the disparity; resolve unanswered questions through a concerted program of research and data collection; and seek new strategies to ameliorate the inequities.

Within the Department there has been created a new office under the Assistant Secretary for Health to help implement these recommendations including developing new directions for Departmental activities that would help reduce the minority health disparity.

American Lung Association

CHILDHOOD RESPIRATORY DISEASE

Q: Childhood respiratory diseases are the leading causes of death in the first year of life and there is increasing evidence that early injuries to the lung can be magnified in later years and may predispose the adult to chronic lung disease. What should the Federal Government do to prevent childhood respiratory diseases and to minimize its sequelae?

A: The Federal Government has supported a number of research projects in this area. Many of these projects have been conducted in the Specialized Centers of Research sponsored by the National Heart, Lung, and Blood Institute as these problems require multidisciplinary approaches to understanding the natural history, pathogenesis, and possible methods of prevention.

One of the important advances made by the pulmonary research scientist has been development of methods of diagnosis of pulmonary abnormalities in early childhood with advances in pulmonary function technology applicable to the less cooperative younger child. The development of simpler and more convenient methods for evaluating alternations in the immune system as well as in diagnosing viral infections has been of considerable benefit for both short-term and long-term prospective studies of the relationship of immunologic-allergic and infectious factors in causing acute and chronic respiratory disorders.

In spite of the tremendous advances that have been made over the past 10 to 15 years with respect to understanding the pathophysiology of a number of disorders producing chronic airflow obstruction in infants and children, many unanswered questions remain and much research still needs to be conducted so that the morbidity and mortality from these conditions can be minimized. The National Heart, Lung, and Blood Institute has recently completed an indepth review of the research needs and opportunities in the area of Pediatric Respiratory Disorders. The report of this review, in which dozens of pediatric pulmonary physicians and basic scientists participated, will be available in the spring of 1986 and is expected to be widely distributed throughout the United States and abroad. This report should stimulate additional research projects and lead to even more progress in this important area.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

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ENERGY AND COMMERCE
SUBCOMMITTEES:
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TELECOMMUNICATIONS, CONSUMER PROTECTION, AND FINANCE
COMMERCE, TRANSPORTATION, AND TOURISM
SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES
RANKING MINORITY MEMBER
REPUBLICAN POLICY COMMITTEE

November 13, 1985

The Honorable Bob Packwood
Chairman
Senate Committee on Finance
SD-219
Washington, DC 20510

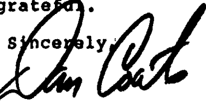
Dear Senator Packwood,

I was thrilled to learn that President Reagan nominated Dr. Otis Bowen to become Secretary of Health and Human Services.

As a Hoosier, I am pleased to inform you that Dr. Bowen has distinguished himself as an excellent medical doctor, legislator, and Governor of the State of Indiana. His experience and commitment to integrity, compassion, and common sense are second to none. I can think of no one better qualified to guide the Department of Health and Human Services.

I respectfully urge your support for the speedy and unanimous confirmation of Dr. Bowen, by your Senate Committee on Finance. If you could share my comments with the members of your Committee, I would be most grateful.

Sincerely,



Dan Coats
Member of Congress

DC:cs:st

STATEMENT

FOR THE RECORD

OF THE

AMERICAN ASSOCIATION OF RETIRED PERSONS

ON

THE NOMINATION OF

GOV. OTIS BOWEN, M.D.

FOR

SECRETARY OF THE

DEPARTMENT OF HEALTH & HUMAN SERVICES

DECEMBER 10, 1985

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700

Vita R. Ostrander *President* Cyril F. Brickfield *Executive Director*

Mr. Chairman, the American Association of Retired Persons, the nation's largest membership organization is pleased to have this opportunity to comment on President Reagan's nomination of Gov. Otis Bowen, M.D. as Secretary of the Department of Health and Human Services.

AARP commends President Reagan for nominating Dr. Bowen -- a health care professional -- to lead our nation's largest federal agency. The Association views this nomination as a positive step forward.

Older Americans have a major stake in the decisions and policies of HHS. Our membership will look to Dr. Bowen for his leadership in controlling the rapid increase in health care costs and at the same time assuring Medicare and Medicaid beneficiaries access to quality care.

AARP finds it sobering that the average Medicare recipient paid the same percentage of income out-of-pocket for health care in 1984, (15%), as the average older person paid in 1966, the year Medicare began. It is just as alarming that older persons are projected to spend, on average, 19% of their out-of-pocket income for health care by 1990.

Older Americans face a health care system in flux. Despite recent changes in the health care system and large savings for the federal government, the out-of-pocket expenses continue to escalate. In short, Medicare bene-

ficiaries are paying more for less. Cost should not dictate the care. Older Americans should not be forced to face a system that is being cut down with apparently little or no regard for the consequences to their health care needs.

AARP believes that as a family physician, Dr. Bowen understands the importance of low cost quality health care. The Association urges Dr. Bowen to assure that HHS protects the Medicare and Medicaid beneficiaries.

The Department of HHS and Congress face a series of difficult choices in the health care system that will set the stage for future health policy. The Association strongly urges Dr. Bowen to closely monitor the impact of recent changes brought about by the introduction of the DRG system on the Medicare beneficiary. AARP urges HHS, under the leadership of Dr. Bowen, to correct the inequities in the system without hurting the frailest, sickest, and those with multiple conditions who often have no resources to rely upon once they are discharged from a hospital.

AARP urges Dr. Bowen to continue making reforms in the health care system by extending the reforms to physician payments. The current system is riddled with serious problems and AARP believes that no one payment methodology will be appropriate for all types of physician services.

We would suggest that HHS look to payment reforms which use a transition system and allow for corrections of certain payment problems to take place over a period of time. This would assure that reform could be accomplished without unduly sharp or unpredictable reductions or changes in payment levels that could disrupt the continuing availability of physician's services to beneficiaries. The Association would also urge Dr. Bowen to look closely at a system which would establish a national Medicare relative value scale.

In closing, Mr. Chairman, the Association would like to say that reform will not be complete until the issue of long term care is addressed. Congress and HHS have delayed facing this matter long enough and cannot continue to ignore the needs of the chronically ill. For reform to be effective it must address the needs of both the acutely ill and the chronic patients.

Mr. Chairman, AARP urges the confirmation of Dr. Bowen to this important post of Secretary of HHS. The Association looks forward to working with Secretary Bowen in addressing the issues regarding access to low cost quality care for all Americans.

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Finance and
Committee on Labor and Human Resources
United States Senate

RE: The Nomination of Otis R. Bowen, M.D. as
Secretary of Health and Human Services

December 6, 1985

The American Medical Association strongly supports the nomination of Otis R. Bowen, M.D., as Secretary of Health and Human Services.

The appointment of the first physician as Secretary of HHS could not come at a more opportune time. During this period of tremendous change in our health care delivery system and serious federal budgetary pressures, it is vitally important that the HHS Secretary have a clear understanding of our nations's health needs and a proven record of effective management. President Reagan said it best when he stated that Dr. Bowen was selected because of "all the qualifications that he had in excess for this particular position."

Dr. Bowen's experience as a family physician, medical professor, Speaker of the State House, and two-term Governor has provided him with extensive experience to direct HHS. In addition, as chairman of the Advisory Council on Social Security, Dr. Bowen has acquired detailed

knowledge of the Medicare program which is destined to be a major point of debate in future deficit reduction efforts.

The American Medical Association strongly supports efforts to provide health care in a cost-effective manner resulting in real reductions in health care expenditures. At the same time, we are committed to ensure that the quality of health care not be sacrificed to achieve short-term budget savings that may well lead to cost increases over the long run.

During the last five years, deficit reduction legislation has targeted the Medicare program for a disproportionate share of budget cuts. Medicare cannot sustain a continuous stream of multi-billion dollar budget cuts without impairing the quality of care provided to senior citizens and the disabled.

The appointment of Dr. Bowen will enable the Administration and Congress to benefit from the counsel of an individual who understands in human terms what effect future budget decisions will have on the health and welfare of American citizens. We are confident that such practical insight will prove to be invaluable to both branches of government in the difficult process of establishing budget priorities.

For nearly one hundred years, the American Medical Association has advocated the creation of a separate cabinet-level federal Department of Health headed by a physician. While the issue has not been actively considered by Congress in recent years, it is more important than ever before that health issues receive the degree of careful attention of a practicing physician such as Dr. Bowen.

We strongly urge prompt approval of Doctor Bowen's nomination.

CLUB of LIFE

P.O. Box 17003, Washington, D.C. 20041-0003

December 10, 1985

Testimony of Club of Life to the Senate Finance Committee on the nomination of Dr. Otis Bowen as Secretary of Health and Human Services.

The Club of Life opposes the nomination of Otis Bowen as Secretary of Health and Human Services primarily for the danger that he represents to the health and welfare of this nation's citizens. In his publically stated policies, Dr. Bowen calls for the termination of treatment and the early death of millions of our elderly and terminally ill, the starvation of handicapped newborns, and "alternative" forms of care, not cures for cancer victims.

Otis Bowen is a "fiscal conservative", who is being billed by the media as the most popular governor in Indiana's history, and as a family doctor straight out of a Norman Rockwell painting. The truth is somewhat different. As one long-time Indiana politician said, people "thought of him as a doctor or a friend, but he was probably this state's shrewdest, toughest politician."

Don Regan called Bowen a "triple crown" nominee referring to his medical practice and to his administrative and political experience which he would ostensibly bring to HHS and its force of 120,000 employees. But, reality is something quite different.

India • Indonesia • Iran • Japan • Thailand • Turkey • New Zealand
Congo • Egypt • Ethiopia • Gabon • Kenya • Nigeria • Tunisia • Burkina Faso • Zaire
Argentina • Bolivia • Colombia • Mexico • Peru • Venezuela
Bahamas • Belize • Guyana • Jamaica • Panama • Virgin Islands • Canada • United States
Italy • Netherlands • Norway • Poland • Spain • Sweden • Yugoslavia

I. Cost Containment Means Murder

While it is true that Bowen is the first physician to be nominated for Secratary, Dr. Otis R.Bowen bears more allegiance to the interests of banking and insurance companies than to his Hypocratic Oath. Wilbur J. Cohen, who served as Secretary of Health, Education and Welfare under the Johnson Administration heralded Dr. Bowen as "the one to manage the Reagan Administration's cost-control program for physicians. He'll be the one who enforces fee controls. That's the right thing to do--appoint a person who can deal with the doctors."

Yes, Bowen is known for certain managerial accomplishments. In fact, his nomination recalled for many the horror of President Carter's threat to enforce the cost- efficient scheme of his secretary, Robert Derzon. In 1977, Derzon suggested in a private memorandum that any state which did not endorse living will legislation, would be cut off from Medicare benefits.

While chairman of the Advisory Council on Social Security in 1982 and 1983, it is said that he displayed a "low-keyed, avuncular style". Yet it was in the capacity of chairman to that Council which was created by the Federal government to recommned cost-containing changes in Medicare, that he became known as the Republican version of Colorado's notorius Governor Richard Lamm. It is said that through his role as Chairman of the Council, that Bowen gained a "more intimate knowledge of that program than any prior Secretary of Health and Human Services". There is no doubt in our mind that the knowledge "gained" by Dr. Bowen was at the expense of this country's

sick and elderly as his "recommendations" before the Senate Finance Committee in April 1984 clearly indicate:

> "The Council endorses the concept of "Advance Directives" or "Living Wills" which are currently recognized by law in fourteen states. The Council called for a study to look at the impact on health expenditures in those states having such laws and encouraged other states to adopt similar legislation. Living Wills would prevent unnecessarily heroic measures being taken in the terminal days of life. Eleven percent of Medicare expenditures are spent in the last forty days of life and some 25 percent of Medicare ependitures are incurred in the last year of life. The Council fully recognizes that this may be a controversial recommendation; however, the Council unanimously endorsed it. As a physician, I initiated Council discussions on this subject having recently lost my father and thus knowing the enormous costs that were incurred in his terminal days prior to death.

Surely, the Senators know the consequences of Dr. Bowen's proposal to eliminate life-saving medical care for this country's 30 million elderly and disabled citizens on Medicare. The only comparable clean sweep of human life in nursing and medical institutions in the history of Western civilization occured during Hitler's reign of terror. Directors of Nazi institutions were then told that: "..it is not possible on economic grounds to continue operating the installations of living corpses." For practical implementation of the plan, Hitler went to the a comparable office

of our Secretary of HHS. Hitler charged the Reich Commissioner for Health, Dr. Brandt, "..with responsibility of expanding the authority of certain officially appointed doctors, so that after a critical diagnosis incurable persons may be granted a mercy death."

Allowing Bowen to take this post means passing a sure and swift death sentence on this nation's elderly, that is close to 12 percent of our population!

Bowen targets the high cost of medical care for those in their last 40 days of life or for those in their terminal days. Are the Senators aware that these are purely subjective terms, applied and used from the onset of an illness as a means of non-intervention: "They are terminal, why prolong dying, why spend thousands trying to keep them alive for a few more days, they are going to be dead soon anyway?" In my capacity as a Club of Life investigator, I have found the term "terminal" can mean anything from a life expectancy of 1-2 months to a year or two of life.

No doubt, Dr. Bowen would agree to let nature and disease take its course for the millions of Alzeimers or AIDS victims, or the 2.8 million U.S. citizens who are permanently disabled or the 3.2 million elderly on Medicaid. Should we just not bother to treat them at all, these thousands upon thousands, after all, they too are 'terminal'. Surely, the Senators can see that according to Otis Bowen, the question is of "who lives, who dies" is determined purely by the size of the budget-cutter's axe.

In addition to nation-wide adoption of "living wills", Bowen's Council recommended other measures which would also mean a radical reduction in the amount and quality of health care available, including: raising the age of Medicare eligibility from 65 to 67, a measure which would mean an early death for tens of thousands of elderly; taxing employer-paid health benefits; and increasing the amount Medicare recipients must pay for medical care.

II. The Murder of 'Baby Doe'

In the case of "Baby Doe" the Bloomington, Ind. infant who was born with a mild case of Down's Syndrome and was allowed to starve to death, Bowen publically backed the decision by State Supreme Court Chief Givan to permit the infant's parents and Bloomington hospital officials to withhold food, water and medical treatment from the baby. The child died after being starved and dehydrated for six days.

We ask the Senate if there is any reason to believe that this Nazi style decision would not be extended by Bowen to the elimination of nutrition and hydration from the terminally ill, handicapped, comatose --all cases where cutting lives would nicely cut costs?

It should be mandatory that each member of the Senate read the decision of Deedham, Massechusetts Probate Court Judge David H. Kopelman of October 22, 1985. Judge Kopleman refused to allow the starvation of a young comatose patient, Paul Brophy, on the grounds that the state "is morally obligated to sustain the life of an ill human being even one in persistent vegetative states." Judge Kopelman makes it clear that death by starvation is a barbaric method of dying.

Approximately 3600 children are born every year with Downs Syndrome in the United States. Should physicians and hospitals across the U.S. choose to follow the mandate of their new Secretary and his starvation "treatment"-- these children would not stand a chance.

In fact, Dr. Bowen's "treatment" would certainly have an killing impact on many of the 4.4 % of American children born yearly with some congenital birth defect. Of these, more than 2300 newborns annually are victims of Spina Bifida, another childhood disease demanding repeated operations, special training and equipment throughout the child's life. In the eyes of the shrewd, cost-effciency 'experts' like Dr. Bowen, these children are fiscal disasters who should not be treated.

Instead of creating a national mandate to stomp out these diseases and to give these children and families much needed support and hope in taking on the challenge of childhood disease, Bowen is more likely to impose a limit to care and high technological intervention.

III. Palliative Care versus Cure

This year it is estimated that over 910,000 Americans will get cancer and over 462,000 will lose their lives to it. This nation urgently requires a military style mobilization to wipe out cancer with national research protocols. Yet Bowen is more likely to use his Cabinet post to initiate the use of heroin or marijuana for "treatment of pain". He openly admits giving his wife, who was dying of cancer, a marijuana derivitive and another drug, dimethyl sulfoxide, which was not approved for treatment of cancer patients.

Bowen not only defended his action but critized the Food and Drug Administration-a part of HHS-for its "interference" in medicine.

The Administration's economic policies have hurled the nation's healthcare over the brink of disaster but the nomination of Dr. Otis R. Bowen will officially bring the nation under the goosestep of another "fiscal conservative" physician, Hitler's Dr. Brandt. That makes him under present circumstances the kind of fellow we Americans hanged at Nuremberg at the end of the last world war.

Linda Everett
Club of Life, U.S.A.

-end-

12/9/85

Statement for Hearing of Dr. Otis Bowen, December 10, 1985

MEMORANDUM FOR A NEW SECRETARY OF HHS

by Wilbur J. Cohen

President Reagan has nominated Dr. Otis Bowen of Indiana as the next Secretary of Health and Human Services a position which a California newspaper recently stated was "one of the toughest in government." Fifteen persons have held this important position since the Department was created by President Eisenhower as a Cabinet post in 1953. Issues such as abortion, AIDS, the financial solvency of four Social Security funds, pure foods, drugs, and cosmetics, welfare, workfare, Medicare and Medicaid, are just some of the many areas a Secretary of HHS must comprehend, handle, and discuss reasonably intelligently in innumerable press conferences, congressional testimonies, on television, and with a wide variety of professional staff.

This situation reopens a perennial question as to how and who should run HHS, (originally HEW) and how should the programs in it be structured, financed and administered.

Number sixteen is coming up to bat. Dr. Bowen, if confirmed will be the first physician to be the head of this important Department. The average half-life of the prior occupants in the

post has been one year and Dr. Bowen's is likely to be less than two years. Only one previous occupant has lasted as long as three years, (Celebreeze) and the shortest tenure was mine--eight months. Despite the controversies which surround the Department's complex programs, policy, and expenditures, there are always several--sometimes many persons--who would still be willing to take on the massive job of Secretary. It involves managing a vast and far-flung network encompassing over 140,000 Federal employees, several hundred different programs, and some 349 billion dollars a year in expenditures. The bulk of these are in entitlements, which are "uncontrollable" budgetwise in the short run. (This compares with $314 billion dollars for the military Budget.) In addition, the Departments' policies affect every Governor, every state legislature andsome 200,000 state and local officials who administer the Federally financed programs in welfare, Medicaid, public health.

Secretary Ribicoff called the Department, in 1962, a can of worms and unmanageable. In my 1968 Annual Report to the President and the Congress of January 14, 1969, I stated that I did not find it so, but the myth has now become the reality. Two of the secretaries, Califano and Heckler were fired by their Presidents. President Carter fired Joe Califano at the same time he fired the Secretary of the Treasury. He didn't fire them because they were incompetent but, in my opinion, rather to try to demonstrate he was in charge. Secretary Finch collapsed from the stress and strain of the job and left government. Ribicoff

left as soon as he could for the independence and prestige of the Senate. He thought he lost about 100,000 votes in Connecticut by taking a year and a half off from his political career to serve as the Secretary. Richardson was transferred to Defense by President Nixon for not cutting back on programs sufficiently. Nixon put in charge "Cap the Knife" Weinberger, who found the experience of managing expanding programs such as Medicare, Medicaid, and Social Security an excellent background for becoming an expansive Secretary of Defense. Gardner probably resigned in frustration because he didn't see how he could accomplish anything more in the light of current political and fiscal conditions. Celebreeze stayed on until he was assured the lifetime security of a circuit court federal judgeship. President Ford discouraged Mathews from taking action on any issue before his election campaign in 1976. HEW teaches many things. The Secretary of HHS may be a training ground for other assignments!

Only Flemming, Richardson, Folsom, and Cohen ever admitted that they really enjoyed the job, the pressures, the challenges, the opportunities to serve. There have been outstanding secretaries, despite the magnitude of the responsibility: Folsom, Flemming, Richardson, and Gardner were among the Greats. Celebreeze was fortunate to be in charge when President Johnson pushed through Congress the most numerous and far-reaching important domestic social reforms since the founding of the republic. In the early days of the nation, a Cabinet appointment

was frequently a stepping-stone to higher elective or appointed office or other influential positions. Today, it may be a stepping-stone to obscurity. Congress and the Executive Branchdo not fully utilize the experience of previous Cabinet officers except in very special circumstances.

Yet the position of being the principal governmental officer concerned full-time with issues from birth to death, teen-age pregnancy, the future of medical research and heart transplants, mental illness and mental retardation, and a host of other wide-ranging matters which sooner or latter affect every one of the 240 million citizens of the United States, and the 330 million who are likely to be here in the not too distant future, is a challenge and an opportunity for innovation and management. In addition, the medical research budget of the Department of over five billion dollars a year represents about three-fourths of all the medical research expenditures in the entire world and thus affects everyone on this planet today and for generations to come.

The Secretary is a political representative of the President and his Administration and must participate in innumerable political decisions on proposed legislation, budgets, and personnel. The Secretary's commission from the president says the appointee serves "at the pleasure of the president" and adds for emphasis, "for the time being." But the magnitude of the Department's responsibilities can be handled properly with a

non-partisan and non-political presence in the hundreds of local Social Security offices, as well as in the distribution of the thousands of medical research grants to universities through the National Institutes of Health and in the periodic seizure of contaminated foods, and the disapproval of unsafe drugs and devices by the Food and Drug Administration.

Now we come again to select a person to conserve and reform the social gains of many decades, to try to eliminate fraud, abuse, and mismanagement, reallocate priorities, maintain the morale of a despondent bureaucracy, constrain rising medical costs, and also try at the same time to protect the health, welfare, and future social security of all the American people.

The first cut at reviewing the qualifications of such a modern Solomon falls upon the seventeen distinguished members of the Senate Committee on Finance and then upon all one hundred members of the entire Senate. In any business or university of comparable magnitude there would be a diversified and well respected search committee appointed to seek out the best candidates in the nation. But unfortunately, we have no established performance criteria for the selection of our Cabinet officers. The Senate should not ask what the nominee can do for the Administration, but rather the Senate should ask what the nominee will do for the country.

Health and welfare functions in the Federal Government were strewn around indiscriminately in various Cabinet departments

before a separate Cabinet Department of Health, Education,and Welfare was created by President Eisenhower with Senator Robert Taft's help in 1953. The Public Health Service and the forerunner of the National Institutes of Health was in the Treasury Department for many years. The Childrens' Bureau created in 1912 by President Taft was in the Labor Department. Vocational rehabilitation and Education were in the Interior Department. Social Security was created as an independent Board in 1935.

Although Franklin D. Roosevelt started the process of consolidation and unification of these agencies by creating the Federal Security Agency (FSA) as a non-Cabinet unit in 1939, it was President Eisenhower who had the courage and the political ability to transform the FSA into a full fledged Cabinet Department (HEW) fourteen years later.

It was the first Republican appointed Secretary, Mrs. Oveta Culp Hobby, with the help of her liberal minded Under Secretary, Nelson Rockefeller, and with the assistance of Marion B. Folsom, the broad guaged businessman Under Secretary of the Treasury, who accepted, endorsed, and expanded the Social Security program in 1954 in opposition to the conservative wing of the Republicans in Congress led by Representative (later Senator) Carl Curtis of Nebraska. Eisenhower accepted the social security improvements in 1954, 1956, 1958, and 1960, crowning these forward steps with the adoption of disability insurance in 1956 and the Kerr-Mills legislation in 1960 which eventually led to Medicaid in 1965.

Although Eisenhower opposed Medicare in 1960 (despite the favorable recommendation from his Secretary of HEW, Arthur Flemming), he allowed Secretary Flemming to propose a liberal and comprehensive Medicaid type plan which was more comprehensive than Medicaid is today.

These Republican supported entitlement improvements today are referred to pejoratively as "uncontrollables". But the one which many Republicans (and some Democrats) and President Reagan tried to restrain since 1983 was put into law by the insistent demand of President Nixon and his Republican supporters, Gerald Ford and John Byrnes, the minority leader in the House of Representatives and the ranking minority on the House Committee on Ways and Means respectively. The so-called Democratic expansionists of the 1950s, 1960s, and 1970s were aided and abetted by the Republicans of the day who disclaim their heritage in their current attacks on entitlements and uncontrollables.

Within HHS today are programs which most conservatives do not seek to repeal or restructure. They wish to restrain their cost and effectiveness and to surround the programs with the proper rhetoric as they see it. The medical research programs of the National Institutes of Health--started a hundred years ago--have widespread support from the middle class and upper income groups, the universities, foundations, and the highly educated. The Food and Drug, founded by the Republican Roosevelt in 1906 has been around for 80 years.

The maternal and child health program was the only general revenue program whose appropriations was increased in 1984. Along with the crippled childrens programs and programs to help the mentally retarded and mentally ill, they are protected by an influential body of taxpayers who are articulate, influential, and affluent.

Along with social security, these health programs can be jewels in the crown of a new Secretary. It will be interesting to watch how a physician negotiates cutbacks with the American Medical association, the American Hospital Association, and his colleagues in medical research in the Universities.

The health programs of the Department can and should be a source of pride to both Republicans and Democrats.

What is needed is a Secretary who basically believes in the fundamental wisdom of the programs Congress, created with the help of at least ten Presidents from both political parties. A person who also believes the programs are manageable and who has no desire to use the temporary appointment as a stepping stone to some other political or higher position in government or business or anywhere else. A person who would reform the welfare system along the lines which President Nixon and Carter advocated and which eight former secretaries--Republican and Democratic--have supported.

What Congress should do immediately to help the new

Secretary is to take social security and Medicare out of the Federal Unified Budget for 1986 by advancing the date from 1993 in the present law. The Congress should also take social security and Medicare out of the Department of HHS and restore it to an independent Board status as it was from 1935 to 1946.

These two changes would make HHS more manageable for a new Secretary--and more understandable to the public--and help to depoliticize social security as a major issue.

Social security (OASDI) is not broke; so the President and Congress should stop trying to fix it. Don't tinker with the COLA or the OASDI benefits or the investment of social security funds. OASDI does not contribute to the deficit. Allow the Secretary to concentrate on the seven million children on welfare (AFDC) and how to enable them to reach adulthood with a good education, job skills, proper nutrition, and appropriate employment opportunities for the three million mothers. Allow the Secretary to work on reducing infant mortality and reducing poverty among the entire population.

Dr. Bowen has a challenging role ahead of him.

I wish him good luck.

Wilbur J. Cohen was the seventh Secretary of HEW in 1968, the only one who was also Under Secretary, Assistant Secretary and Acting Secretary and who rose to the political office from the Civil Service (1935-55). He is currently professor of Public Affairs at the LBJ School of Public Affairs, the University of Texas.

Caylor-Nickel
Medical Center

One Caylor-Nickel Square
Bluffton, Indiana 46714

RE: December 10, 1985 Confirmation Hearing on Otis R. Bowen, M.D.

December 19, 1985

Senator Robert Packwood
Chairman
Senate Finance Committee
259 Russell Senate Office Building
Washington, D.C. 20510

Senator Orrin Hatch
Chairman
Labor and Human Resources Committee
524 Hart Senate Office Building
Washington, D.C. 20510

Dear Senators Packwood and Hatch:

As President of the Caylor-Nickel Medical Center I am pleased to submit our support for the nomination of the Honorable Otis R. Bowen, M.D., former governor of the State of Indiana, to be Secretary of the U.S. Department of Health and Human Services.

Caylor-Nickel Medical Center is a 201 bed not-for-profit entity located in Bluffton, Indiana. In 1984 the hospital served over 65,000 outpatients, of which 70 percent came from counties outside of our own. With inpatients from 39 counties in three different states and a medical staff representing 29 different specialties and subspecialties, Caylor-Nickel is a major regional provider of health care services. As such, we are committed to assuring the highest quality of services to patients from a broad socio-economic background. Our mission also encompasses an allegiance to cost containment through the provision of

innovative new, cost-effective services which maintaining the highest standard of medical care. Given the nature and mission of our institution, we deem it essential to comment on the nomination of Dr. Bowen for the HHS position.

Dr. Bowen is facing a tremendous task. As an HHS Secretary, he will preside over a myriad of federal programs, the combined budgets of which rank third only behind the budgets of the United States and the Soviet Union.

Clearly, the Department of Health and Human Services is at a critical stage. Not only are many substantive issues in demand of prompt and careful consideration, but the unfilled vacancies within the Department's hierarchy stand as pressing reminders of the need for a progressive and proactive HHS Secretary with a distinct and well conceived program of action. A strong and forceful voice for HHS in the highest counsels of government is essential. It is particularly imperative that the programs providing assistance to Americans living in the shadows of life -- the old, the handicapped, and the sick -- retain a strong advocate within this Administration. But this spokesperson must also be sensitive to the current climate of cost containment and the current need for federal deficit control.

Dr. Otis Bowen is just the kind of person the Department of Health and Human services needs at its helm. As a former two-term governor of the State of Indiana, Dr. Bowen's unique combination of medical expertise and political savvy will serve him well in a position which is often times ranked as one of the most difficult appointments in federal government. Throughout his public career, Dr. Bowen has revealed a strong sense of compassion, particularly in the area of bioethics. Dr. Bowen has also proven to be a pragmatic politician. Proposals such as a small increase in Medicare premiums and the development of the "individual medical accounts" concept reveal a understanding of the complex interplay of politics and policy within the health care reimbursement system.

Of great significance is the role Dr. Bowen played as chairman of the Advisory Counsel on Social Security. It was this panel which, early in the Reagan Administration, developed a set of proposals that ostensibly saved the Medicare system from bankruptcy. Dr. Bowen's medical experience will also provide a necessary substantive expertise in departmental affairs. Taken together, these experiences ensure that the new HHS Secretary will have the right combination of political sensitivity, administrative capability and issue-oriented knowledge. Indeed, Dr. Bowen's nomination suggests the potential for renewal and reaffirmation within the one executive agency known as the "people's" department.

We at Caylor-Nickel strongly support the nomination of Dr. Bowen for the position as HHS Secretary. We believe that in approving this nomination, the Senate proves its willingness to work with the Reagan administration in forging a compassionate and responsible health care policy. I appreciate the opportunity to comment on this important nomination.

Sincerely,

Charles H. Caylor, M.D.

President

Caylor-Nickel Medical Center

CHC:lb

CURE

Citizens United Resisting Euthanasia
R. 1, Box 3, Shepherdstown, WV 25443
304/876-2374

"Where There's Life, There's Hope."

Earl E. Appleby, Jr.
Executive Director

Elsie Paxon Lewis
Secretary

M-Madeleine Appleby
Treasurer

John Haring, Esq.
General Counsel

December 23, 1985

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(partial listing)

Ms. Ann Kantrell
Senate Finance Committee
Room 219
Dirksen Senate Office Building
Washington, DC 20510

Dear Ms. Kantrell:

Attached is our testimony regarding the nomination of Otis R. Bowen as Secretary of Health and Human Services. I am hand-delivering it to the above address this date in compliance with the fourteen-day period for submittal of written testimony for inclusion in the hearing record as confirmed by you to our Legislative Chairman, Mrs. Madeleine Appleby.

Your courteous assistance is most appreciated. If it would be possible to receive a copy of the official record of the hearing including all written testimony incorporated in the record, it would be appreciated as well.

May I take this occasion to wish you a blessed and holy holiday.

With best wishes,

Sincerely,

Earl E. Appleby, Jr.
Executive Director
CURE

EEA/efl
Enclosure

I call heaven and earth to witness this day, that I have set before you life and death, blessing and cursing. Choose therefore life, that both thou and thy seed may live. Deut. 30:19

TESTIMONY TO SENATE FINANCE COMMITTEE RE NOMINATION OF OTIS R. BOWEN
M-Madeleine Appleby, Leg. Ch., CURE, Dec. 10 1985

Mr. Chairman. As an educational organization striving to inform our fellow Americans about the deadly dangers of euthanasia, we call on you to contribute to the public's education by scheduling open, oral testimony by opponents of the nomination of Otis R. Bowen as Secretary of Health and Human Services rather than orchestrate today's chorus line in the guise of a "hearing."

As a support group working to help besieged families protect their loved ones' lives and well-being, we demand that you stop driving this railroad to ruin for the victims and the targets of checkbook euthanasia-- the infirm, the impaired, the aged and permit the American people to be heard <u>before</u> not after the Bowen train reaches the station.

The nominee's record is as clear as it is callous. As chairman of the Advisory Council on Social Security, Mr. Bowen abused his mandate from the President by appearing before this very committee to urge that states enact euthanasia laws to balance the Medicare budget on the dead backs of Medicare recipients. (Att. A) Bowen's dying-for-dollars school of graveside economics (reminiscent of Hjalmar Schacht) indicts him as the Dick Lamm of the Republican Party and renders him morally unfit to serve as Secretary of Health and Human Services. To confirm Otis Bowen as guardian of the people's health is to place, not a fox, but a wolf in charge of the chicken coop, and a hungry wolf at that.

In 1972, Bowen advocated abortion-on-demand throughout the first twelve weeks of life. (Att. B) In 1985, anonymous administration spokesmen claim he now backs baby-killing on a somewhat more restricted scale. Has the anti-life leopard changed some of his spots?

not on euthanasia, the danger CURE was founded to combat, the impending holocaust which will dwarf the body count of the abortion chambers and fulfill America's suicidal death wish.

Appearing before this committee in April of 1984 (not 1972), Mr. Bowen, endorsed legislation legalizing euthanasia suicide pacts. In just two paragraphs in which Bowen urges states to enact "living will" laws to "eliminate the financial burden" on Medicare, he cites "health expenditures," "Medicare expenditures" (twice), "financial burden," trust fund" (twice), "savings," "revenues," "revenue," and "costs" (the latter in describing his father's recent death). Eliminating brainwashed, bullied, and bludgeoned Medicare recipients will indeed "eliminate the financial burden." But Bowen's "viable alternative sources of revenue" will prove anything but "viable" for the victims of checkbook euthanasia.

Nor does Bowen discriminate in his anti-life philosophy. He is an equal-opportunity-to-die euthanasia advocate. When the chief injustice of the Indiana Supreme Court, Richard Givan, who had sentenced Baby Doe to starve to death, was reconfirmed in November of 1984 (not 1972), it was with the blessing of Otis Bowen, who decried the" dangers" posed by "single-issue advocacy." (Att. C) Why to hear Mr. Bowen, you would think it was the Remember Baby Doe Committee and not the starve Baby Doe judge that threatened the public welfare.

Mr. Chairman. Members of the Committee. In the names of yesterday's, today's, and tomorrow's euthanasia victims, young, old, and in-between, we call on you to reject this ill-advised and immoral nomination. Mr. Chairman. In the name of the American people and their right to be heard on a matter of life and death, we demand that you let them be heard BEFORE not after the damage has been done. Thank you.

M. Madeleine Appleby
Mrs. M-Madeleine Appleby, Legislative Chairman
Citizens United Resisting Euthanasia (CURE)
R. 1, Box 3
Shepherdstown, WV 25443
304-876-2374

ATT. A

STATEMENT

BY OTIS R. BOWEN, M.D.

CHAIRPERSON

ADVISORY COUNCIL ON SOCIAL SECURITY

BEFORE THE SENATE COMMITTEE

ON FINANCE

APRIL 9, 1984

MR. CHAIRMAN, MEMBERS OF THE COMMITTEE ON FINANCE, I AM OTIS BOWEN FORMER GOVERNOR OF INDIANA AND CHAIRPERSON OF THE ADVISORY COUNCIL ON SOCIAL SECURITY. I AM ACCOMPANIED TODAY BY MR. SAMUEL H. HOWARD, A MEMBER OF THE COUNCIL, AND MR. THOMAS R. BURKE, THE COUNCIL'S EXECUTIVE DIRECTOR. I AM HERE TO REPORT ON THE FINDINGS AND RECOMMENDATIONS OF THE COUNCIL.

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FINALLY, THE COUNCIL ENDORSES THE CONCEPT OF "ADVANCE DIRECTIVES" OR "LIVING WILLS" WHICH ARE CURRENTLY RECOGNIZED BY LAW IN FOURTEEN STATES. THE COUNCIL CALLED FOR A STUDY TO LOOK AT THE IMPACT ON HEALTH EXPENDITURES IN THOSE STATES HAVING SUCH LAWS AND ENCOURAGED OTHER STATES TO ADOPT SIMILAR LEGISLATION. LIVING WILLS WOULD PREVENT UNNECESSARILY HEROIC MEASURES BEING TAKEN IN THE TERMINAL DAYS OF LIFE. ELEVEN PERCENT OF MEDICARE EXPENDITURES ARE SPENT IN THE LAST FORTY DAYS OF LIFE AND SOME 25 PERCENT OF MEDICARE EXPENDITURES ARE INCURRED BY PATIENTS IN THE LAST YEAR OF LIFE. THE COUNCIL FULLY RECOGNIZES THAT THIS MAY BE A CONTROVERSIAL RECOMMENDATION; HOWEVER, THE COUNCIL UNANIMOUSLY ENDORSED IT. AS A PHYSICIAN, I INITIATED COUNCIL DISCUSSIONS ON THIS SUBJECT HAVING RECENTLY LOST MY FATHER AND THUS KNOWING THE ENORMOUS COSTS THAT WERE INCURRED IN HIS TERMINAL DAYS PRIOR TO DEATH.

THE COUNCIL RECOMMENDATIONS I HAVE JUST REVIEWED WOULD, IF ENACTED, ELIMINATE THE FINANCIAL BURDEN ON THE HOSPITAL INSURANCE TRUST FUND. IF THOSE RECOMMENDATIONS WHOSE SAVINGS OR REVENUES HAVE BEEN QUANTIFIED WERE TO BE IMPLEMENTED PROMPTLY, THE TRUST FUND WOULD BE FULLY SOLVENT IN 1995 WITH A MODERATE RESERVE TO GUARD AGAINST CONTINGENCIES. THOSE RECOMMENDATIONS WHICH HAVE NOT BEEN QUANTIFIED REPRESENT, IN OUR VIEW, VIABLE ALTERNATIVE SOURCES OF REVENUE IN THE EVENT OF DELAYS OR FAILURE TO ADOPT PORTIONS OF THE QUANTIFIED PACKAGE.

ATT. B

STATE of INDIANA

INDIANAPOLIS 46204

OTIS R. BOWEN, M.D.
SPEAKER
HOUSE OF REPRESENTATIVES
THIRD FLOOR STATE HOUSE
INDIANAPOLIS, INDIANA

304 NORTH CENTER STREET
BREMEN, INDIANA 46506

April 28, 1972

Ms. Mildred Bailey, R.N.
1115 North Adams Street
South Bend, Indiana 46628

Dear Ms. Bailey:

In response to your letter concerning abortion legislation I shall be as candid as I can.

The present law concerning abortions in Indiana is very rigid and permits abortion only to save the life of the mother. I am not for opening the abortion law wide open but do believe there may be reasons for loosening it a very little bit. I shall not have such a bill as a plank in my platform as a candidate. In the event that there be any liberalization I would insist that the following safeguards be present:

1. A residency requirement of at least six months to a year in Indiana.
2. A definite rigid length of gestation not to go beyond twelve weeks.
3. That specific requirements be such that it could only be done in a licensed institution.
4. That it could only be done by a physician with an unlimited license to practice medicine.
5. That there be accurate record keeping so as to keep track of complications so that reevaluation could be done at any time.
6. That it be equally available to the poor as well as the rich.

I realize from the tone of your letter that you would have preferred that I said absolutely and under no circumstances would I approve. I assure you that I will never push for change but also recognize that there is a great push by our young people of all denominations for liberalization and that other states have done so. In the event that the Legislature should pass such a bill, I would veto it unless it had the rigid requirements that I have just mentioned.

Kindest personal regards,

Otis R. Bowen, M.D.
Speaker

THE INDIANAPOLIS STAR

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Letters to the editor

Judging the Givan record

The chief justice of the Indiana Supreme Court is being attacked by a small group of people, called the "Remember Baby Doe" committee, who unfortunately do not understand the way the Indiana judicial system operates.

They propose the defeat of Justice Richard M. Givan in the general election on the basis of erroneous and unfair assumptions about the tragic "Infant Doe" case.

It should be emphasized that the case was before the Supreme Court only on a question of the jurisdiction of a trial court. Because the action was not an appeal and case evidence was not before it, the Supreme Court under the Constitution and the law could not and did not decide whether the lower court's decision was right or wrong.

We members of the Bipartisan Committee to Support Chief Justice Givan, who have signed this letter, are alarmed about the dangers which single issue advocacy can pose for the integrity of the state's system of justice. If the administration of justice is to be fair and even-handed, judges must not depend for their continuance in office on the approval of narrow interest pressure groups. Rather, judges should be evaluated on the basis of their total records.

Indiana is fortunate to have judges of Justice Givan's quality and integrity serving on the Supreme Court. His continuance in office clearly is justified by his 15 years on that court and the 10 years of his leadership as chief justice. The voters of Indiana should vote "yes" for Justice Givan on the retention ballot of Nov. 6.

Other members who endorse this statement are:

James D. Blythe, Otis R. Bowen, Sheldon A. Breskow, James V. Donadio, Francis J. Feeney Jr., Samuel A. Fuller, George B. Gavit, Stephen Goldsmith, Mary Godsey, Paul G. Jasper, Frank Lloyd, Virginia Dill McCarty, Lawrence McTurnan, Peter D. Miller, Arthur L. Payne, William J. Regan, George A. Rubin, John M. Ryan, Irv Sacks, Thomas M. Scanlon, Karl J. Stipher, John F. Townsend, Donald W. Ward, Matthew E. Welsh and Marilou Wertzler, all of Indianapolis.

Gerald Finney and Ralph Sipes of Anderson, George N. Craig of Brazil, Jeffrey V. Boles of Danville, [illegible] F. [illegible], [illegible] John L. Carroll and [illegible] of Evansville, William A. [illegible], William F. [illegible] and G. [illegible] Randall of Fort Wayne, [illegible] Ruman of Hammond, [illegible] of Highland, [illegible] Withered of Lafayette, Robert J. [illegible] and [illegible] Stimson of Lawrenceburg, [illegible] College of [illegible], [illegible] Chipman of Plymouth, [illegible] Maley of Richmond, John R. [illegible] of Scottsburg, Thomas H. [illegible] of South Bend, Hansford [illegible] of Terre Haute, Quentin A. [illegible] and Glenn J. Taber of [illegible], and Rabb Emison of Vincennes.

HOWARD S. YOUNG JR.
[illegible]

FRANK W. CAMPBELL
[illegible]
Co-chairmen

National Democratic Policy Committee

Lyndon H. LaRouche, Jr.
Chairman Emeritus
Advisory Council
Warren Hamerman
Chairman
Barbara Boyd
Treasurer

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Statement of Warren G. Hamerman
Chairman, National Democratic Policy Committee
Task Force Chairman of the Biological Holocaust
Task Force of the Executive Intelligence Review

On the matter of the nomination of
Otis Bowen to be Secretary of Health
and Human Services

Submitted for the written record, December 10, 1985

The National Democratic Policy Committee absolutely denounces the appointment of Otis Bowen to be Secretary of Health and Human Services. I also absolutely denounce the KGB-style methods that are being used to railroad this nomination through the Senate, without allowing for public testimony. It is normal Senate procedure, and should be a guaranteed right in a republic, for opposition witnesses to be afforded time to present their case to the Senate, especially in the case of a controversial witness. But, to the contrary, a colleague of mine was told, by a Finance Committee staff member, that verbal testimony was being refused on the Bowen nomination "because it's too controversial." These tactics are repugnant to the American system of government.

The record on Dr. Bowen is clear. He supports the doctrine that some lives are not worth living -- this is the policy of euthanasia. His appointment will guarantee a further, rapid institutionalization of the kind of "useless eaters" policies, through which the Nazi regime murdered millions of innocent people, in part, because they were considered a drain on financial resources. This is not the first time that someone with a medical degree has abused that degree. Will Dr. Bowen become this decade's version of Dr. Joseph Mengele, the Angel of Death?

What we see with the Bowen appointment is the logical consequence of the decision, promoted by Donald Regan and publicly announced by Treasury Secretary James Baker III at the International Monetary Fund meeting last April, that the U.S. economy should be subjected to the same 'surveillance' and austerity measures which have already decimated the developing sector. IMF policies are merely the modern version of Shakespeare's Shylock -- the debt must be collected or the deficit reduced, no matter what the price paid in lives.

It is no accident that Donald Regan was the person who sold the President on Bowen. Regan is an IMF mole, and he knows that Bowen will start slashing medical costs to meet the budget goals dictated by the IMF and the international financial establishment.

Bowen's pro-euthanasia stand is a matter of public record. As head of the President's Advisory Commission on Social Security, he told the Senate Finance Committee in 1984 that Congress should act to incorporate, into the Medicare system, "living wills [which] would prevent unnecessarily heroic measures being taken in the terminal days of life." Such heroic measures, he argued, cost too much. In his testimony, Bowen continued, "Eleven percent of Medicare expenditures are spent in the last 40 days of life and some 25 percent of Medicare expendutires are incurred by patients in the last year of life. The Council fully recognizes that this may be a controversial recommendation; however, the Council unanimously endorsed it."

Bowen also endorsed the reappointment of Indiana Supreme Court Justice Givan, in the face of widespread criticism of Givan's role in the legal murder by starvation in 1982 of a Bloomington, Ind. infant, "Baby Doe," whose Down's Syndrome afflicted identified him as another life not worth living.

It is an abomination to appoint someone who puts a dollar sign on human life. It is a danger to national security to appoint such a person at a time when the AIDS epidemic is raging out of control in the African AIDS belt, where between 10 and 60 million Africans are infected, and at a time when the epidemic threatens to break outside of the "risk populations" in the advanced sector. Emergency U.S. government policies are necessary. We must spend WHATEVER is necessary to carry out a crash mobilization to halt the AIDS epidemic, not what the financial community tells us is affordable. Not only must an Apollo-style crash medical research program be launched, but the collapsed economies of Africa and the collapsing economy of the United States must be rebuilt. The debt-repayment and deficit-closing demands of the bankers must be put aside, so that Western civilization can save itself from biological holocaust.

As the EIR's Biological Holocaust Task Force, of which I am chairman, has revealed, it is, in part, direct Soviet influence in the World Health Organisation, which is responsible for spreading the disinformation line that AIDS is only a homosexuals' or drug users' disease. WHO's top official, responsible for AIDS, is Dr. Sergei Litvinov, simultaneously a top official in the Soviet Health Ministry. Dr. Litvinov willfully ignores the pandemic nature of the disease in Africa, in an effort to prevent the appropriate public health mobilization in the West.

At a time when most Americans are convinced, correctly, that AIDS, and the necessary public health response, are a matter of national security, it is a danger to the nation that someone, whose philosophy stands directly opposite, has been appointed.

At the just concluded Bishop's Synod in Rome, Josef Cardinal Ratzinger, prefect for the Vatican's Congregation for the Doctrine of the Faith, spoke for peoples of all faith when he denounced immorality of the "free market" policies of Adam Smith. He attacked the "astounding presupposition" that "the natural laws of the marketplace are by their nature good." Ratzinger said, "It has become an increasingly clear fact of economic history that the formation of economic systems and their grounding in the general welfare, depends upon a certain moral discipline."

The Senate can begin to recognize the moral force of that concept, by rejecting the nomination of Dr. Bowen, and any concept of a life toeexpensive to maintain.

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