S. HRG. 110–227

FIELD HEARINGS FOR FISCAL YEAR 2008

HEARINGS

BEFORE THE

COMMITTEE ON THE BUDGET UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

February 20, 2007—THE IMPACT OF FEDERAL FUNDING ON LAW ENFORCEMENT AND FIRST RESPONDERS

August 7, 2007—AN EXAMINATION OF HEALTH CARE COSTS: CHALLENGES AND OPTIONS FOR REFORM

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U.S. GOVERNMENT PRINTING OFFICE

37–526pdf WASHINGTON : 2007

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CONTENTS

HEARINGS

	Page
February 20, 2007—The Impact of Federal Funding on Law Enforcement and First Responders	1
August 7, 2007—An Examination of Health Care Costs: Challenges and Options for Reform	49

STATEMENTS BY COMMITTEE MEMBERS

Chairman Conrad 1, 49

WITNESSES

Candace Abernathy, Patient, Minot, ND 81, 84
Burch Burdick, State's Attorney, Cass County 11, 13
Janis Cheney, State Director, AARP North Dakota, Bismarck, ND 78
Ken Habiger, President, Casselton Ambulance Service 40, 42
Terry G. Hoff, Chief Executive Officer and President, Trinity Health, Minot, ND 91, 94
Bruce Hoover, Fire Chief, Fargo Fire Department 27, 29
Mark A. Johnson, Executive Director, North Dakota Association of Counties 32, 34
Paul Laney, Sheriff, Cass County Sheriff's Department, Cass County 19, 22
L. John MacMartin, President, Minot Area Chamber of Commerce, Minot, ND 88, 90
Keith Ternes, Chief of Police, Fargo Police Department 15, 17
Terry Traynor, Assistant Director, North Dakota Association of Counties 32
Mary K. Wakefield, PhD, RN, Associate Dean for Rural Health and Director, Center for Rural Health University of North Dakota, Grand Forks, ND 58, 63
Hon. Dennis Walaker, Mayor, City of Fargo, ND 9

THE IMPACT OF FEDERAL FUNDING ON LAW ENFORCEMENT AND FIRST RESPONDERS

TUESDAY, FEBRUARY 20, 2007

U.S. SENATE,
COMMITTEE ON THE BUDGET, FARGO, N.D.

The committee met, pursuant to notice, at 1:32 p.m., in room 201, Fargodome, Hon. Kent Conrad, chairman of the committee, presiding.

Present: Senator Conrad.

Staff Present: Mike Jones, John Fetzer, Sean Neary, and Jolene Thorne.

OPENING STATEMENT OF CHAIRMAN CONRAD

Chairman Conrad. The hearing before the Senate Budget Committee will come to order.

First of all, I want to thank the witnesses for being here. I want to especially thank the very distinguished panels that we have to talk about the resources needed for law enforcement and first responders.

As you know, we face now the challenge of writing a budget for the United States, and we have to do that in the next 30 days. So this is a critically important time to get input from those who are especially affected by these decisions.

Let me just start and talk about the budget the President has sent to us and how it affects law enforcement and first responders. There are parts of the President's proposals that I must find—I must say I find startling.

President's Budget Cuts Funding for First Responders

	2007 Adjusted for Inflation	President's 2008 Request	% Difference
COPS	$553 M	$32 M	-94%
Byrne/JAG	$530 M	$350 M	-34%
State Homeland Security Program	$535 M	$187 M	-65%
Law Enforcement Terrorism Prevention Program	$382 M	$263 M	-31%
Firefighter Grants	$675 M	$300 M	-56%

Source: OMB, SBC Democratic staff

The first is the COPS program that the President has proposed cutting by 94 percent; from $553 million to $32 million.

A second area the President has proposed major reductions is the Byrne grants; so important to local law enforcement. $530 million provided in 2007 by the Congress, and the President has proposed cutting that 34 percent.

On State Homeland Security Program funded at $535 million for fiscal year 2007, the President proposes cutting that 65 percent. And we are not talking about here Washington talk about cuts where they talk about reduction in the increase. I am talking about real cuts. I am talking about dramatic reductions from the amount of money we had last year.

On Law Enforcement Terrorism Prevention Program. $382 million last year. The President proposes 263 million; a 31 percent cut.

Firefighter grants. Last year Congress provided $675 million. The President has proposed $300 million; a 56 percent cut. Let me just say the needs of law enforcement, the needs of first responders have not been reduced. If anything, the need for law enforcement, the need for Homeland Security, the need for first responders' resources, has increased in the country. Certainly not been reduced.

Let me go to the next slide, if we could. In terms of the funding, these programs have provided North Dakota.

North Dakota First Responder Funding

COPS (1994 – 2006)	$36,810,451
Byrne/JAG and Local Law Enforcement Block Grants (1988 – 2006)	$42,003,868
State Homeland Security Program (2003 – 2006)	$48,530,232
Law Enforcement Terrorism Prevention Program (2004 – 2006)	$12,118,993

Note: Local Law Enforcement Block Grants merged into Byrne/JAG in 2005.
Source: DOJ, DHS, and ND Attorney General's Office

The COPS program from 1994 to 2006 has provided over $36 million.

The Byrne grants and local and law enforcement block grants from 1988 to 2006 have provided $42 million to North Dakota.

State Homeland Security Program from 2003 to 2006 has brought over $48 million to North Dakota.

And the Law Enforcement Terrorism Prevention Program from 2004 to 2006 has brought $12 million to North Dakota.

Now I know in Washington sometimes they ridicule the notion that North Dakota gets terrorism-prevention grants. I just say to those people you are only as strong as your weakest link. This is the United States of America. It is not just the East and West Coast of America.

And anybody who has watched how terrorists think about coming into this country know that they search and probe for a weakness, for an area of vulnerability, and that is where they seek to come through the border.

So yes, we should have less funding—we understand that—than in New York or Los Angeles or San Francisco or in Washington, D.C.

They are the high-threat areas. They have to get a disproportionate share of the funding. But the notion that none of the rest of the country gets anything, frankly, makes very little sense, at least to me.

Let's go to the next slide because I want to focus on the COPS program.

COPS Program Adds Police Officers to North Dakota Communities

Fiscal Year	Police Officers
1994	2
1995	53
1996	62
1997	24
1998	41
1999	18
2000	14
2001	18
2002	24
2003	11
2004	5
2005	2
2006	0
Total	274*

*In addition, COPS Grants have funded 10 part-time officers for North Dakota.
Source: Department of Justice

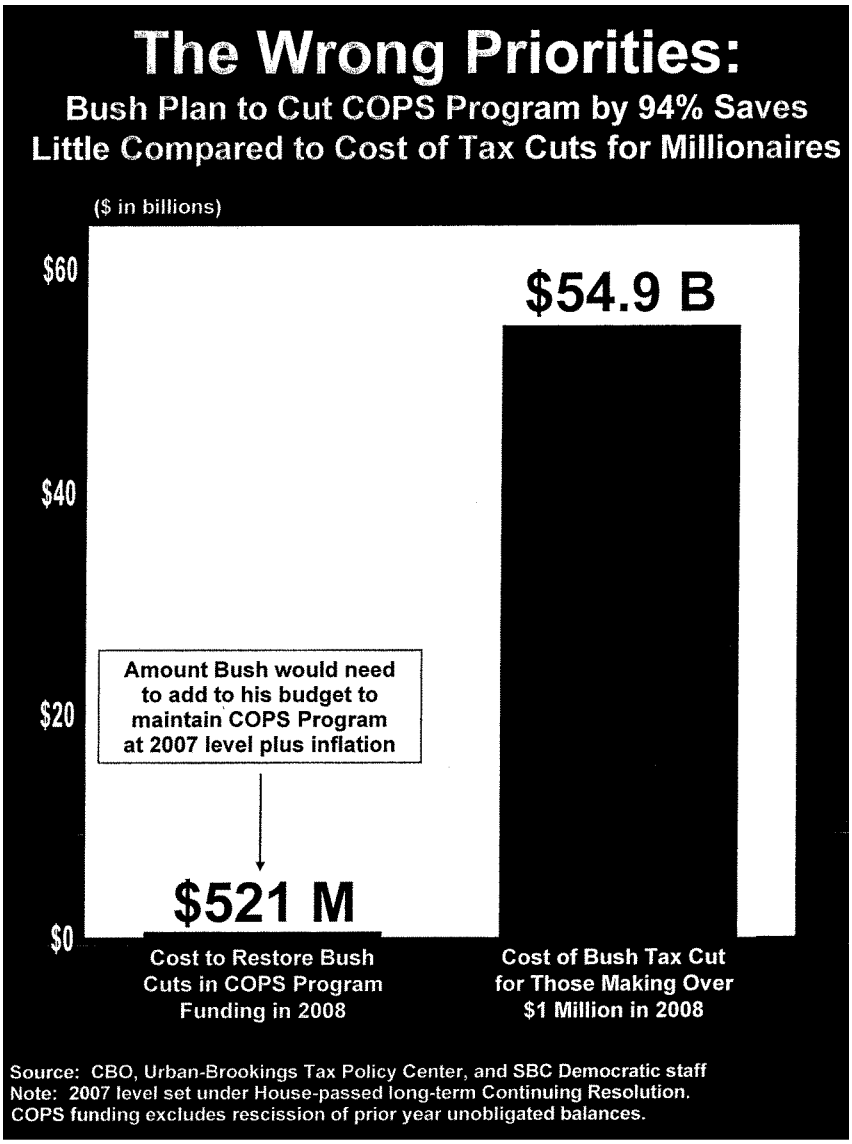
This is the President's—one of the President's proposals that I find most disturbing, to cut the COPS program 94 percent when crime is rising across the country. This is a program that has put a hundred thousand police officers on the street. In North Dakota it has put 274 officers on the street.

It just makes no sense to me to take these officers off the street. Not only in North Dakota, but right around the country. We need these officers on the street.

We know that it works to have officers on the street. We know that it suppresses crime. We know that it leads to a more effective law enforcement environment to have more sworn officers available, on patrol, meeting the needs of communities.

So the proposal here to cut the COPS program by 94 percent just—I do not think is supported by any of the facts, and I hope we will be able to establish today the importance of the COPS program in North Dakota.

Let's go to the next.


The Wrong Priorities:
Bush Plan to Cut COPS Program by 94% Saves Little Compared to Cost of Tax Cuts for Millionaires
($ in billions)
$60
$40
$20
$0
$54.9 B
Amount Bush would need to add to his budget to maintain COPS Program at 2007 level plus inflation
$521 M
Cost to Restore Bush Cuts in COPS Program Funding in 2008
Cost of Bush Tax Cut for Those Making Over $1 Million in 2008
Source: CBO, Urban-Brookings Tax Policy Center, and SBC Democratic staff
Note: 2007 level set under House-passed long-term Continuing Resolution.
COPS funding excludes rescission of prior year unobligated balances.

Let me just deal with the question of priorities, because a budget is fundamentally about priorities. How do we use the resources that the taxpayers provide us in a way that is most efficient and most effective.

In the President's budget, the cost of the tax cuts for those earning over a million dollars a year for 2008 alone is $55 billion. That is the cost of the tax cuts in the President's proposal for those earning over a million dollars a year.

The cost of the tax cuts in 2008 alone is $54.9 billion. The cost to restore the COPS program is $521 million. Now to me that is a priorities that just do not make much sense.

I think it would be reasonable to ask those who are the very wealthiest among us to give up a tiny proportion of their tax cuts, a very tiny part, in order to restore COPS funding. Frankly, I think it would be in the interest of those people to make certain that the COPS program is restored. But we will have a chance to raise these questions and these issues as we go forward with this hearing.

I want to first call on our mayor, mayor of Fargo. I am delighted that he is here, and I thought it would be most appropriate to begin this Budget Committee hearing by getting the perspective of a mayor, somebody who is responsible for budgeting, for determining what the priorities are and where the resources should go.

So, Mayor Walaker, we are delighted that you are here. We especially appreciate your attendance, and if you would just give us your perspective on, being the chief administrative officer of this city, the importance of law enforcement and other first responder Federal resources.

STATEMENT OF HON. DENNIS WALAKER, MAYOR, CITY OF FARGO, NORTH DAKOTA

Mayor Walaker. Well, the No. 1 priority has always been the same, and that is what we need, is a safe and a healthy community.

In 2005 we put together the budget, and it made a lot of sense to do some things to assist our police chief in early hiring and so forth, and that is what we did and we put on new—two new police officers in Fargo without the COPS grant.

The COPS grant basically allows us to transition in our budget. They pay basically for police officers for the first year, and then it dwindles down after 3 years. Then it becomes a city obligation, but it allows you to transition.

When I saw Senator Conrad's process there on the people making over a million dollars, and we are talking about 1 percent of that to restore COPS grants, it just befuddles me that there is that kind of exposure.

What is going to happen in the next budget is we are going to be struggling, and I mean struggling, to hire new people to meet our needs once again.

Our fire chief, which is also a first responder, is going to try and staff a new fire station. Our transit facility that we just put on will ask for some people, andour new library is going to come. So it is going to be a difficult time for us to do it locally.

We need people, because our community continues to expand, and, first of all, there is no one among us that does not understand the need for safety. It is No. 1.

Back in the middle 1990's, we had some serious problems with gangs infiltrating our basic area, Moorhead, Fargo, and we put a foot down and we stopped it and it has been pretty decent, but it can come back. They are getting smarter all the time. They are not going to identify themselves, but they look just like any other business. They want to expand from Chicago and so forth and they are looking for new markets and so forth, and it will happen if we are not forward in that whole process.

I would hate to think that I cannot go for a walk in my community, in my neighborhood at any time of the day or night without feeling relatively safe.

So we have some huge challenges here in the future, and the COPS grants do an awful lot.

We were criticized some time ago about the money that we took from Homeland Security and we spent it on communications. Well, now many of the areas of the United States are finally understanding how important communications is, and they are looking for additional funding to do that.

Well, where that is going to come from in this very, very extremely sparse budget that Senator Conrad has put before us, we are going to be above that. We are going to have our—are they going to take the money then from our area and use it for other areas that did not do communications first? I hope not. I sincerely hope not.

But we need to restore some funding, and I know everybody's taxes right now in North—especially in Fargo, they feel they are at the brink and so forth, but we have a safe community and we need to extend that.

So I applaud Senator Conrad for bringing this issue to us from a national level. And the testimony that you are going to hear from the people that are on the front line will only bolster those needs to our Congressional, and we spent some time out there in January and priorities are, because there is not enough money for everything. So you have to prioritize, and to me safety is No. 1. Thank you.

Birch Burdick, our State's Attorney, Cass County State's Attorney; somebody who has deep experience in law enforcement.

Our police chief, Keith Ternes; somebody who is respected not only in this community, but regionwide. Weare delighted that you are here.

Paul Laney, our new Cass County sheriff, who has already acquitted himself very well and is earning respect across the State for the way he has conducted his department. So welcome. We are delighted to have the three of you.

I know, Mayor Walaker, that you have other responsibilities, so we will excuse you, but we thank you very, very much for coming and providing testimony to the Senate Budget Committee.

Mayor Walaker. It has been a pleasure. Thank you.

Senator CONRAD. Thank you, Mayor Walaker. Mr. Burdick. Good to have you here.

Mr. BURDICK. Senator Conrad, glad to be here.

Senator CONRAD. Please proceed with your testimony, and we will go right through this panel. We have a second panel as well made up of, I probably should indicate at this time, Bruce Hoover, our fire chief here in town; Terry Traynor, the assistant director of the North Dakota Association of Counties, who is filling in for Mark Johnson, I understand, who had a little accident over the weekend; and Ken Habiger, the president of Casselton Volunteer Ambulance Service, who will be part of our second panel as well. With that, again, welcome to our Cass County State's Attorney, Birch Burdick.

STATEMENT OF BURCH BURDICK, STATE'S ATTORNEY, CASS COUNTY

Mr. BURDICK. Thank you, Senator.

Cass County is, of course, the home, the crossroads of Interstates 94 and 29. It is home to about a fifth of the State's population, and as a result, we have all the benefits that that entails and some of the crime that, unfortunately, accompanies that level of population and that kind of travel intersection that we have here.

And as Cass County State's Attorney, my office prosecutes everything from essentially traffic violations to murder, and we have all of that going on in Cass County.

In the past, Federal funding has been beneficial to our office, both directly and indirectly. We have had in our office Byrne grant funds, then later JAG funds that help support part of one prosecutor that we dedicated to drug prosecution. That is half of three people that we actually have working full-time on drug prosecution. So we have benefited from that very directly.

And we have also benefited indirectly, because all of the money that comes in to support the law enforcement officials, either through the sheriff's office, through the Fargo police chief's office or otherwise, help put feet on the street that help put cases in our hands. But as a result of having those cases in our hands, again, we havegot a heavier caseload.

And I would like to talk really just about two areas of primary interest for me: One relates to drug cases. We have had a growing drug caseload in this jurisdiction.

The drug caseload doubled in the course of about five or 6 years during—since the year 2000, and as a result, as I said, I went from having one person working on drug crimes full time to three people doing nothing but drug prosecution.

And the North Dakota Legislature has responded to the kind of drug issues that they have seen here and particularly the meth issues that have arisen here in the Midwest, throughout the Midwest. They have increased the penalties associated with meth-related crimes. There is no misdemeanor meth crime. They are all felony meth crimes.

As a result, defendants are fighting harder because the penalties are more severe, which has a corresponding impact on our office. We are able to get stronger sentences. We send them to the penitentiary, and, of course, we have had problems with having enough room at the inn in Bismarck in order to accommodate the people that we are sending there.

But the Byrne grant funds, the JAG funds have helped us not only in providing additional support to our prosecution effort, but also in the asset forfeiture area. Not only can we punish somebody by sending them off to the penitentiaryfor committing drug crimes, but we can also take from them the assets that were related to their drug crimes so that we remove some of the profit incentive from those crimes.

Senator CONRAD. Let me ask you this, if I could. Does it make sense to you to cut the Byrne/JAG grants by 34 percent or the COPS program by 94 percent?

Mr. BURDICK. It does not make sense to me. I mean, as my perspective is that of a prosecutor. As a prosecutor, we have a lot of drug crimes going on here, and we need to throw strong resources at it, and cutting those resources at this time makes no sense to me.

I have to admit that my vision of what is needed is somewhat limited by the scope of my work, but in what I see, this is no time to be lessening the impact, lowering the number of feet on the street or cutting back on funds that may be available to prosecutors to help support processing and prosecuting the cases that the law enforcement folks put together.

Senator CONRAD. OK.

Mr. BURDICK. So I think that—and I think that there is a Federal aspect here. I mean, some could say isn't this just a State issue, and my response to that would be no, because drug crimes, people who commit drug crimes are no respecters of State lines, lines on the map.

We have drugs that come into this State across all fourborders. We have people who are committing crimes within our jurisdiction and living in Minnesota or South Dakota or wherever.

So because of the nature of where the drugs come from, the nature of the impact that they have on our community, I think it is really a shared responsibility between State and Federal agencies, and I think that our Cass County folks are throwing a lot of resources at it, but we welcome the Federal resources that are also available to supplement those.

I would add one other area, and this is a little different and has not come from a Byrne grant in the past, but in addition to the drug cases, we see an unfortunate level of sex crimes here in our community. Those sex crimes, always odious, are particularly reprehensible when they are perpetrated on young children.

And in the not-distant past, we created here a Multidisciplinary Child Advocacy Center, and the purpose of the Advocacy Center is to put all these people together, to work together on these cases in one facility, essentially, to both enhance our investigative capability, but also to minimize the footprint that law enforcement and criminal justice makes on the spirit of those child victims.

And we do that by limiting the number of interviews that have to be done, by consolidating those resources, byworking together on those cases.

I think that the Child Advocacy Center is a remarkable resource to our community and is one also that I would like the Congress to think about when it is looking at funding for law enforcement

purposes, because I think that that Advocacy Center in this community serves a vital role.

So I welcome the opportunity to share those couple of ideas with you and your willingness to come and speak with us about Federal funding for law enforcement.

[The prepared statement of Mr. Burdick follows:]

U.S. Senate
Committee on the Budget - Field Hearing
February 20, 2007 - Fargo, North Dakota

Testimony Regarding
Federal Funding of Law Enforcement and First Responders

Submitted by:
Birch P. Burdick
Cass County State's Attorney
Fargo, North Dakota

The Fargo/Moorhead area contains the highest concentration of people in North Dakota and western Minnesota. It rests at the crossroads of interstate highways 29 and 94. It is home to North Dakota State University, Concordia College, Minnesota State University-Moorhead, University of Mary-Fargo, and a variety of other educational institutions. It is a key employment and economic hub in the region. It is not an insular community, but rather a blend of people with differing backgrounds, cultures and birthplaces - home to a growing population and a temporary way-station for others. For many reasons this convergence of factors is a great blessing and must be nurtured. For multiple reasons, such as the level of drug and sexual crimes, that convergence is not a blessing.

As Cass County State's Attorney, my prosecutorial staff handles everything from traffic violations to murder. I have seen our greatest growth in drug cases. In 2006, our new drug crime and related asset forfeiture cases numbered about 1,100. Over the last 6 years the drug cases have doubled. During that same time frame, the ND Legislature increased the severity level of many drug crimes and implemented significant mandatory minimum penalties. Facing ever more aggressive prosecution and incarceration, defendants' efforts to contest their drug charges have grown. In order to address these changes, I increased our staff from one full-time drug prosecutor to three, and formed them into a drug team with dedicated support staff.

Under ND law, every meth charge is a felony. Some charges, such as possessing 50 or more grams (about 1/10th of a pound) of meth, or possessing with intent to deliver meth within 1,000' of a school, are ranked as our highest level of crime and punishable by up to life imprisonment. While you can find almost every drug illicit drug in this community, by volume the primary concerns are meth and marijuana. Not only is a significant and growing portion of our drug charges meth-related, but because of the potential penalties those cases form a disproportionately high number of the heavily contested cases. Yet the impact of meth on the criminal justice system cannot be measured by drug charges alone. Although difficult to measure, meth use also accounts for increased robberies, burglaries, thefts, assaults and domestic violence. Two years ago, a brutal murder occurred just a few blocks from my Fargo home. It was

about a drug debt worth a few hundred dollars. At the time of the murder, the defendants said they were using meth. A violent and senseless murder also occurred about two years ago near Moorhead, again over a small drug debt.

A particularly disturbing impact of meth use is its contribution to child abuse and neglect. Children exposed to meth at home may have related medical issues. The long-term impacts of those issues are little understood. Here and around the country social service agencies are reporting increased out-of-home placements for children of meth-using parents. A recent study indicated that 34% of our local social service cases had some meth component. This same drug use complicates and lengthens family reunification efforts. Even if reunification occurs, given meth-related recidivism, the reunification may not last. Furthermore, when parents expose their kids to a meth environment we may prosecute the parent for child endangerment.

With the assistance of past Byrne Grant funding we formed a drug task force pooling the resources of various local law enforcement agencies and the State's Attorneys office. It is separate from, but works in conjunction with, the local DEA drug task force efforts. That funding in the past has helped support about 0.5 FTE drug prosecutors in my office. In addition to aggressive investigation, arrest, prosecution and asset forfeiture, we have made progressive efforts to deal with low level drug offenders. For example, within the criminal justice system we established both adult and juvenile drug courts to concentrate on treatment and rehabilitation of drug users who are neither dealers nor manufacturers. Recent changes in federal budgeting has essentially limited that assistance to our office to a *de minimus* amount.

The increasing drug caseload not only impacts police and prosecutors, but clogs the court calendars and taxes the jails, the prison and the foster care system. It does not stop with these direct impacts on the "system". Unfortunately meth use leads to disintegration of the lives of its users and those around them. Not only do these drug offenders drain their financial assets, endanger their health and forfeit their liberty, they also lose their careers, their families, their friends, and their ability to comprehend or care about anything other than their next fix. We are unable to gauge another potential impact of their drug use - namely, what choices their children may make in the future about using drugs themselves.

In addition to drug issues, we see here an unfortunate number of sexual crimes against children. In order to properly provide for the medical and emotional needs of the victims, together with limiting the footprint the criminal justice system leaves on their spirits, we formed a multi-disciplinary Child Advocacy Center (CAC). The use of the internet to set up victims of sexual crimes, and the multi-state travel of the criminals themselves, reflects a crime that seems to know no boundaries. The CAC supports the region, straddling both county and state lines.

The impact of meth usage on individuals and families strains local and state resources. The same is true of the CAC. With those strains, and the multi-state aspect of the crimes, it seems appropriate to share the responsibility of combating those impacts between the local, state and federal government.

I thank Sen. Conrad for this important hearing regarding financial resources for law enforcement and first responders. I am concerned about the recent decrease in related federal funding at a time when the problem of drug and sexual crimes are at a high level. I encourage Congress to increase its assistance to local efforts in combating meth use, manufacture and delivery across the United States, and to support the important efforts of the Child Advocacy Center. That assistance is a needed and valuable investment in our communities.

Senator CONRAD. Thank you very much. Now we will turn to Chief Ternes. Welcome, Keith. Good to have you here.

STATEMENT OF KEITH TERNES, CHIEF OF POLICE, FARGO POLICE DEPARTMENT

Mr. TERNES. Thank you very much, Senator. It is an honor and a privilege to be here and offer testimony relative to this issue.

As the city of Fargo continues to grow, both economically and geographically, the challenges associated with maintaining a safe and secure environment for the city also continues to grow, and although Fargo is a community free from most forms of violent crime, the city is experiencing an increase in crime similar to that of other cities across the country.

Challenged predominantly by property crime, the Fargo Police Department remains committed to keeping our city one of the safest in the Nation. The continuous effort that is put forth by the men and women of the Fargo Police Department, however, has been adversely impacted by the ever-diminishing financial support received from the Federal Government.

With the drastic reductions in funding for the COPS program, Byrne grants and other law enforcement programs, many police agencies, including the Fargo Police Department, are no longer able to readily obtain the resources needed to effectively address the increasing crime rate.

Without question, the most pressing need for mydepartment is personnel. Regardless of the crime issue we are attempting to resolve, whether it be the continuous challenges associated with methamphetamine use, crimes against children via the Internet, gang-related crime or petty thefts, I need police officers to do the work. The ability to add officers at a rate, which, at a minimum, parallels Fargo's growth, is absolutely essential for maintaining a safe environment within the community.

And although the city's elected officials recognize the need to fund this resource on the local level, there is still a need for the Federal Government's financial support.

In the mid to late 1990's, when the COPS program was adequately funded, the city of Fargo took full advantage of the financial assistance offered through this program and was able to add a number of the much-needed police officers to its understaffed police force.

In fact, during this time, the department was able to add nearly 20 officers to the force, which would have been virtually impossible without the financial aid of the COPS program.

Since the Federal Government's shift in focus in priority from providing support to local law enforcement agencies to Homeland Security, the Fargo Police Department has found it increasingly difficult to add police officers.

The policymakers in Washington, D.C. have repeatedlytold local officials that the concept and strategy of Homeland Security starts at the local level, but as the support received from the Federal Government becomes less and less available, it becomes increasingly difficult for police agencies such as mine to effectively follow this plan.

What has become even more frustrating is that the one thing I, as the city's police chief, need more than anything else, personnel, it is the one resource I cannot seem to get my hands on, while other resources which I do not need are readily available.

I do not need any more gas masks, flashlights, generators or duct tape. What I need is people. What the city of Fargo and its police force needs is the reestablishment of the funding of the COPS program and Byrne grants, which allows the Fargo Police Department and other law enforcement agencies to be successful in keeping our community safe.

And in that regard, I respectfully ask that these programs receive their due consideration and an appropriate allocation of funding, and I sincerely appreciate your efforts, Senator Conrad, in assisting us in that endeavor.

[The prepared statement of Mr. Ternes follows:]

Testimony for Senate Budget Committee
February 20, 2007

Prepared by Keith A. Ternes
Chief of Police
Fargo Police Department
Fargo, North Dakota

As the City of Fargo continues to grow both economically and geographically, the challenges associated with maintaining a safe and secure environment for the city also continues to grow. Although Fargo is a community free from most forms of violent crime, the city is experiencing an increase in crime similar to that of other cities across the country. Challenged predominately by property crime, the Fargo Police Department remains committed to keeping our city one of the safest in the nation.

The continuous effort put forth by the men and women of the Fargo Police Department has been adversely impacted however, by the ever diminishing financial support received from the federal government. With the drastic reductions in funding for the COPS program, Byrne grants, and other law enforcement programs, many police agencies (including the Fargo Police Department) are no longer able to readily obtain the resources needed to effectively address the increasing crime rate.

Without question, the most pressing need for my department is personnel. Regardless of the crime issue we are attempting to resolve; whether it be the continuous challenges associated with methamphetamine use, crimes against children via the internet, gang related crime, or petty thefts, I need police officers to do the work. The ability to add officers at a rate which (at a minimum) parallels Fargo's growth is absolutely essential for maintaining a safe environment within the community. And although the city's elected officials recognize the need to fund this resource on the local level, there is still a need for the federal government's financial support.

In the mid to late 1990's when the COPS program was adequately funded, the City of Fargo took full advantage of the financial assistance offered through this program and was able to add a number of the much needed police officers to its understaffed police force. In fact during this time, the department was able to add nearly twenty officers to the force, which would have been virtually impossible without the financial aid of the COPS program. Since the federal governments shift in focus and priority, from providing support to local law enforcement agencies to Homeland Security, the Fargo Police Department has found it increasingly difficult to add police officers.

The policymakers in Washington, D.C. have repeatedly told local officials that the concept and strategy of "Homeland Security" starts at the local level. But as the support received from the federal government becomes less and less available, it becomes increasingly difficult for police agencies such as mine to effectively follow this plan.

What has become even more frustrating is that the one thing I as the city's police chief need more than anything else (personnel) is the one resource I cannot seem to get my hands on, while other resources which I do not need are readily available. I don't need any more gas masks, flashlights, generators, or duct tape. What I need is people! What the City of Fargo and its police force needs is the re-establishment of the funding of the COPS program and Byrne grants, which allows the Fargo Police Department and other law enforcement agencies to be successful in keeping our communities safe. In that regard, I respectfully ask that these programs receive there due consideration and an appropriate allocation of funding.

Senator CONRAD. Well, let me just say, one night I had the opportunity to ride with the Fargo Police Department, and I was so impressed by the professionalism of the way your officers conducted themselves. And I saw them in a lot of different situations, and they were just such first-rate professionals, so you are to be commended for what you have done here.

Let me just ask you this question: Does it make sense to you to cut the COPS program by 94 percent, to cut the Byrne/JAG grants that are used for law enforcement by 34 percent, to cut the State Homeland Security Program by 65 percent?

Chief Ternes. Senator, absolutely and unequivocally, no, it does not. It makes no sense to me.

The one thing that we have here, not only in the city of Fargo, but throughout the State of North Dakota, is something that I think many, many other jurisdictions around the country envy, and that is, a climate of safety. But it is only because the people who live and work in our communities are committed to that.

As I mentioned earlier and as the mayor mentioned earlier, our elected officials have and continue to make public safety the top priority. But the resources are not unlimited on the local level.

And so what we need, what we desperately need is thecontinued financial support from the Federal Government to not only keep existing programs in place, but really to maintain that atmosphere of safety and security in our State.

Senator CONRAD. Let me ask you this, Chief, because one of the reasons that has been given for these really draconian cuts is that agencies around the country have used these funds for gold plating. That these moneys have flowed to local departments and they have been used for extravagant uses that are unneeded and unrelated to effective law enforcement. Would you just comment for the record with respect to how those funds have been used locally and in your department?

Chief Ternes. Well, within the Fargo Police Department, we have used those funds in what I would describe as a very, very responsible way. We do not ask for things and we do not purchase things that we do not need.

Like I mentioned, my—the one resource that I need more than anything else is people, and if there are other jurisdictions which have misused funds, then I am all for having the Federal Government hold those people accountable. But for those of us that have acted responsibly, to cutoff a resource that is much needed is not only incredibly unfair, but it really puts us at risk of being able to maintain that safety.

Senator CONRAD. Well, thank you for that. And I think you have hit the nail on the head. I think agencies across North Dakota have been very responsible in the way they have used these funds.

Are there places in the country that have abused it? Yes. Let us make no mistake about it. We have done our due diligence. We know there are places in the country, and, unfortunately, mostly on the East Coast and the West Coast, that have squandered funds that were provided to them, and I might be swift to say not just Federal money. They have squandered some of their own money. That is a much larger problem than this question before us.

The question before us is, does it make sense for the Federal Government to dramatically cut back in its support for law enforcement around the country? Does it make sense to cut back on these Byrne grants and JAG grants that have been very essential to the fight against meth? Does it make sense to cut back on the State Homeland Security Program? I just say my experience in North Dakota is those moneys have been used wisely and well and responsibly.

Sheriff Laney, good to have you here. This is the first chance we have had an opportunity to meet, but your reputation precedes you and I have heard very good things from within your department and from other departments about the way you have conducted your business. So welcome, andplease proceed with your testimony.

STATEMENT OF PAUL LANEY, SHERIFF, CASS COUNTY SHERIFF'S DEPARTMENT, CASS COUNTY

Mr. LANEY. Well, thank you, Senator. It is truly an honor to be here, and I truly appreciate your kind words as well.

Each year the demands on local law enforcement agencies grow. As we enter a time when we are asked to become more involved in all aspects of society, we are also seeing proposed cutbacks in our support from the Federal Government.

As the protectors of our communities, we are committed to doing whatever it takes to keep our citizens safe.

We have law enforcement officers in schools, we are involved in senior programs, neighborhood watch programs, drug awareness programs, youth programs, leadership programs, drug courts and a myriad of safety awareness programs to include drug interdictions, removing alcohol-impaired drivers and seat belt blitz.

We also provide law enforcement officers to Federal programs such as the Drug Enforcement Administration's Drug Task Force and the Federal Bureau of Investigation Joint Terrorism Task Force.

With all of these programs, we are also asked to step up to the plate and take on larger roles in Homeland Security.

We are active in development of the buffer zone protection plans for local businesses designated as potential terrorist targets, we develop training and are active in preparing for terrorist attacks on our infrastructure.

We are also developing action plans to deal with security at the Points of Dispensing for the Center of Disease Control's Strategic National Stockpile through the City Readiness Initiative. We do all of this——

Senator CONRAD. Let me just stop you there, Paul, on that point, because I do not want that point to be lost.

Let me just say that all of us know one of the great potential threats to our country is the threat of avian flu or some other epidemic.

We have just held a hearing in the Senate Budget Committee about that matter. We are spending billions of dollars in preparation for some kind of pandemic.

We all know the 1918 flu epidemic was devastating to our country and devastating in North Dakota. We know that we are overdue for some kind of similar incident. We know that there is the potential with avian flu.

If, God forbid, something like that were to occur, the dispensing of medicine would be absolutely critical, because the whole strategy and plan is if there is an outbreak, to attack that outbreak, to keep it from spreading.

This requires close coordination with law enforcement, and that is what Sheriff Laney is just referencing with respect to working with the Centers for Disease Control in the case of such an outbreak.

And one thing we know with air travel, with people being highly mobile, that a disease that might start in Asia could come here, could come right here to Fargo, North Dakota.

Mr. LANEY. Absolutely.

Senator CONRAD. And the whole strategy is to kill it before it spreads, and that is why what he is referencing is very important.

Mr. LANEY. Yes, sir. I agree.

We do all of this while also providing critical members of our agencies to National Guard units who are regularly being called up and deployed. This puts a strain on our ability to meet our everyday service needs, much less support the requests put on us from the State and Federal Government.

The support we receive from the Federal Government is critical to our success in all of the above-mentioned programs. The following Federal grant programs assist us daily in serving our communities.

The Byrne/JAG grants. They allow us to participate in drug task forces that attack the ever-growing and changingmethamphetamine problem.

The Law Enforcement Community Block Grants. These grants allow us local law enforcement agencies to identify a critical need and apply funding to meet these needs. This grant assisted our region in 2003 by allowing us to purchase a SWAT command post transport vehicle. Our team serves a seven-county area in southeastern North Dakota. These funds benefit the entire region.

The COPS grants. The COPS grants have allowed so many law enforcement agencies to add additional personnel to meet the demands placed upon us. It has put more law enforcement officers on the streets, in the schools and on State and Federal task forces, while allowing local governments the ability to budget over a period of time for the additional personnel.

Local Law Enforcement Terrorism Grants. These grants have allowed agencies required to respond to terrorist incidents the ability to purchase the proper equipment and training necessary to ensure

our personnel are equipped and trained to respond to a terrorist incident.

Local law enforcement has always stepped up when called upon to meet the needs of our citizens. You will never hear from us we cannot do it. We continually meet the demands asked of us, and we will continue to do so. But we need the partnership and the funding from the Federal Government tocontinue to meet these demands.

With the proper Federal support and our local can-do attitude, we will be ready to meet the needs of our region, our State, and our country.

Thank you, and thank you, Senator, for allowing me to testify today.

[The prepared statement of Mr. Laney follows:]

UNITED STATES SENATE
Budget Committee Hearing

Testimony on "Federal Support to Local Law Enforcement Agencies"

Submitted by:
Sheriff Paul D. Laney
Cass County, North Dakota
February 15, 2007

Each year the demands on local law enforcement agencies grow. As we enter a time when we are asked to become more involved in all aspects of society, we are also seeing proposed cutbacks in our support from the federal government.

As the protectors of our communities, we are committed to doing whatever it takes to keep our citizens safe. We have law enforcement officers in schools; we are involved in senior programs, neighborhood watch programs, drug awareness programs, youth programs, leadership programs, drug courts and a myriad of safety awareness programs to include Drug Interdictions, Remove Alcohol Impaired Drivers, Seatbelt Blitzes, etc.

We also provide law enforcement officers to federal programs such as the Drug Enforcement Administrations (DEA) Drug Task Force and the Federal Bureau of Investigations (FBI) Joint Terrorism Task Force (JTTF).

With all of these programs, we are also asked to step up to the plate and take on larger roles in Homeland Security. We are active in development of Buffer Zone Protection Plans (BZPP) for local businesses designated as potential terrorist targets. We develop training and are active in preparing for terrorist attacks on our infrastructure. We are also developing action plans to deal with security at Points of Dispensing (PODS) for the Center for Disease Control (CDC) Strategic National Stockpile through the City Readiness Initiative (CRI).

We do all of this while also providing critical members of our agencies to National Guard units who are regularly being called up and deployed. This puts a strain on our abilities to meet our everyday service needs, much less support the requests put on us from the state and federal government.

The support we receive from the federal government is critical to our success in all of the above mentioned programs. The following federal grant programs assist us daily in serving our communities.

- Byrne/JAG grants- Allow us to participate in Drug Task Forces that attack the ever growing and changing methamphetamine problem.

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- Local Law Enforcement Terrorism Grants- These grants have allowed agencies required to respond to terrorist incidents the ability to purchase the proper equipment and training necessary to ensure our personnel are equipped and trained to respond to a terrorist incident.

Local law enforcement has always stepped up when called upon to meet the needs of our citizens. You will never hear from us "We Can't Do It!" We continually meet the demands asked of us, and we will continue to do so, but we need the partnership and the funding from the federal government to continue to meet these demands. With the proper federal support and our local "Can Do" attitude we will be ready to meet the needs of our region, our state and our country.

Senator CONRAD. Thank you, Sheriff, for really very important testimony.

Let me ask you, for the record, what I have asked the others, because I want to—we are, in part, trying to establish a record here that I can take to my colleagues as we prepare our answer to the President's budget.

Does it make any sense to you to cut the COPS program 94 percent or the Byrne/JAG grants by 34 percent or to cut the State Homeland Security Program by 65 percent or the Law Enforcement Terrorism Prevention Program by 31 percent? Do those priorities make sense to you?

Mr. LANEY. No, Senator, they do not make sense to me. You know, there is an old saying that every American knows: If it isn't broke, don't fix it.

We have been proving year after year after year in the law enforcement community that these funds make a difference in our local communities.

We have been able to demonstrate by the numbers on the street, by the way we have been able to go after the methamphetamine problems, the way we have been able to meet the needs asked of us for these terrorism situations and to be ready for an attack on the infrastructure. We have stepped up and we have done it because of these grants. It is working.

So to see it go away is like taking a step backwardand where—you know, at a time when every region struggles to meet its financial needs, to lose that support is critical to us.

Senator CONRAD. Well, I thank you for that. I would ask Chief Ternes, if I could. Some are saying look, this is not a Federal obli-

gation or responsibility. The Federal Government has got no obligation for these local resources. What would be your response to those who advance that argument?

Mr. TERNES. Well, Senator, I do think that the Federal Government does have at least some responsibility to support first responders and public safety on a local level.

It is interesting, at least speaking for my own agency, how this seems to work in reverse. Since the—since September 11th of 2001, my department has been called upon time after time after time to supply officers to meet the Federal needs. In other words, in the form of National Guardsmen, the troops who have been summoned to overseas military duty.

And repeatedly those individual officers and the organization as a whole have stepped up and met that need for the Federal Government.

Now what I need, what this community needs, is assistance in the form of financial assistance to pay for additional police officers, and to have those——

Senator CONRAD. How many of your officers, Chief, have been called up for Guard duty overseas?

Mr. TERNES. Well, many, many have been called on several occasions, and so to go back the better part of 5 years, I would have to say upwards of 30 to 35 as a rough guess.

Senator CONRAD. And how big is your department?

Mr. TERNES. I have one hundred and—I am authorized to have 129 officers.

Senator CONRAD. And I recall at one point you had eight or ten gone at one time. Is that not the case?

Mr. TERNES. Actually, immediately following September 11th, I was missing upwards of 15 officers to active military duty. As we sit here today, I am missing six. Over the course of the last four or 5 years, on average, it has been between six and ten police officers that are absent for that.

Senator CONRAD. How long does it take you to train an officer?

Mr. TERNES. Approximately 9 months.

Senator CONRAD. And so when there is a call-up like occurred, I assume it is very hard for you to fill those slots quickly.

Mr. TERNES. Police officers, sheriff's deputies do not grow on trees. I cannot simply walk out, put an ad in thepaper and expect somebody to fill that position in 2 weeks. It takes the better part of 9 months to hire and train a police officer so they are out on the street, functioning as a full-fledged police officer.

Senator CONRAD. OK. Sheriff Laney, what would you say in answer—again now, this is a question I am going to get from my colleagues when I present my budget. I am going to have colleagues of mine say, well, Senator, what are you talking about? This is not a Federal issue. This is not a Federal Government responsibility. Law enforcement is a local responsibility. What would you say?

Mr. LANEY. I would say the Federal Government is the representative of its citizens, and we are its citizens. We are the ones that—we are the Federal Government, and we are telling them that we need this support. It is our tax dollars that go in there in the first place. It is our money going to the Federal Government, and we are asking for it to be reinvested back in our people.

Senator CONRAD. Well, that is a pretty powerful answer. You know, one of the things I say to my colleagues is crime does not respect borders. These criminals, they do not say, well, we are just doing crime in Fargo. Doesn't work that way. We have gangs coming in here, peddling drugs. I have seen intelligence that says they are going from Mexico all the way to Fargo, North Dakota.

And we know that if, God forbid, we faced a pandemic, a pandemic can come to our towns, our State from half a world away in 24 hours. We have seen the modeling of what could happen in a pandemic.

That would put enormous demands on law enforcement all around the country. And, you know, that is not just a local matter. That is a matter that affects every American everywhere, because to the extent we are able to prevent it from spreading is critical to a successful strategy.

So, Birch, how long have you been State's Attorney now?

Mr. BURDICK. Just over 8 years.

Senator CONRAD. Is crime—are you seeing a dramatic reduction in crime? Are people giving up on a criminal lifestyle?

Mr. BURDICK. You know, you learn in law school that one of the theories behind criminal justice is deterrence. If you punish somebody for committing a crime, you have a couple of kinds of deterrents.

You deter them from committing the crime again because you are making an example of them that they do not want to repeat.

Two, you are taking them off the street for a period of time so they cannot commit that crime again.

And, three, hopefully somebody else will see what happened to them and not want to commit that crime.

I believe that is out there in theory. I am not sure how well it is working in practice. I would like to think it has some value, but I am not seeing a reduction. I am certainly not seeing a reduction in drug crimes.

We have seen a little leveling maybe in the last year or last half a year or so, but the drug crimes, as I said, since about the year 2000 or so, have doubled, at least through our office, the ones we are prosecuting.

And as you noted, I think two things are important about that: One, a lot of it is meth. The meth we have here, a very small portion of that is homegrown. It has come in from Mexico or California or the West Coast. It is coming here in a variety of ways. It is not being developed in our backyard.

So there is an interstate, certainly an international—national and certainly international aspect to drug crimes. And that is why I think, among other things, there is a relationship here between Federal, State, and local agencies.

And second, we work hand in glove with the U.S. Attorney's office here. They handle a certain kind of drug crime. We handle other drug crimes.

And we figure out who is going to handle what crime often by picking up the telephone and just chatting about where it might best be prosecuted. That relationship is important, but it also outlines the sort of integrated nature of the Federal and State agencies dealing with drugs.

Senator CONRAD. And really, it is a partnership.

Mr. BURDICK. It is.

Senator CONRAD. To be effective, everything we have seen, if you want to effectively combat crime, you want to effectively combat drug supply, that you have to have a coordinated effort.

It involves Federal, it involves the U.S. Attorney, it involves the FBI, it involves DEA at the Federal level, it involves local law enforcement, police chief, the sheriff, the State's Attorney.

And that if you do not have a strong partnership to take on these criminal elements that are clearly growing, and they are energized by massive flows of money. It is truly startling how much money goes through the drug trade in this country.

So if we want to fight that, you have to have a partnership just like they do. The drug networks, they are not operating just on a local level. They are operating nationally and internationally.

And if you want to fight them effectively, you better have a partnership. That is one thing we have learned with these drug task forces.

I would just ask you, Chief Ternes, do you find these drug task forces to be effective? Are they an important part of your arsenal?

Mr. TERNES. Very much so. You know, you just mentioned how we have to have this partnership, and I think my colleagues here would agree that the one thing that we have that, again, many other jurisdictions around the Nation are envious of, and that is, a phenomenal amount of cooperation that takes place between both the Federal law enforcement agencies, the local law enforcement agencies, the prosecutors, and the street cops.

And so what is befuddling to me is the fact that we have something here that is working, and in many other places it does not work. Our drug task forces are incredibly important to keep our ability to combat that issue.

And so for the Federal Government to throw a wrench into this and withdraw or withhold financial support has a potential, at least, to make what is a very functional, working thing, dysfunctional.

Senator CONRAD. Well, I think that is pretty powerful.

Let me just say, I referenced earlier that I have ridden with the Fargo police, and I noticed the officer that I rode with is in the back, Grant Benjamin. And at the risk of embarrassing him, I tell you, that is absolutely a professional officer. We are incredibly lucky to have somebody of that skill to be willing to put on the uniform.

And if we are going to be effective, we better have partnerships, because these guys are not giving up bringing in illicit drugs. These guys are not giving up engaging in every kind of scam.

By the way, a couple years ago I was informed I had won the Spanish lottery. They told me I had won $974,000, and all I had to do was immediately send 10,000 to some guy over in Europe and I would get my money very soon thereafter.

And, well, it was obvious to me it was a complete scam. It was pretty good, though. I mean, it was very impressive. The envelope I got, it had seals on it.

We had the postal inspectors come in and wired up the phone, and I called the people I was supposed to call and had an inter-

esting conversation. I said, you know, I said, "One of the things that is most interesting to me is that you claim you are the Spanish lottery, and yet the phone number I have called is in Germany." I said, "How does that work?" And the guy said, "Well, that is the way all these operations are being run now. They are outsourced." The Spanish lottery is now outsourced to Germany. That is a good one.

Anything the three of you would want to add? Anything I have not asked that I should ask? Anything that you would want to add for the record?

Mr. BURDICK. Not I. Thank you.

Mr. TERNES. No, sir. Thank you.

Senator CONRAD. All right. If not, I want to thank each of you for your contribution to the work of this committee.

I have an obligation to present a budget proposal to my colleagues early in March, and this testimony will be very helpful as we address these specific issues. And I can tell you, no budget that I will present will have these kinds of reductions in these very important law enforcement accounts.

If there is one thing I have learned in my time, first as tax commissioner in North Dakota and as a U.S. Senator, is this partnership in law enforcement has been very effective, and we have faced a really tough change in the tactics and strategy of the criminal elements.

And we certainly see that in meth, where, as you say, Birch, we have seen a big reduction in terms of local production, but we have seen a tremendous influx of this stuff from elsewhere.

And everybody I have talked to has talked about how toxic meth is, how devastating it is for a society and a culture, and how devastating it is to families.

This is not the time to let up on the pressure against those people who would just undermine our communities and our families. You got to be taking these guys on tough, and it is not tough to cut the resources 90 percent. That makes no sense.

Thank you very much. I appreciate it.

I will now call the second panel. Bruce Hoover, the Fargo fire chief; Terry Traynor, the assistant director of the North Dakota Association of Counties; and Ken Habiger, the president of Casselton Volunteer Ambulance Service.

Again, I appreciate very much all of you being here for this hearing. I appreciate your willingness to testify.

You know, sometimes in Washington we put the witnesses under oath. I do not feel any need to do that with North Dakota witnesses.

One of the wonderful things about North Dakota people is, by and large, the vast majority of them are honest, and one thing I know for certain is these officials, their word can be counted on. That is one reason I asked them to come here and testify.

Chief Hoover, good to have you here. Please go forth with your testimony.

STATEMENT OF BRUCE HOOVER, FIRE CHIEF, FARGO FIRE DEPARTMENT

Mr. HOOVER. Thank you, Senator.

I just want to reiterate what the first panel said about the spirit of cooperation we have in North Dakota. In North Dakota, as emergency responders, we know that there is no political subdivision in the State that has the resources to survive on our own. So we have to cooperate just to survive.

Senator CONRAD. Maybe if you draw that microphone closer, it would be great.

Mr. HOOVER. So, you know, part of that cooperation is that on subdivisions like Fargo, cities like Fargo, it does really strain our resources. Communities throughout the State have the expectation, if they have a major incident, they have resources from larger cities that are going to come and assist them with that.

And we want to be a good neighbor, but we have difficulty not only providing for our own needs, much less the needs of political subdivisions that we do not receive taxes from.

And the cost of specialized equipment, it is very high, and so when we are expected to have this equipment that is used not only in our own city, but in other jurisdictions as well, it is nice to have an external source of funds to assist us with that.

So, you know, it is important to us to have these funds coming in so that we can cooperate between jurisdictions.

[The prepared statement of Mr. Hoover follows:]

United States Senate Budget Committee
February 20, 2007

Prepared by Bruce Hoover
Fire Chief
Fargo Fire Department
Fargo, North Dakota

My name is Bruce Hoover and I am the Fargo Fire Chief.

As a member of North Dakota's fire service, and chief of the fire department in the largest city in North Dakota, I sincerely appreciate the opportunity to testify today. I am going to address the importance of federal assistance in providing quality emergency services for the citizens of North Dakota.

North Dakota emergency responders are acutely aware that no political subdivision within the state has the resources to successfully mitigate large emergencies without assistance from other agencies and jurisdictions. I take a great deal of pride in stating that Fargo is a role model for inter-agency and inter-jurisdiction cooperation among emergency responders. This cooperation is demonstrated in the following:

- Red River Regional Dispatch Center: This center is the public safety answering point and dispatch service for all political subdivisions in Clay County, Minnesota. It also services all political subdivisions in Cass County, North Dakota with the exception the city of West Fargo.
- The Moorhead/Fargo Hazardous Materials Response Team provides service for all of Cass County, North Dakota and several counties in Minnesota.
- Cass County and the City of Fargo have a joint powers agreement that provides consistent Emergency Management services to the city and county.
- Numerous functions within law enforcement demonstrate similar levels of cooperation.

Inter-agency and inter-jurisdiction cooperation have benefited all involved communities but we still have additional needs. Federal funding has been helpful in this regard. For example:

- An interoperable radio communications system is nearly complete for all emergency responders in Cass County, North Dakota, and Clay County, Minnesota. Federal funds made this major project a reality.
- Homeland security funds have been used to provide a response vehicle for emergency response to hazardous materials incidents.

I am concerned with funding issues as we have additional needs. These needs are well beyond what we can fund through our budget.

- Communities throughout the state of North Dakota have the expectation that emergency services in larger cities will be available to respond to emergencies in small communities. Although we wish to be good neighbors, we do not have the resources to provide all of the services we need within our own jurisdiction, much

less for others. The current method of distributing Homeland security funds to the state, and the state distributing them to local jurisdictions has intensified this problem as those communities that have made a commitment to public safety are not recognized and many of the funds have been distributed to communities with no capability to respond to emergencies. A method of allocation that provides funds to population centers would be helpful.

- The cost of specialized equipment is very high and places an unreasonable burden on the citizens of an individual city when there is the expectation that it will be available to multiple jurisdictions.
- Currently, it appears that there is no program in place to protect investments made with Homeland Security Funding. Funding for WMD response equipment requires a long term commitment due to the short life expectancy and high maintenance costs of equipment such as monitors, chemical protective suits, and other personal protective equipment. We do not have the funds locally to make this commitment.
- The expectation that larger communities will provide emergency services to smaller communities will require that funds be allocated to begin provision of those services, and that a base level of funding continue to cover the expense of maintaining and replacing response resources. Personal protective equipment and monitoring equipment have a life expectancy of five years or less. Locally we have equipment that has reached the end of its life expectancy and we cannot afford to replace it.

There are several federal programs and funding sources that have been valuable to our department and fire departments throughout the state.

- Assistance to Fire Fighter Grants,
- Homeland Security Funds,
- Staffing for Adequate Fire and Emergency Response Grants (SAFER),
- Emergency Management Performance Grants,
- COPS grants (used for interoperable communication equipment), and
- National Fire Administration and National Fire Academy.

I will provide a brief discussion of the value of each of these to our jurisdiction.

Assistance to Fire Fighter Grants:
The city of Fargo has benefited from these funds for safety equipment and training. I feel they are particularly valuable to less populous states and I would like to see funding continued at the current level.

Staffing for Adequate Fire and Emergency Response Grants (SAFER):
These grants provide an extremely limited number of new positions. The criteria for funding positions with these grants are very narrow (funding priorities are based on NFPA 1710), as it must be for such a small pool of funds and such a significant need. If this program continues I feel that greater value would be achieved by adding additional considerations, these include:

- Communities that have identified significant risks,
- Communities with the capability to respond locally and through out the state,

- Communities with an increased demand for emergency services.

Homeland Security Funds and Emergency Management Performance Grants:
These funds are extremely valuable in communities such as Fargo and Cass County. Our communities have invested significant resources in identifying potential risks and planning to minimize the effect of these risks on our communities should a problem arise. These funds are distributed throughout the state, and like the Homeland Security Funds, appear to be distributed with little concern for potential risks or the size of the population at risk. A method of direct distribution to local jurisdictions would be beneficial.

National Fire Administration and National Fire Academy:
These national functions are very valuable to less populous states such as North Dakota as we lack the resources to develop our own training programs. Many larger cities can afford to develop jurisdiction specific training programs. There is no fire department in North Dakota with this ability. I ask that funding for the National Fire Academy be a priority. The demands on the fire service are growing every year, yet the fire academy lacks the funds to develop programs and courses that address these growing demands. Additional funds for program and course development are particularly valuable to rural states.
An additional consideration with regard to the National Fire Administration is the National Fire Incident Reporting System (NFIRS). This is a cumbersome and out dated system. For example, the Fargo Fire Department completes an incident report for each emergency we respond to. Monthly, these reports are sent to the state, and the state makes annual reports to the National Fire Administration. With this system it can take two years to identify a trend in response issues. The fire service of today is very dynamic and this system is no longer adequate. If a web based reporting system could be developed, reports could be filed daily and trends could be identified immediately.

If you have any questions I will be happy respond to them.

Thank you again for the assistance our department has received, and thank you for providing me with the opportunity to comment today.

Senator CONRAD. And, Bruce, the firefighter grants, are they something that you think have merit?

Mr. HOOVER. Oh, actually firefighter grants are very helpful to States like North Dakota inasmuch as they are need-based grants, and in areas like North Dakota, there is a tremendous need. And so those jurisdictions that have the greatest need have the greatest likelihood of getting those grants.

So in rural States, I think they are more valuable than they are in other States because we do not have the capability to tax for a lot of the resources that we need.

Senator CONRAD. Bruce, when we see one of those bright, red fire engines responding to an emergency, I see them go by me. In fact, as we drove downtown today, I saw one of your engines out. It would help people understand, I think. What does an engine like that cost?

Mr. HOOVER. Well, the fire engine that responds to a residential dwelling is—probably start at $400,000.

Senator CONRAD. $400,000.

Mr. HOOVER. $400,000 and upwards from there. A ladder truck is in the neighborhood of three-quarters of a million dollars and upwards from there.

Senator CONRAD. So a ladder truck, something that would respond downtown to something that would occur, $750,000.

Mr. HOOVER. Will get you an entry level.

Senator CONRAD. For an entry level. What is the most expensive truck that you would have?

Mr. HOOVER. Right now it is our ladder truck, and we have had that for several years. We do try to extract the maximum out of our equipment. And we paid about $600,000 for that a number of years ago we got it.

We also have—we need heavier rescue rigs and apparatus to respond to hazardous materials incidents, and those are in that $350- to $400,000 range for a modest piece of equipment.

Senator CONRAD. So this is an expensive business.

Mr. HOOVER. It is very expensive.

Senator CONRAD. All right. Terry, welcome. Good to have you here. I know you are filling in for Mr. Johnson, who had an unfortunate injury over the weekend.

STATEMENT OF MARK A. JOHNSON, EXECUTIVE DIRECTOR, NORTH DAKOTA ASSOCIATION OF COUNTIES, PRESENTED BY TERRY TRAYNOR, ASSISTANT DIRECTOR, NORTH DAKOTA ASSOCIATION OF COUNTIES

Mr. TRAYNOR. Yes. And he apologizes for not being here, but I thank you for allowing me to sit in for him. It is a great honor to be here.

I want to start out by saying that the county officials and the counties that I represent are very concerned about the Byrne/JAG and the COPS grant reductions; that working with them on a daily basis are essential.

What I really came today prepared to talk more about, the Homeland Security, something that our agency is involved with directly and how vital we feel this funding is to terrorism prevention, disaster preparedness, and public safety, really from a local government perspective.

Just like to note a couple things that have happened since this money has been available to local governments.

Cities, counties, their first responders, including firefighters, law enforcement, emergency medical service, public works, have received about $22.9 million in North Dakota just for response/protection equipment.

About $21.8 million has been distributed for communications equipment; something that we really need in North Dakota to get all of us communicating better as we are called more often to back up and to cooperate with each other on incidents. We need to have that integrated communication.

Communities and emergency management personnel have utilized about 2.1 million of this money for planning, firefighters, law enforcement personnel, and other first responders have spent about $3.1 million for training and over $600,000 in exercise to be ready.

Today over 32,000 individuals across the State have participated in Homeland Security funded training. 32,000 individuals I think is a huge, remarkable number for a State the size of North Dakota.

I would like to point out, as you know and as everyone knows, that Homeland Security funding for States like North Dakota has decreased already.

In 2004, we had $19 million, and in 2006, we are down to $10 million. That is about a 50 percent decrease in 2 years, with additional mandates that we are responsible for, requirements to meet, as well as restrictions on how the money is spent.

The current budget, talking about cutting another $300 million from Homeland Security grants, is just going to be devastating to our efforts.

A couple of things that we would hope that you would take back to Congress is that, first, we feel that there must not be a decrease in Homeland Security funding for the State Homeland Security Program or the Law Enforcement Terrorism Prevention Program.

These programs place resources in the hands of those that are there to respond on a daily basis to both natural disasters as well as terrorism threats.

And second, we feel that States should be guaranteed at least a minimum allocation of three-quarters of 1 percent of the funds rather than some of the discussion about reducing that minimum allocation.

States like North Dakota, it is not a lot of money when you look at it from a State like California or New York, but it is so vital to a State like North Dakota.

We in North Dakota, we have heard it talked about here about the cooperation. Our State has developed a Disaster Emergency Advisory Committee, or DESAC, as they call it, which brings together local governments, first responders from all across the State, to help prioritize this money, and I feel like it is a very good process. It is proven that we can collectively do what is best with this money.

We feel that North Dakota has been very responsible. We are very good stewards of this money and we will continue to do that. So we need your Congressional committee's support for stabilizing the formulas and the methodology for future Homeland Security grants to facilitate multiyear funding that supports North Dakota's strategic plan.

The constant fluctuation and our uncertainty we have experienced in the past makes it difficult for planning long-term investments and setting benchmarks.

So thank you, Senator Conrad, for coming to listen to this, and we are very hopeful that in the future we can retain this important funding.

[The prepared statement of Mr. Johnson follows:]

Senate Budget Committee Testimony February 20, 2007
State and Local Homeland Security Grant

Dear Senator Conrad and Distinguished Guests:

Thank you for the opportunity to provide information about Homeland Security funding and how vital this funding is to terrorism prevention, disaster preparedness and public safety from a local government perspective. My comments reflect the feelings of elected and appointed leaders, and first responders representing city, county, and tribal governments across North Dakota.

Background Information:

In Fiscal year 1999 the US Department of Justice began a "State Domestic Preparedness Equipment Program". The purpose of the program was to enhance the ability of state and local jurisdictions to respond to terrorist incidents involving the use of weapons of mass destruction. North Dakota's allocation for that program was $400,000. The authorized equipment list was two pages; the program guidance was a mere booklet and the reporting requirements were three to four pages.

Since 1999 North Dakota has received over $66 million in Homeland Security Funding to prevent respond and recover from acts of terrorism and significant natural disasters. Its scope has enabled States and communities to prepare for not only weapons of mass destruction but single acts of terrorism and natural disasters.

Today, the FY 2007 Grant application encompasses five grant programs with a series of three inch binders; an authorized equipment list so large it's on the web and a web based reporting tool of immense detail. Current Homeland Security Funding mandates that 80% of the funding received by the state be directly obligated to local units of government.

It is significant to note where the funding has been applied and what has been accomplished.

- Cities, counties and their first responders, including firefighters, law enforcement agencies, and emergency medical personnel and public works departments have received $22,916,983 in response and protection equipment. $21,849,756 has been distributed for communication equipment.

- Communities and emergency management personnel have utilized $2,187,883 for planning, fire fighters, law enforcement personnel and other first responders have spent $3,137,758 for training and $630,680 for exercises.

- Today, fire fighters and law enforcement agencies, emergency medical personnel, school, communities and tribes from Fargo to Beach have increased their ability to prevent, respond and recover from acts of terrorism and natural disasters through the acquisition of necessary response equipment.

- Today, 32,128 individuals have participated in Homeland Security approved training.

- Today, every county and select local community have upgraded their emergency operations plans and incorporated terrorism annexes and provisions for mass care and sheltering.

- Today, 254 schools in 34 counties have participated in emergency response training.

- Today, communication equipment has been upgraded in every county throughout North Dakota.

It is also noteworthy to point out that Homeland Security funds through the 20% allotted for state programs has enabled North Dakota to start building the necessary communication infrastructure to improve the communication systems and provide communication needs to the Highway Patrol and other state law enforcement agencies. Terrorist prevention activities are the main objective of the North Dakota Intelligence Fusion Center which houses analysts from the ND Highway Patrol, Bureau of Criminal Investigation and National Guard. Active participation in the protection of our international border in cooperation with the US Border Patrol and strengthening critical governmental infrastructure sites including the State Capitol, have received increased emphasis.

To accomplish the above North Dakota has adopted and set in place a Homeland Security strategic plan to protect the citizens of North Dakota from terrorist acts and help respond and recover from natural disasters. The plan is robust and inclusive. Its success relies on our ongoing partnerships with counties, cities,

tribes and involved citizens throughout the state. The plan outlines a key concept of anchor capabilities throughout North Dakota. It builds on North Dakota's ability to establish partnerships across multiple jurisdictions in building capabilities cooperatively. Major events in North Dakota will exceed the capacity of any single jurisdiction. It is imperative for North Dakota to take a holistic view in defining and providing the capabilities necessary to respond effectively. The state in cooperation with firefighters, law enforcement agencies and communities is building this comprehensive program for response.

The Future:

Despite our great accomplishments our needs are even greater. Our current gap analysis has determined that close to $30 million is needed to fulfill jurisdictional communication needs. The state contains over 15,000 volunteer firefighters in need of basic and advanced training to respond to disasters and acts of terrorism. Law enforcement personnel, emergency medical personnel and community leaders are in need of comprehensive disaster and Homeland Security training. Additional response equipment is needed throughout the State of North Dakota. Emergency response plans, equipment and training must be tested through periodic exercises. Our needs are great; our prospects for future federal funding are small.

Despite our needs, our successes and the complexity of demands from the Homeland Security implementing agencies, funding levels have steadily decreased. Homeland Security funds have decreased from $19 million in 2004 to a little over $10 million in 2006. This approximate 50% decrease in funding has been coupled with increased mandates from the Department of Homeland Security to address a number of issues. States like North Dakota are forced to partially fund areas of greatest need to address ever increasing federal mandates.

The current budget for 2008 contains a number of troubling cuts for Homeland Security activities. The new federal funding formulas indicate that State Homeland Security grants will be cut by over $300 million, Law Enforcement Grants will be under funded by over $100 million. Overall the program is under funded by an estimated $150 million from FY 2007. These cuts directly affect the ability of North Dakota to proceed on a strategic course to protect its citizens from harm. Equally troubling are provisions currently being debated to cut the minimal amount of funding in FY 2008 to .45% of the total funds appropriated for the State Homeland Security Grant Program. This additional reduction will have a significant effect on North Dakota.

Recommendations: There are a number of steps which will aid North Dakota in fulfilling our partnership in protecting the nation and its citizens.

1. First, Congress must not decrease the amount of funding to the State Homeland Security Program and the Law Enforcement Terrorism Prevention Program. These programs place the resources in the hands of those that respond on a daily basis to threats and natural disasters.

2. States should receive a minimum of .75% of the total funds appropriated for the State Homeland Security Grant Program. This baseline would ensure program stability and allow for continuity in planning, Homeland Security program and implementation. The fluctuation of the budgets over the past years is not conducive to implementation of strategic national and or state objectives.

3. Allocation of funding is based on risk and effectiveness. States have no input into the federal government calculation of "risk." Additionally the funding allotment for this concept is based on two thirds risk and one third effectiveness. A value system weighing effectiveness on a 50% level would be more appropriate.

Local Government Perspective:

As you well know, the overwhelming majority of our local fire departments and ambulance services are community volunteers. In addition, local government law enforcement agencies are minimally staffed based on strained local budgets. These volunteers need to be provided the opportunity to have Homeland Security training courses offered locally. In addition to their respective technical skills and credential training, they cannot afford the time to attend resident schools like their fully staffed, fully paid counterparts from urban and metropolitan jurisdictions. Homeland Security funds are critical to keeping our first responders well equipped, trained and exercised for potential acts of terrorism or natural disasters. North Dakota has experienced many natural disasters whereby all city, county, tribal, and state governments responded in harmony to mitigate the results. Continued levels of Homeland Security funding are required to provide the necessary incident management training, increase the response agencies capability, integration of mutual aid response and interoperable communications on a regional basis.

Oversight and Governance: By State statute, all Homeland Security grant applications and appropriated funds are reviewed and prioritized by the Department of Emergency Service Advisory Committee (DESAC). The committee is chaired by the State Adjutant General, who also serves as the Director of Department of Emergency Services. The committee is comprised of eleven members, who represent fire, law enforcement (state and local), and emergency medical services, public health, hospitals, city and county government. This committee ensures oversight that the Homeland Security funding meets the priorities within the State's Homeland Security Strategic Plan.

Innovative Approach: In 2003 a unique partnership was created between the Department of Emergency Services, the North Dakota Association of Counties, and the North Dakota League of Cities. This partnership created the Local Government Homeland Security Training and Exercise Program (LGHSTEP). The program's mission is to provide training and exercise support to local governments in accordance with Department of Homeland Security guidelines. It was considered the best approach for delivering cost effective training for the ever increasing Department of Homeland Security mandates for training and exercise compliance by local officials and responders. This program has been instrumental in providing the mandated National Incident Management System (NIMS) and Incident Command System (ICS) compliance training throughout the state. Since 2003 the LGHSTEP has delivered over 400 training courses, 150 scenario based exercises resulting in training over 20,000 city/county/tribal/state personnel. The program consists of a staff of five personnel which is funded by contractual agreements between the program and the counties using portions of the 80% of State Homeland Security grant funds distributed to county/tribal governments.

Rural versus Metropolitan: Unfortunately North Dakota gets categorized as a sparsely populated region with little to no significant threats of terrorism and is not recognized for its potential targets of opportunity. Therefore North Dakota does not qualify for Urban Area Security Initiative (UASI) grants as do larger populated states. We must keep in mind we are a Northern border state with eight counties neighboring Canada with a vast and porous border. North Dakota has a large number of power plants, petroleum producing facilities, a major hydroelectric plant providing power to WAPA on the Missouri River (Garrison Dam) and two federal Air Force Bases that should be considered as critical infrastructure. Damage or loss to any of these facilities due to a terrorist attack would result in a significant economic impact to the United States.

Planning: Change is constant. The lessons learned from September 11, 2001, Hurricanes Katrina and Rita, as well as other disasters continue to filter down from federal agencies to all state and local governments. The need to constantly change emergency operations plans, develop Continuity of Government and Continuity of Operations plans, provide building and technology systems security, and develop all hazards vulnerability studies are just a few of the examples for the need to sustain Homeland Security planning funds.

WMD Awareness Training: Increased emphasis is needed on WMD/HazMat awareness training at the local first responder level. A DHS/ODP approved course (AWR-160-WMD Awareness) exists, but inadequate funding is provided to the rural states to conduct this training. Increased funding for this program is paramount to first responder safety and credentialing/qualification standards for fire, law enforcement and emergency medical services personnel.

Community Emergency Response Team (CERT): Federal funding to states for the CERT program is crucial to providing training and equipment to local CERT volunteers. CERT volunteers, comprised of citizens within our communities, are invaluable resources for augmenting already stretched first responder assets and personnel support to local agencies during disasters.

Our local government membership supports legislation that ensures these crucial federal resources are sustained at appropriate levels to allow state and local government leaders to invest in our homeland security strategy. We would suggest continued Congressional support for stabilizing the formula for State Homeland Security grant to facilitate a multi-year funding plan at the state level to promote better planning and implementation of North Dakota's Homeland Security strategic plan

Senator Conrad, thank you for your concern about this important federal-state-local partnership that will provide the resources to accomplish our Homeland Security strategic goals and increased pubic safety for the citizens of our state and nation.

Sincerely,

Mark A. Johnson, CAE
Executive Director
North Dakota Association of Counties

Senator CONRAD. Thank you very much for your testimony.

Maybe I could just ask you, as it is important we establish for the record, do you believe it makes sense to cut the State Homeland Security Program by 65 percent or the Law Enforcement Terrorism Prevention Grants by 31 percent?

Mr. TRAYNOR. Absolutely not. I think maintaining the money that is there, as I said, we have already experienced cuts, and I think the level that we are at now is essential to maintain and continue to improve our communication infrastructure and keep our

people well-trained and exercised so they can respond to the emergencies that sooner or later we will probably have to deal with.

Senator CONRAD. Chief Hoover, if I could ask you the question on firefighter grants. Do you believe it makes sense to cut the firefighter grants 56 percent?

Mr. HOOVER. Well, see, from my perspective, the scope of fire department activities is growing all the time. You know, we are getting more responsibilities as time goes on, and with that responsibility comes added expenses.

So from my perspective, of course, I would like to see more funding go into the SAFER grants to help us with that personnel and these responsibilities, more money into the fire grants, because, you know, the scope of our job is growing, and so——

Senator CONRAD. The fact of the matter is, you are getting asked to do more. Isn't that the case?

Mr. HOOVER. Right, and the expectations of the citizens is that we provide more services, and then here is the funding stream that is drying up on us. So it is very problematic.

Senator CONRAD. You know, it is interesting. If you look at what the Federal Government is sending out in terms of guidelines and requirements and responsibilities for first responders, for local law enforcement, for sheriffs, for emergency medical services, for fighter departments, dramatic increase in what they are asking local law enforcement, local first responders, to do. Isn't that the truth? I would ask you, Chief Hoover. Aren't you being asked to do more?

Mr. HOOVER. Well, that is exactly correct. The expectations and the responsibilities that are coming down to the local jurisdiction have increased and, you know, at the very time that the support we are getting is going away.

Senator CONRAD. Yeah. I must say it just makes no sense to me.

Ken, welcome. Good to have you here. Ken Habiger, who is the president of the Casselton Volunteer Ambulance Service. We know in North Dakota volunteer ambulance service is critically important to being able to deliver health services.

Please proceed with your testimony.

STATEMENT OF KEN HABIGER, PRESIDENT, CASSELTON AMBULANCE SERVICE

Mr. HABIGER. Thank you, Senator, for allowing me to be here today to testify.

As the Senator said, I am the president of the Casselton Volunteer Ambulance Service in Casselton, North Dakota, and also a former Casselton fireman. I have been an emergency medical technician since we started the Casselton Volunteer Ambulance Service in 1978. I am here today to represent the emergency service providers in the State of North Dakota, many of whom are volunteers.

I have been involved with the ambulance service starting at a very early age when funeral homes provided this service and have been part of the evolution of ambulance services to be the professional healthcare providers they are today.

Our services, along with three other volunteer basic life support services and Fargo-Moorhead advanced life support services, provide medical services throughout Cass County, where the main railroad freight line and two interstate highways cross.

We operate under medical direction in a tiered response system starting with 911 dispatch, first responders, then moving up into basic life support and ALS ambulance services, LifeFlight, police and fire departments.

Our main support in North Dakota starts with the North Dakota Department of Health Emergency Medical Services and moves down through the county government and the county emergency manager.

The reason we are here today is our concern for the cutbacks in funding through the President's budget, which may cause our inability to fill all of our needs that Homeland Security and other agencies require and mandate of ambulance services in the field of preparedness—?

EMS gets a small portion of Homeland Security and other sources of funding. In Cass County, I sit on the Cass-Fargo Emergency Planning Committee that assists in identifying concepts for preparedness, prevention, mitigation, response, and recovery from natural and man-made disasters.

Nationally EMS funding is around 4 percent of the money made available. EMS also has a difficult time getting on national boards and on down that are involved in planning and funding of EMS. These findings were the result of a large number of participants from the EMS and medical community through a study done through New York's Center for Catastrophe Preparedness and Response. EMS is part of what is called "The Forgotten Responder."

Funding we have been able to access provided us a new interoperable digital radio system and soon-to-come digital paging equipment.

This leaves us short in funding for equipment, even with help from the North Dakota Department Emergency Medical Service. We are unable to fully implement the North Dakota Regional Response Plan for our services.

Senator CONRAD. You do not have sufficient resources now——

Mr. HABIGER. Right.

Senator CONRAD [continuing]. To do that. Well, how about a 65 percent cut?

Mr. HABIGER. Oh, that 4 percent will be gone that we are getting now.

Senator CONRAD. Yeah. Two-thirds of it would be gone. Does that make any sense to you?

Mr. HABIGER. No. No. It is tremendous. Statistics show the population of North Dakota is aging. We see funding for this aging population cut through the President's budget. Also, we see beneficial programs like emergency medical services for children and many other programs suffering drastic cuts.

Across the Nation, every State is dealing with a looming crisis to attract volunteers to its services. I believe the last figure that was presented showed that in the 1980's, the average volunteer ambulance squad had more than 35 volunteers. Today that figure is down to 12 members.

I thank you for allowing me to be here today. We are grateful for the support and funding we have received, but we realize we have a long way to go to move up from that 4 percent figure of funding.

[The prepared statement of Mr. Habiger follows:]

Field Hearing of the US Senate Budget Committee
20 Feb 2007
Room 201 Fargodome
Fargo North Dakota 58102

Testimony of Kenneth G. Habiger NREMT-B
Casselton Volunteer Ambulance Service
Casselton, North Dakota

Senator Conrad, Members of the Committee, Honored Guests, Ladies and Gentlemen:

Thank you for allowing me to testify before you this afternoon. My name is Kenneth Habiger. I am the President of the Casselton Volunteer Ambulance Service in Casselton North Dakota and also a former Casselton fireman. I have been an Emergency Medical Technician since we started the Casselton Volunteer Ambulance Service in 1978. I am here today to represent the emergency service providers in the state of North Dakota, many of whom are volunteers. I have been involved with ambulance services starting at a very early age when funeral homes provided this service and have been part of the evolution of ambulance services to be the professional health care providers they are today.

Our service along with 3 other volunteer BLS (Basic Life Support) services and Fargo-Moorhead ALS (Advanced Life Support) service provide emergency medical services throughout Cass County, where the main railroad freight line and 2 interstate highways cross.

We operate under medical direction in a tiered response system starting with 911 dispatch, first responders, moving up into BLS and ALS ambulance services, Lifeflight, police and fire departments.

Our main support system in North Dakota starts with the North Dakota Department of Health EMS (Emergency Medical Services) and moves down through the county government and the county Emergency Manager.

The reason we are here today is our concern for cutbacks in funding through the President's budget which may cause our inability to fill all of our needs that Homeland Security and other agencies require and mandate of ambulance services in the field of preparedness.

EMS gets a small portion of Homeland Security and other sources of funding. In Cass County, I sit on the Cass-Fargo Emergency Planning Committee that assists in identifying concepts of preparedness, prevention, mitigation, response, and recovery from natural and man-made disasters. Nationally, EMS funding is around 4% of the money made available. EMS also has a difficult time getting on national boards and on down that are involved in the planning and funding of EMS. These findings were the result of a large number of participants from the EMS and medical community through a study done through New York University Center for Catastrophe Preparedness and Response. EMS is part of what is called "The Forgotten 1st Responder".

The funding we have been able to access provided us a new interoperable digital radio system and soon to come digital paging system.

This still leaves us short in funding for equipment even with help from the North Dakota Department of Health EMS. We are unable to fully implement the North Dakota Regional Response Plan for our services.

Statistics show the population of North Dakota is aging. We see funding for this aging population cut through the President's budget. We also see beneficial programs like EMS-C (Emergency Medical Services for Children) and many other programs suffering drastic cuts.

Across the nation, every state is dealing with a looming crisis to attract volunteers to its services. I believe the last figures that were presented showed that in the 1980s the average volunteer ambulance squad had more than 35 volunteer members. Today, that figure is down to 12 members.

I thank you for allowing me to be here today. We are grateful for the support and funding we have received, but realize we have a long way to go to move up from that 4% figure of funding.

Senator CONRAD. Well, I thank you for that, Ken. And I thank each of these witnesses.

I just think we are headed in the direction here that would be a profound mistake. If these proposed cuts were actually implemented, I think the effect on local law enforcement, I think the effect on fire departments, the effect on emergency responders and the effect on counties would be very dramatic, especially over a number of years.

I went through before the amount of money that has come to North Dakota through these programs over the last several years, and we are talking, as I had indicated, $36 million for the COPS program from 1994 to 2006. $42 million through Byrne and JAG local law enforcement grants from 1988 to 2006. $48 million from the State Homeland Security Program from 2003 to 2006. Terry, you especially referenced those. That is over a 4-year period. $48 million. $48 million makes a big difference in North Dakota. Law enforcement terrorism prevention, $12 million from 2004 to 2006. The firefighter grants that have been important to communities across North Dakota and now are proposed to be cut by 56 percent.

Let me just conclude this panel by asking each of you, if you could speak to my colleagues on the Senate Budget Committee, because we will be in markup within the next month, what would you say to them? What would you want them to understand before they cast their votes on these questions? Chief?

Mr. HOOVER. Well, I guess I would say that, you know, I would like you to realize that the services the citizens expect from the fire service today are far greater than they were even 10 years ago. And they get greater every day. And so as that demand for service grows, the needs grow as well. So it seems incongruent to me to, at a time of growing need——

Senator CONRAD. Let me just say, if you used the word "incongruent" with some of my colleagues, you will really——

Mr. HOOVER. It does not make any sense to me.

Senator CONRAD. Yeah, that we can understand.

Mr. HOOVER. You know, it does not make any sense to reduce funding during a time of growing need.

Senator CONRAD. Yes, sir. Terry.

Mr. TRAYNOR. I just want to reflect back on what you had said in your opening remarks about Homeland Security and North Dakota.

We have this huge, 320-mile border, international border, that oftentimes local law enforcement is called to help bolster the resources there. We do a lot of exercises on the border with Federal officials, Canadian officials, State and local.

We are constantly working together to keep our State and our Nation safe, and I think we have a big role in that here in North Dakota. And I hope that your colleagues can understand how important it is to keep the funding there so we can be ready to respond to any emergency that comes along.

Senator CONRAD. Thank you, Terry. Ken.

Mr. HABIGER. Well, I think a lot is expected of EMS in North Dakota, especially with things that—like a pandemic flu attack here or a major—something happened to our food-supply chain and a lot of people got sick. You could go on and on with the preparedness and having the necessary stuff to attack what you have to do.

And then I think when we see the population of the ambulance, you know, declining, less and less ambulance services, more demands put on, and if something major happens, part of the State response plan that we are in now, we are expected, our services, to be able to take care of about 10, 12 people at one major event. So you multiply that to something major coming through, why——

Senator CONRAD. We would have our hands full.

Mr. HABIGER. Right.

Senator CONRAD. Let me just conclude this by saying those who say there is no Federal responsibility here deny the nature of the threat with respect to law enforcement in the first order.

One of the great threats we face is these drug gangs that operate not just locally. These drugs are not coming just locally. These drugs are coming both nationally and internationally. And anybody that does not see a Federal responsibility for a partnership to combat that threat I think is just missing reality.

I would say on the question of the threat of pandemic, we have just had the Secretary of Health and Human Services before the Budget Committee. One part of his testimony talked about the very real threat of a pandemic at some point and the strains that that would put on us all nationally. And nobody can tell you where it might break out.

It could break out here in North Dakota. It could break out in Casselton, North Dakota, could be the first place we see it. Somebody could fly here on a plane from some Asian country and come here and first have the symptoms in Casselton, North Dakota.

If that were to occur, they would have to cordon off the area and immediately try to identify everyone exposed, every animal exposed, treat them with vaccine, treat them with antivirals, close them off so they didn't infect others.

That would be a demand that would be put on all first responders. EMS would have a role, local law enforcement would have a role, firefighters would have a role. I mean, this is the plan.

So to suggest that there is no national or Federal responsibility or role is to deny the reality of the threats we face. We are in a world that is globalizing, and these threats have become global in nature, and you cannot respond just locally. You have to respond locally and regionally and nationally and even internationally, and that requires partnerships.

And if we are going to have partnerships, we have to partner up on the funding. That is just the reality. Some of these things are already in place and are working well.

For the life of me, I do not understand what sense it makes to cut the COPS program 64 percent, or to cut the Homeland Security program 65 percent, or to cut firefighter grants 56 percent, or to cut the Byrne/JAG grants 34 percent, or the Law Enforcement Terrorism Prevention Program 31 percent.

I do not think the record sustains those proposals, and I can say, without equivocation, they will not be included in any budget that I submit. I just think those are the wrong priorities for the country.

With that, I want to thank each of you. If you have anything you would like to add, I would certainly want to give you that opportunity before we close the hearing. Chief?

Mr. HOOVER. Well, you know, not in terms of local funding, but, you know, looking at the President's budget, the National Fire Academy is a very valuable resource to a fire service in an area like North Dakota, because we do not have the resources to develop our own site-specific programs and training. So we rely heavily on it.

And as the demand on the fire services increases, you know, I see a decrease in your budget or this year a very incremental increase. And so we depend on them for training programs to help us train, and they are really not keeping up with the changing demand. And I feel a little bad about saying positive things about a Federal bureaucracy, but——

Senator CONRAD. That's OK. After that incongruent, you have totally flummoxed them down there.

Mr. HOOVER. Thank you, Senator.

Senator CONRAD. Yes.

Mr. TRAYNOR. I just want to comment. From reviewing the President's budget, there appears to be more of a shift away from formula funding to a discretionary, grant-based, and too often we do not fare very well in North Dakota.

A lot of the Homeland Security money is based on a risk assessment that we do not control locally. It is a national risk assessment, and we do not have—we have very little input into that. So

we do not fare well on those sorts of things, and to move away from the formula type funding is pretty difficult for us.

Senator CONRAD. You know, the truth is—must be very blunt—when they make the decisions in someplace far removed from rural America, rural America never does well, because, frankly, we are out of sight, out of mind.

They do not understand our part of the country. They have almost no conception of what it is like. They really do not. They are good people, they are well-intentioned, but many of them have never been anywhere close to here. So they really do not understand parts of the country they are not familiar with. I guess that is just human nature.

But shame on us if we do not develop a policy that allows the threat, wherever it exists, to be met with resources that are sufficient to combat it.

And that goes whether it is a fire threat, or a disaster threat, or a law enforcement challenge, or the potential, God forbid, of a pandemic. You know, we have an obligation to kind of think ahead here, look over the horizon to see what is out there and how we can best prepare ourselves. That is an obligation we all have.

Ken, any last——

Mr. HABIGER. Well, I guess the issue we are dealing with is, and it is a nationwide issue, is the lack of volunteers because of the time constraints and the lack of anything of a financial reward a lot of times, and we are dealing with budget cuts on top of that. And we are—I think in our area we talk a lot about this pandemic flu. You know, hospitals, will they be able to take care of the people?

Senator CONRAD. And this is something we have experienced before. My own grandmother died in that flu epidemic of 1918, and you know, you look at the statistics. Anybody thinks this was confined to the East Coast or West Coast, no, no, no. We were very hard hit by a pandemic flu in 1918. And, you know, we have an obligation to be ready, and, of course, EMS is being very hard hit by the demographic changes.

We are an aging population. Rural areas, more and more of the people are going to the cities. So we have fewer people to volunteer, and yet we have more elderly people who are vulnerable, that may well, you know, rely on for saving their lives by an ambulance service that is volunteer.

Let me just conclude by thanking each of you. Thanks for your contribution to the work of this committee. Thanks for what you do in our communities and our State. We appreciate very, very much the contributions that you make.

With that, we will conclude the hearing.

[Whereupon, at 2:49 p.m., the committee was adjourned.]

AN EXAMINATION OF HEALTH CARE COSTS: CHALLENGES AND OPTIONS FOR REFORM

TUESDAY, AUGUST 7, 2007

U.S. SENATE,
COMMITTEE ON BUDGET,
Minot, North Dakota

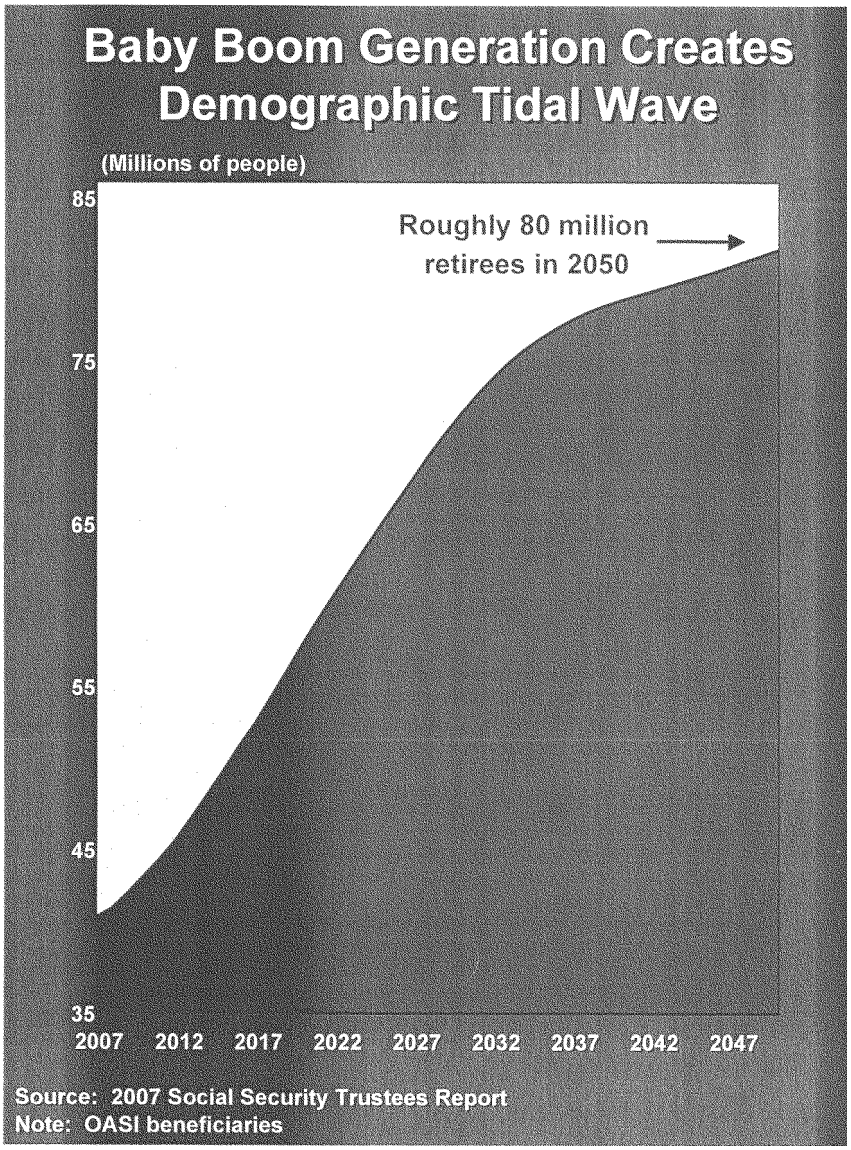
The committee met, pursuant to notice, at 4:02 p.m., in Grand Ballroom, The Grand International, 1505 North Broadway, Minot, North Dakota, Hon. Kent Conrad, chairman of the Committee, presiding.

Present: Senator Conrad.

OPENING STATEMENT OF HON. KENT CONRAD, U.S. SENATOR FROM NORTH DAKOTA

The CHAIRMAN. We'll bring this hearing before the Senate Budget Committee to order. I want to thank everybody for being here, especially thank our distinguished witnesses and thank all of you for attending as well.

This is really one of the great challenges to our country. We're facing a health care crisis. I think all of us recognize that we're on a course that is unsustainable. As I have said many times in Washington, this is the 800-pound gorilla. This is the problem that could swamp the boat in terms of our budget. It is also the 800-pound gorilla that can swamp employers and those who require health care. I think all of us understand that the health care system in this country is in crisis.



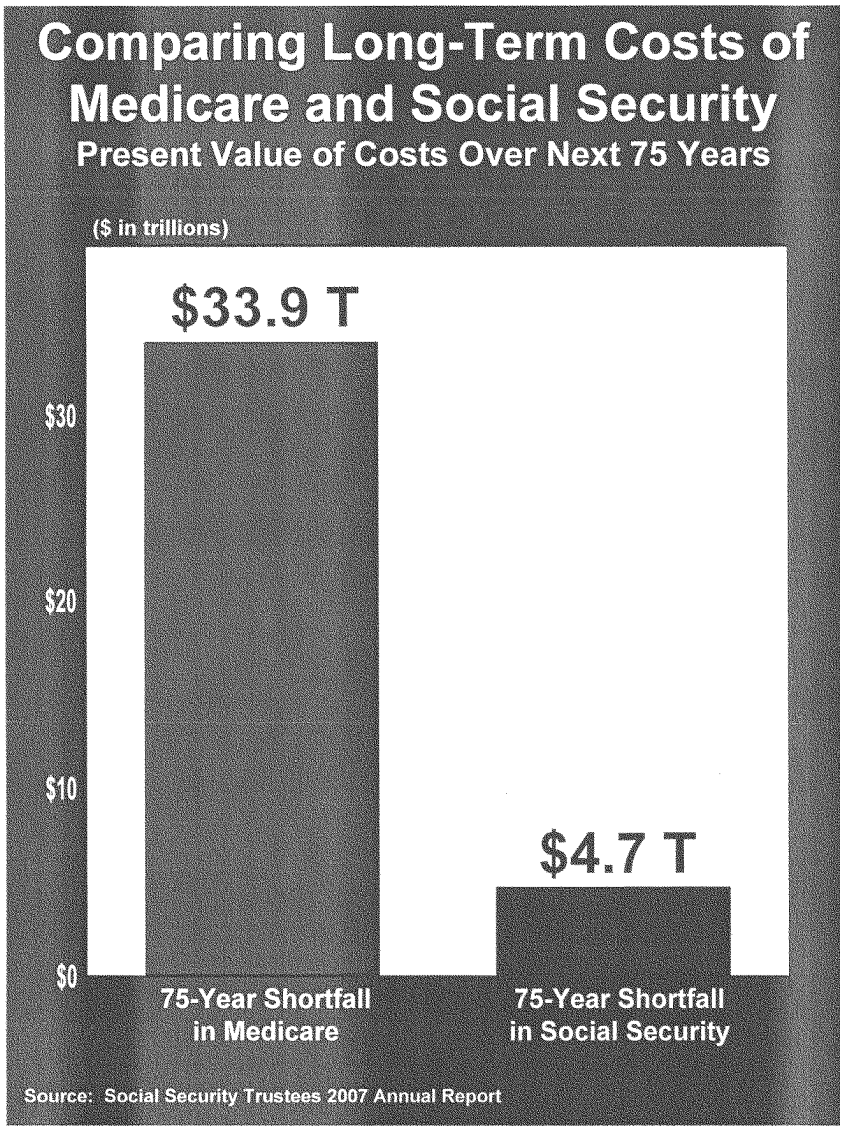
Probably the most daunting challenge that we face is this demographic tidal wave of the baby boom generation, and in very short order is going to double the number of people that are eligible for our programs that provide for health care, Medicare, Medicaid, Veterans health.

And let's go to the next slide if we could, Lindsey. Let me introduce Lindsey Henjum, who is with me. She is my health legislative assistant. She is a Minot native. The Henjum family, I think, is known to many of you here. Lindsey has done a very superb job

in Washington and has a very good reputation, so Minot can be proud of her.

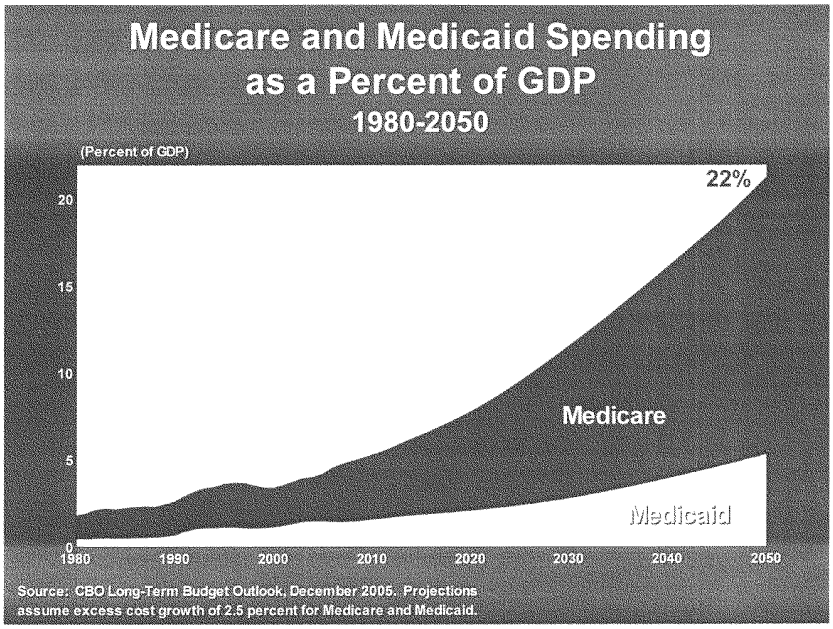
Also assisting me today is Chris Gaddie, who is also a Minot native. He is my deputy communications director. He is in the back. I think many of you know the Gaddie family. So Minot is well represented here today.

This gives you some measure of the problem that we confront. We all know about the shortfall in social security. That's estimated to be just under $5 trillion over the next 75 years. But look at the difference. Look at the shortfall in Medicare. About $34 trillion. That is truly a stunning amount of money. And trillion, that's with a T. We're not talking about billions here. We're talking about trillions.

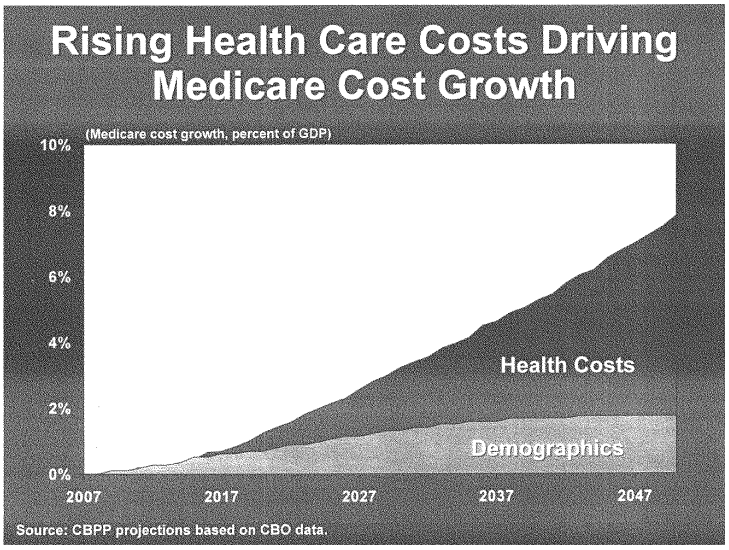


Let's go to the next slide if we could, Lindsey. And we know that our country is spending far more on health care than any other country in the world. We're spending about 16 percent of gross domestic product on health care. If these trend lines continue, Medicare and Medicaid spending, as a percentage of our gross domestic product, will be over 20 percent by 2050. That's if these current trend lines continue. So we know that's unsustainable because that's more than we spend on the entire Federal Government today. And here we are, we're just talking about two programs, just Medicare and Medicaid. No money for social security. No money for national defense. No money for parks. No money for education. No

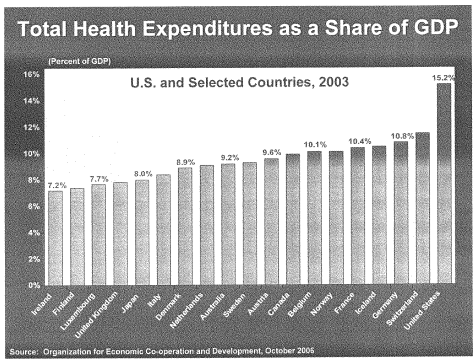
money for law enforcement. No money for any of the other things. So we know we can't stay on this course.



Let's go to the next. Then we know that while demographics play a big role in this cost explosion, the biggest factor is health care costs themselves. When we look at rising Medicare costs, the biggest factor is not demographics, although that's significant, as that first chart showed, but even bigger is health care costs themselves. Underlying health care costs are driving this equation, and that's something we need to know.



Let's go to the next if we could. And this goes back to the point I was making earlier. Here's where we stack up with the rest of the major industrialized countries. You can see in this slide we're at 2003, because that's the last year for which we have data for all these other countries. We were at 15.2 percent of GDP then. The next highest was Switzerland with 11 percent of GDP. We already know we've gone to 16 percent of GDP now for health care. That means one in every $6 in this economy is going for health care. One in every $6 is going for health care. And you have to ask where does it stop.



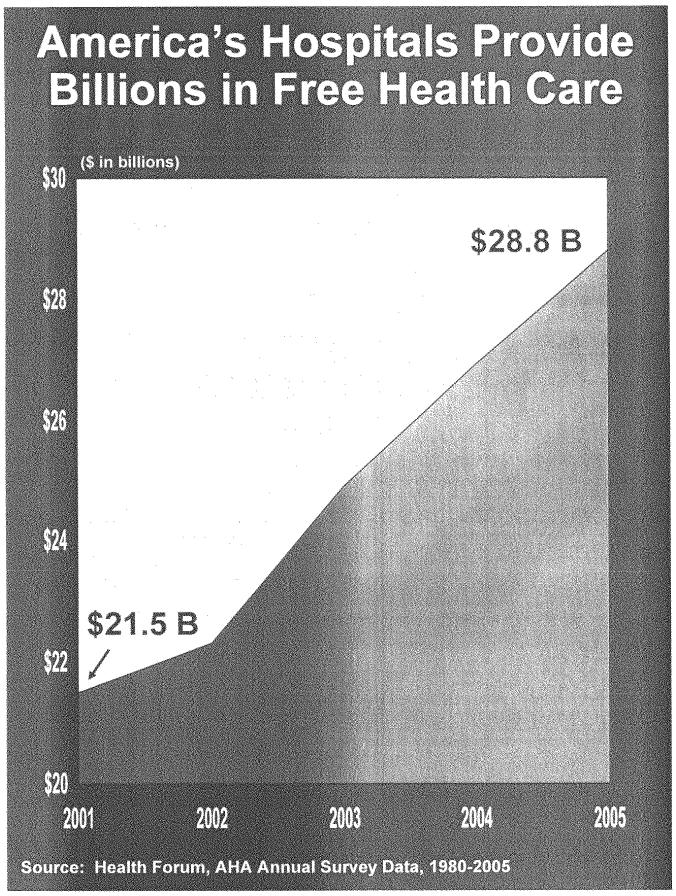
We know that this is a challenge not only for government and these government programs. It is a big challenge for employers. It is a big challenge for employees who are paying part of their health care, and certainly for those who don't have employment, those who are trying to pay for health care on their own.

This rising health care cost places enormous pressure on businesses. Let's go to that slide, if we could. I think we've left that slide out. But the point I wanted to make is rising health care pre-

miums are putting enormous pressure on business. Health care premiums for business are rising twice as fast as the rate of inflation.

I had a businessman stop me the other day in Bismarck, and he came up to me and he said, "Kent, I just got my latest premium increase, 18 percent." He said, "Last year my premium increase was 18 percent." He said, "The year before that my premium increase was 18 percent." He said, "I've had 3 years in a row where my premiums rose by 18 percent." He said, "I don't know if that's the magic number or they've just targeted me." I said, "No, you haven't been targeted, you're not alone." I think John MacMartin here, representing the Chamber, will be able to confirm that our employers are seeing their costs rise and rise geometrically.

Health care providers themselves are feeling the pinch. They're feeling it from uncompensated care. That's increased from $21.5 billion in 2001 to $28.8 billion in 2005. You think of these numbers. They're staggering, aren't they? $28 billion of uncompensated care. You know, some have said we've got the most expensive health care system in the world partly because we provide health care in the most expensive way. That is, when we have 45 million people who are uninsured, that doesn't mean they don't get health care. That means they go to the emergency room for their health care, and that is the most expensive way to provide health care. So, goodness, we have to do a better job of this. And I'm sure Terry Hoff, who runs our hospital here, will be able to give us an insight in terms of how these numbers translate locally as well.



So what do we do about it? Well, I've argued to my colleagues one of the first things we have to do is focus like a laser on 5 percent of our patient population that uses half of the money. Hard to believe, isn't it? Five percent of the patient population uses half of the money. They're the chronically ill, they're people with multiple serious conditions. And we're doing a very poor job of coordinating their care. The result is that they're taking too many prescription drugs. They're being subjected to multiple tests not because, you know, somebody's got bad motive or evil design, but because there's a lack of coordination of care.

We just did a study with some 20,000 patients, a pilot study. We went into their homes. We had case managers go into their homes. First thing they did was get all the prescription drugs out on the table. And what they found was on average they were taking 16 prescription drugs. After reviewing them, they were able to conclude half of those were unnecessary. They were able to reduce it from 16 prescriptions to eight.

I did this with my own father-in-law in his final illness. We went to his house, got all the prescriptions out on the table. I got on the

phone to the doctor and sure enough, he was taking 16 prescription drugs. And I went down the list with the doctor, and I got to the third drug, and he said, "Kent, he shouldn't be taking that, he shouldn't be taking that the last 3 years." I get a little further down the list, he said, "Kent, he should never be taking those together, they work against each other." I said to the doctor, "How does this happen?" He said, "Very simple how it happened. He's got a lung doctor, lung specialist, he's got a heart specialist, he's got an orthopedic specialist, he's got me as his family practice doctor, and while I'm the one that should know what's happening, I don't know." And the result is he's taking prescriptions. He's getting them far and wide. He's getting them at the corner pharmacy, getting them at the hospital pharmacy, he's getting them mail order. He's sick and confused, his wife is sick and confused, and we've got a mess. Same thing with tests. He had three MRIs in a 6-month period. You know, hospital in New York, hospital in Richmond, Virginia, hospital down at the beach.

And, you know, this is costing us a ton of money. And we're not getting better health care outcomes as a result. That's one of the things that jumps out at you that in parts of the country they're doing five times as many procedures as in other parts of the country and getting worse health care results. So another thing we need to look at is researching the effectiveness of different treatments, medical devices, and drugs, so that we can know that we're using best practices.

We also need to encourage better life-styles and screening tests. You know, we've got a health care system that's focused on illness rather than wellness. And we really need to kind of change the way we approach it and create incentives to keep people healthy, to encourage people to exercise and eat responsibly, drink responsibly. This is going to be an area where there's personal responsibility, you know. This is not all on somebody else. We've got to do a better job of managing our own health. We've got to get much more serious about exercising, we've got to get more serious about how we eat and what we drink.

And then I mentioned adopting health information technology to avoid medical errors and to improve the efficiency and the effectiveness of the health care we deliver. One of the things that jumps out at you in the studies that have been done, things like the Rand study that showed you can save $81 billion a year if you fully deploy information technology in health care.

So those are some ideas of things we could do and probably need to do. But we won't do it until we've really reached conclusion on the direction we're going to take. The thing we know now is we're on a course that's unsustainable. That I think is beyond dispute.

Now the question becomes what choices do we make, what direction do we turn. And for that reason we have I think really excellent witnesses with us today, five witnesses to testify before the Senate Budget Committee.

Let me just indicate we are operating under the rules of the Senate Budget Committee. We have a stenographer here. All of this will go in the record of the Senate Budget Committee and will be provided to the other committees of jurisdiction. So this is a hear-

ing that will have resonance beyond the borders of Minot, beyond the borders of North Dakota.

Our first witness will be Dr. Mary Wakefield. Mary is the director of the UND Center for Rural Health and is a commissioner on the Commonwealth Funds Commission on the High Performance Health System. She's also a member of the esteemed Institute of Medicine. Mary has done an extraordinary amount of research on the health care system, its successes, its failures. She is also an expert on the health care system in North Dakota, and also for a shining moment in time was my chief of staff in Washington. Thank you, Mary Wakefield, for being with us, and please proceed.

STATEMENT OF MARY K. WAKEFIELD, PHD, RN, ASSOCIATE DEAN FOR RURAL HEALTH AND DIRECTOR, CENTER FOR RURAL HEALTH UNIVERSITY OF NORTH DAKOTA, GRAND FORKS, NORTH DAKOTA

Dr. WAKEFIELD. Pleasure. Thank you and good afternoon.

I was asked to comment on the national and state level challenges facing health care and to identify potential solutions to those challenges. The challenges that I'll discuss stand in the way of creating a health care system that consistently delivers high quality care, every day, to every person, everywhere. This goal sounds pretty simple, but as we know, the strategies to achieve a high performing health care system are quite complex.

Across our nation, we have some of the most advanced technology and the best educated health care providers in the world. Yet the United States performs worse than other industrialized nations in a number of important areas, including poorer health outcomes on some key measures and large pockets of people without health insurance, all at considerably greater expense. To illustrate how we compare, this line shows U.S. average spending on health per capita, which clearly far outstrips the next nearest countries. And this slide just reinforces your slide, Senator Conrad. Additionally, expenditures——

The CHAIRMAN. I like your slide even better.

Dr. WAKEFIELD. Thank you. We'll get it to you. Actually, this is showing both average spending on health per capita, and then the other point you make, Senator Conrad, the total expenditures of health as a percentage of GDP. Additionally, expenditures for some of our largest programs, Medicare, for example, are not projected to level off any time soon. You can see from the 2007 Medicare Trustees' Report that expenditures are projected to continue to steeply rise.

This slide and the next slide shows you how well the United States does in terms of deaths that, with appropriate medical care, would likely be preventable. This is just one indicator of what we are getting for some of the money that we're spending. Here the United States is 15th out of 19 countries in terms of deaths per 100,000 people. Of these 19 countries, only four do more poorly than we do.

These data that you're looking at right now have been updated using 2002–2003 data and that new information will be published next month. But I can already tell you what the new slide is going to show. It's going to show improvement in the United States on

this measure and it's going to show more rapid improvements in the other countries. So in the new data that will be published next month, the U.S. will no longer be 15th out of 19 countries; rather, we will be in 19th place. That is last place. Again, this slide is showing you how well we do in terms of deaths that, with appropriate medical care, would likely be preventable deaths.

What has happened elsewhere in these intervening years, in the United Kingdom, for example, they have mounted a massive campaign to address heart disease. They've raised standards in hospitals, they've provided technical assistance and so on. So other countries are moving much more rapidly to improve. We're improving as well, but at a slower pace.

Additionally, we have troubling variation within the United States. On the right-hand side of this slide, you'll see that some states do extremely well on this same measure within the United States and some do quite poorly. On the next slide you see how North Dakota compares again on this measure. That's the red bar. And we actually do quite well.

To achieve a consistently high performing system, the Commonwealth Commission, of which I'm a member, advocates focusing efforts in four core areas. First, we need to focus on delivering high quality care. Second, we need to ensure access to care for everyone. Third, we need to provide care that is efficient and of high value. And, fourth, we need to re-engineer the health care system so that it has capacity to improve. I'll comment about these areas from both the national and state perspective.

First, delivering high quality care. When care is well coordinated with information readily available to clinicians and patients, the quality of the care is better. Let's look at just a few international comparisons and then I'll go across states.

In terms of coordinated care, this slide indicates when compared to four other countries the U.S. consistently performs more poorly on care coordination measures such as test results and patient records being unavailable at the time of appointment.

This next slide indicates that we have more medical errors than in five other comparable countries, and that when you have more doctors treating you, the likelihood of medical error increases in the United States and in other countries as well. Patients report errors, though, most frequently in the U.S. While seeing four patients over 2 years might seem like a lot of physician visits, 20 percent of Medicare beneficiaries in the U.S. with five or more conditions receive services from an average of almost 14 doctors per year. Given the tools and structures that are available in our current system, this is a recipe for fragmented care. In spite of these findings, we have some evidence that certain care coordination efforts underway in the U.S. markedly improve patient outcomes and care quality.

Coordinated care is a fundamental underpinning of a concept gaining a lot of attention—medical homes. In North Dakota we have one award winning example that I just want to mention to you this afternoon of collaboration between two stakeholders, MeritCare and, the payer, Blue Cross Blue Shield of North Dakota. They've collaborated in terms of payment reinforcement and the creation of a medical home to build on at its core care coordination

for patients. And their data are now showing improved health outcomes, improved clinician satisfaction, improved patient satisfaction with care, and decreases in costly interventions like that that you mentioned, emergency room visits in a group of diabetic patients.

The next slide. In addition to testing new models, delivering high quality of care is also evident in measures of quality that help us see how we're doing in North Dakota. Here are just a few slides to give you an example. This slide provides one example of the variations—the previous one, actually—variation in quality, readmission rates to hospitals. North Dakota does better than the national average on readmissions to hospital within 30 days, although we're not the very best on that particular measure, on this measure.

On the next slide, using data reported to CMS, we can see how our hospitals do on a different set of measures, those that focus on care for specific conditions. This one is a measure of care for heart failure patients, a costly disease. On this measure, on average, North Dakota hospitals do better than the national average. On the next slide, care for pneumonia patients. I put this up here because I wanted to show you that one rural hospital in North Dakota does exceptionally well and well above the national average.

On to the second point or second focus in terms of areas on which we need to pay attention, and that is ensuring access to care. The national numbers on uninsured across the U.S. are, while disconcerting, well known, so I'm not going to spend time on those. However, I do want to comment on two special populations that are very important when we think about ensuring access to care. Those populations are children and farm families.

Regarding children, your work on the Budget and Finance Committee was critical to the recent Senate passage of the State Children's Health Insurance Program. This program expansion is extremely important for all kids, but particularly for rural children. National studies tell us that more rural children than urban children live in economically vulnerable families. In fact, over 1.3 million rural children are uninsured.

Compared to other states, North Dakota does well on health insurance coverage with about 85 percent of our state insured. However, that 15 percent uninsured includes about 11,000 kids.

In terms of coverage for another important population, farm and ranch families, at the Center for Rural Health, we've recently undertaken a survey of non-corporate farmers and ranchers in seven states, including North Dakota, to get a better sense of affordability of medical bills and medical debt in this population. I don't have all the data for you. We're about 3 weeks away from having all that completely analyzed. But what is interesting is that almost one in four farmers across those seven states indicate that health care expenses contribute to their financial problems, including difficulty paying other bills. And about 27 percent of respondents with debt owed money to hospitals, and almost half had debts to individual providers, physicians and dentists.

This brings me to the third of four areas on which I think we need to focus, and the Commonwealth Commission members agree, and that is trying to focus on ways to solve problems around ineffi-

ciencies in care. I'm going to briefly comment on three dimensions of high performing systems, primary care, health information technology, and comparable effectiveness.

In terms of primary care, the medical program, as you know, gets a very good deal in terms of value in North Dakota. North Dakota ranks second across all states in Medicare reimbursements per enrollee. Part of what is going on in North Dakota is what this graph shows. North Dakota is in the top 15 or so states that has a higher proportion of primary care inputs and associated higher quality of health care. There are a lot of reasons for this finding, but it's worth noting that North Dakota is higher than the national average in the number of primary care providers to population, and primary care is key to many things, including providing chronic care, care for illnesses such as diabetes.

We know that countries and states that rely more on primary care to manage chronic illness tend to have lower spending and they use fewer hospital beds. The people who live in areas with higher per capita health resources tend to receive in the United States more interventions, such as hospitalizations and diagnostic testing, yet there is no evidence, as you indicated, that people who receive more care have better health care outcomes. In fact, there's evidence that more care leads to worse outcomes for patients. That's a really important piece of information in terms of helping us direct our attention, whether you're talking about clinical care or about public policy. However, there tend to be greater rewards for providing specialty care than for primary care and there is no incentive to establish medical homes that have at their core primary and the coordination of specialty care.

The second of the three areas I wanted to mention in terms of high value and efficiency is the use of health information technology. HIT is an important contributor to efficient high value care. The United States lags behind other industries in the use of HIT, as this next slide shows. Compared to other countries, our primary care providers in the United States do not have the tools they need to make their practices efficient. Electronic medical records help to reduce duplicate tests. They help reduce medical errors. They promote coordination and they increase efficiency.

In North Dakota, as you will recall, Senator, you spearheaded a focus on strengthening HIT that you sponsored last year. That summit catalyzed the creation of a steering committee that has been meeting monthly since then with a focus on improving HIT, with improving health care quality and efficiency, but facilitating HIT. It's critically important that in this state we do not lose ground in adopting technology that will enhance efficiency and care quality.

Comparative effectiveness research. We noted in the IOM report, Crossing the Quality Chasm, that our current approach in organizing and delivering care just doesn't meet expectations. One of the reasons that health care in this country falls short of its potential and costs so much is because we don't have a very good idea about which drugs, devices, and procedures used to treat the same conditions are the most effective and most efficient. Senator Conrad, you wisely recognized that need and the need to shore up that function when, as chairman of the budget committee, you in-

cluded a place in the budget for this important research, and the commission has taken note of that.

Last, building on system capacity to improve. In rural North Dakota, as in other rural areas across the country, necessity is the mother of invention, and capacity for innovation, while challenging, is often led by rural administrators and rural providers. Rural health care is typically nimble and new interventions can be adopted there in a matter of hours and days. Rural facilities, with tools and expertise, can be rapid learning organizations that test and serve as models for the rest of the country. From a rural perspective, I can tell you, too, that quality improvement organizations play a pivotal role in working with all types of providers to help them improve the way the care is delivered.

In summary, not only do we see variation among countries, we also see considerable variation within our own country, variation that costs money, days lost from work, and even patients' lives. We also find that there is no systematic connection between high spending and high quality care. What is needed is a coherent set of expectations, tools, and rewards for measuring and improving dimensions of health care that are essential to high performance. That means having matrix for health outcomes, matrix for access to care, and measures for efficiency and care quality.

It means realigning payment, to pay more for value and pay less for valueless care. We need comparative effectiveness research, health information technology, and we need to work to make sure that all Americans have health insurance. Using these approaches to create high performance health care is a big part of the answer. Asking health care providers and administrators to simply work harder, doing a lot more of the same isn't the answer. All of this is hard work, but at the end of the day when we invest wisely in good health, we get healthy, productive people, we get a strong, vibrant economy, and we get healthy communities in return.

Thank you, Senator Conrad, for your commitment on so many of these critical fronts, all of which, taken together, can help us create high performance health care.

[The prepared statement of Dr. Wakefield follows:]

501 North Columbia Rd., Stop 9037
Grand Forks, ND 58202-9037
Phone: (701) 777-3848
Fax: (701) 777-6779
Website: http://medicine.nodak.edu/crh

United States Senate
Budget Committee
North Dakota Field Hearing
Senator Kent Conrad

Health Care Costs and the Need for Reform

Testimony:

Mary K. Wakefield, Ph.D., R.N.
Associate Dean for Rural Health and Director
Center for Rural Health
University of North Dakota
School of Medicine and Health Sciences

Minot, ND
Tuesday, August 7, 2007
4:00 p.m.

Good Morning. My name is Mary Wakefield and I direct the Center for Rural Health at the University of North Dakota School of Medicine and Health Sciences. I want to begin by thanking you Senator Conrad, for holding today's hearing on Medicare Payment Policy Challenges. While this topic is quite significant nationally, in North Dakota, because of our high proportion of elderly and the fact that our health care facilities treat a higher percent of Medicare patients on average, it is especially important to this state, that we get Medicare payment policy right.

Your record of efforts and accomplishments in this area speaks volumes about your commitment to addressing the thorny problems that I and the other witnesses are describing to you today. Thank you and I look forward to continuing to work with you on these health care issues.

Good afternoon. My name is Mary Wakefield and I am the Associate Dean for Rural Health at the University of North Dakota, School of Medicine and Health Sciences.

I was asked to comment on some of the national and state level challenges facing health care and identify potential solutions to those challenges. The challenges I'll be talking about stand in the way of creating a health care system that consistently delivers high quality care, every day, to every person, every where. This goal sounds simple, but as we know, the strategies to achieve it are quite complex. Achieving a high quality, safe system for everyone in this country has been the concern of a number of different organizations, including one on which I serve, the Commonwealth Fund's Commission to create a High Performance Health Care System.

Across our nation, we have some of the most advanced technology and best educated health care providers in the world. Yet the U.S. performs worse than other industrialized nations in a number of important areas, including lack of consistent preventive care, poorer health outcomes on some key measures, fragmented care for individuals with chronic health care problems and large pockets of people without health insurance; all of this, at considerably greater expense.

To illustrate how we compare on just a few measures, this slide shows US average spending on health per capita, which clearly far outstrips the next nearest countries, and total expenditures on health care as a percent of Gross Domestic Product. Additionally, expenditures for some of our largest programs, Medicare for example, are not projected to level off any time soon. You can see from the 2007 Medicare Trustees' Report that expenditures are projected to continue to steeply rise and Medicare program insolvency is projected to occur 12 years from now if we continue down this path.

This slide shows you how well the U.S. does in terms of deaths from causes that are considered amenable to health care, that is, deaths that, with appropriate medical care, would likely be preventable. This is just one indicator of what we're getting for some of the money that we're spending. Here, the US is 15th out of 19 countries in terms of deaths per 100,000. Of these 19 countries, only four do more poorly than we do. Additionally, not only do we have troubling differences between the US and other countries, we also have troubling variation within the United States. On the right side of this slide you see data that indicates some states do extremely well on this measure and others do quite poorly. And, on this slide you see how North Dakota compares to other states-quite well. Overall though, what these first few slides tell us is that we spend more on health care than any other country and within the United States, we get some exceptional care, but we also get tremendous variability that comes at significant cost.

To change these characteristics and achieve a high performing health care system, the Commonwealth Commission's framework is a useful place to begin. The Commission advocates focusing efforts in four core areas: 1) delivering high quality care, 2) ensuring access to care for all people, 3) providing care that is efficient and of high value, and 4)

reengineering the health care system so that it has capacity to improve. I'll make a few comments about these areas from both a national and a state perspective.

Delivering high quality care. Let's look at a few international comparisons first and then look across the states. When care is well coordinated, with information readily available to clinicians and patients, care quality is better. In terms of coordinated care, this slide indicates that, when compared to 4 other countries, the US consistently performs more poorly on care coordination measures such as test results and patient records being unavailable at the time of appointment. This slide indicates that we have more adults reporting medical errors than in five other comparable countries. And this slide indicates that when you have more doctors treating you, in the US as elsewhere, the likelihood of medical error increases. Patient reported errors however, are highest again for the United States. While seeing four patients over two years may seem like a lot, 20% of Medicare beneficiaries in the US, with five or more conditions receive services from an average of almost 14 physicians per year. Given the tools and structures available in our current system, that is a recipe for fragmented care. In spite of these findings, we have some evidence that certain care coordination efforts underway in the United States markedly improve patient outcomes and care quality.

A recently released report from Stanford University shows how a number of coordinating strategies do improve patient outcomes. Cost-effectiveness is associated with care coordination for patients with depression and care coordination for elderly patients with congestive heart failure. Coordinated care is a fundamental underpinning of a concept gaining a lot of attention-medical homes. In North Dakota, we have an award winning example of a collaboration between two key stakeholders, a provider and a payer; MeritCare in Fargo and Blue Cross Blue Shield of North Dakota. This example of a medical home built on care coordination for patients with diabetes is now serving as a model for other entities, including national associations of physicians and payers. The model has at its core, chronic disease management, engages patients through improved knowledge and self management skill development, and uses electronic medical records, measurement and physician and patient feedback and data. The results of a study of this model show improved health outcomes, improved clinician and patient satisfaction with care, and decreases in costly interventions such as emergency room visits. This program is now being expanded, and both the payer and provider are sharing in the savings.

In addition to testing new models, delivering high quality care is also evident in measures of quality that help us to see how we're doing in North Dakota. Here are just a few. This slide provides one example of the variation in quality-readmission rates to hospitals. North Dakota does better than the national average, although not the very best.

Using data reported to CMS, we can see how our hospitals do on a different set of measures, those that focus on care for specific conditions. This one is a measure of care for heart failure patients, a costly disease. On this measure, on average, North Dakota hospitals do better than the national average. On the next slide, care for pneumonia patients, one rural hospital in North Dakota does exceptionally well and well above the national average.

Related to measures of care for heart failure, pneumonia and heart attacks, less than a month ago, an article in the journal Health Affairs published findings indicating that high performance on three common medical conditions- heart attack, congestive heart failure and pneumonia, found that high performance in hospitals on these measures was consistently and significantly associated with fewer patient deaths in those same hospitals. The point is, across the United States, when it comes to quality of care, there is significant variation in performance; variation that has associated costs in both lives and financial resources.

Ensuring Access to Care

The national numbers on uninsured across the U.S. general population are, while disconcerting, well known, and so I won't spend time on those. However, I do want to comment on two special populations, children and farm families. Regarding children, your work on the Budget and Finance Committees was critical to the recent Senate passage of the State Children's Health Insurance Program reauthorization. This program expansion is extremely important for all American children, but particularly for rural children. National studies tell us that more rural than urban children live in economically vulnerable families, and a majority of uninsured children in rural America, 54% of them, live in families where the head of the household works full-time, year-round. In fact, over 1.3 million rural children are uninsured.

Compared to other states, North Dakota does well on health insurance coverage, with about 85% of our state insured. However, that 15% uninsured includes about 11,000 children.

In terms of coverage for another important population, farm and ranch families, the Center for Rural Health at UND, in conjunction with the Access Project in Boston recently undertook a survey of non-corporate farmers and ranchers in seven states, including North Dakota, to get a better sense of affordability of medical bills and medical debt in this population. While these findings will be released fully in just a few weeks, what is interesting to note is that almost all of the respondents across the 7 states had some health insurance coverage and more than a quarter reported having to pay out of pocket for health care. Almost one in four farmers indicated that health care expenses contribute to their financial problems including difficulty paying other bills, paying the mortgage, needing to take off farm or off ranch employment and delaying making investments in the farm or ranch. About 27% of respondents with debt owed money to hospitals and almost half had debts to individual providers, such as physicians and dentists.

Affordable health care coverage is essential for all Americans. As long as we have large numbers of uninsured or underinsured, where people aren't getting care when they need it and, when they do receive it, are unable to pay for it, achieving high performance health care systems will be unattainable.

Efficient, high value care. I'm going to briefly comment on three dimensions of high performing systems that contribute to efficient, high value care; primary care, health information technology and comparative effectiveness research.
Primary Care. The Medicare program gets a very good deal in terms of value in North Dakota. ND ranks second across all states in Medicare reimbursement per enrollee. North Dakota has the lowest average number of days spent in ICU across all states. Part of what is going on in North Dakota is this graph that shows ND in the top 15 or so states that has a higher proportion of primary care inputs and associated higher quality of care. There are a lot of reasons for this finding but it's worth noting that ND is higher than the national average in the number of primary care providers to population, and primary care is key to managing many things well, including chronic conditions like diabetes and asthma. Managing chronic conditions well has significant implications. Twenty per cent of Medicare beneficiaries with five or more chronic conditions account for about 66% of all Medicare spending.

We know from international data and from the Dartmouth data, that countries, and states that rely more on primary care to manage chronic illness tend to have lower Medicare spending and use fewer hospital beds. We also know that the amount and quality of care chronically ill Medicare beneficiaries receive varies extensively across the country, by region and by health care provider. People who live in areas with higher per capita resources receive more interventions, such as hospitalizations, physician visits and diagnostic testing. Yet according to the Dartmouth Atlas data, there is no evidence that people who receive more supply sensitive care have better health care outcomes. In fact, there is evidence that more tests, hospitalizations, intensive care admissions and physician visits lead to worse outcomes for patients and lower patient satisfaction. This is an important piece of information in terms of helping us direct our attention- whether you're talking about clinical care or public policy. However, there tend to be greater rewards for providing specialty care than for primary care and there is no incentive to establish medical homes that have at their core primary care and the coordination of specialty care.

Health Information Technology. The use of Health information Technology –HIT- is another important contributor to efficient, high value care. At the national level, we've seen some progress in encouraging standard electronic transactions in health care. However, health care in the US still lags behind other industries in use of information technology. As is clear from this slide, compared to other countries, primary care and other providers in the US don't have the tools they need to help make their practices efficient. One might think that HIT in small practice settings is inordinately difficult to do. However, while it is a challenge, it can be done. In Denmark for example, the medical association and their national government got behind electronic medical records, and now virtually all health care practices in the country are linked. Important to note is that 80% of those practices are solo or 2 person practices. Electronic medical records and information systems help to reduce duplicate tests, provide decision support for clinicians and patients, reduce medical errors, promote better management of chronic conditions and care coordination and increases efficiency. In terms of health care claims, some

sources indicate that the average cost per claim, if handled electronically, is 85 cents compared to $1.58 if submitted on paper.

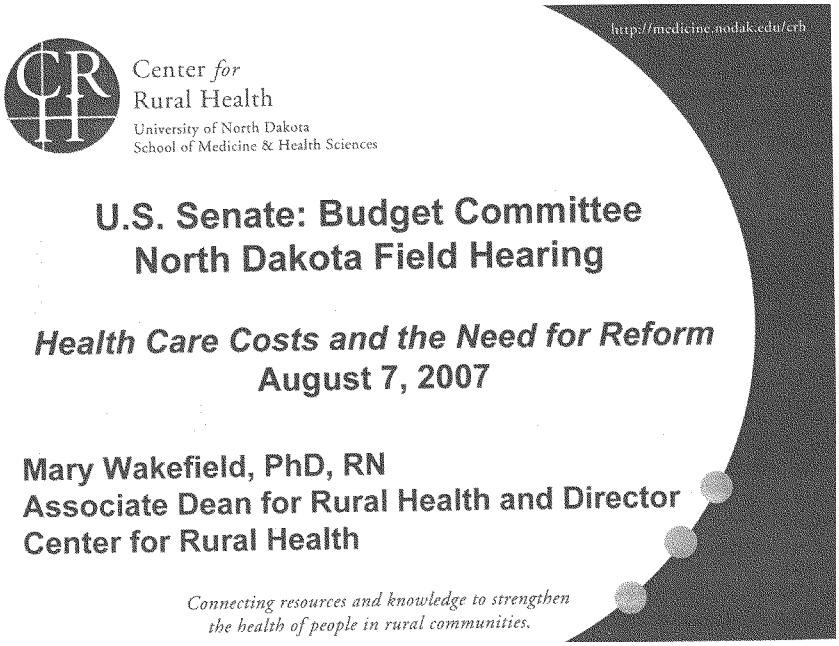
In North Dakota, as you will recall, you spearheaded a focus on strengthening Health Information Technology through an HIT summit you sponsored last year. That Summit catalyzed the creation of a HIT steering committee that has been meeting monthly since then—with a focus on facilitating the adoption and use of HIT to improve health care quality, and efficiency in North Dakota. It's critically important that in this state, we don't lose any ground in adopting technology that will enhance efficiency and care quality. At regional levels in North Dakota, new partnerships are being formed around building HIT infrastructure, many of these with support from federal programs. HIT linkages moves us from the concept of Centers of Excellence often associated with urban areas, to networks of excellence, that help to connect and integrate health care across regions in new ways.

Comparative effectiveness research. We noted in the landmark IOM report, Crossing the Quality Chasm that our current approaches to organizing and delivering care just can't meet expectations. The science and technologies involved in health care drugs, devices, and procedures, have advanced more rapidly than the health care system's ability to deliver them safely and efficiently. One of the reasons that health care in this country falls short of its potential and costs so much is because we don't have a very good idea about which drugs, devices and procedures used to treat the same conditions are most effective, safe and efficient. Other countries have well developed comparative effectiveness research processes that produce objective information. In this country, we need to ensure that payers, providers and patients have timely information to evaluate which treatment options will achieve better outcomes while lowering health care costs. Senator Conrad, you wisely recognized the need to shore up this function when as Chairman of the Budget Committee, you included a place in the budget for this important research.

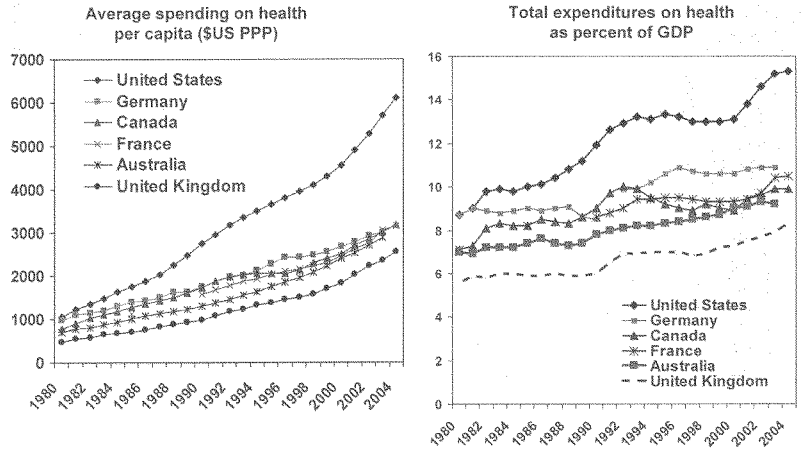
Building system capacity to improve. In rural North Dakota, as in other rural areas across the country, necessity is the mother of invention and capacity for innovation while challenging, is often led by rural administrators and care providers. The nature of rural health care lends itself to creativity, collaboration and regional coordination. Rural health care is typically nimble and new interventions can be adopted in a matter of hours or days when it can take that same intervention months to be adopted in a large facility. Rural facilities, with tools and expertise can be rapid learning organizations that test and model efforts for the rest of the country. Encouraging networks and partnerships through financial and other incentives are important in order to get economies of scale, and cast regional solutions. Strong national policies that support local players to develop common agendas and pool resources are important. From a rural perspective, I can tell you that Quality Improvement Organizations, like the one in Minot that services the entire state, play a pivotal role in working with all types of providers to help them measure and institute appropriate improvements and innovations in the way care is delivered.

In summary, not only do we see variation among countries, we also see considerable variation within our own country; variation that costs money, days lost from work and even lives. We find large gaps in quality of care, access to care, avoidable hospitalizations and healthy lives across our states. We also find that there is no systematic connection between high spending and high quality health care.
What is needed is a coherent set of expectations, tools, and rewards for measuring and improving dimensions of health care that are essential to high performance. That means having metrics for health outcomes, access to care, efficiency and care quality.

It means realigning payment to pay more for value and pay less for valueless care. We need comparative effectiveness research, information technology, and we need to work to make sure that all Americans have health insurance. Using these approaches to create high performance health care is a big part of the answer. Asking health care providers and administrators to simply work harder, doing a lot more of the same isn't. All of this is hard work but at the end of the day, when we invest wisely in good health care, we get healthy productive people, a strong vibrant economy and healthy communities in return Thank you Senator Conrad, for your commitment on so many of these critical fronts, all of which taken together, can help us create high performance health care.



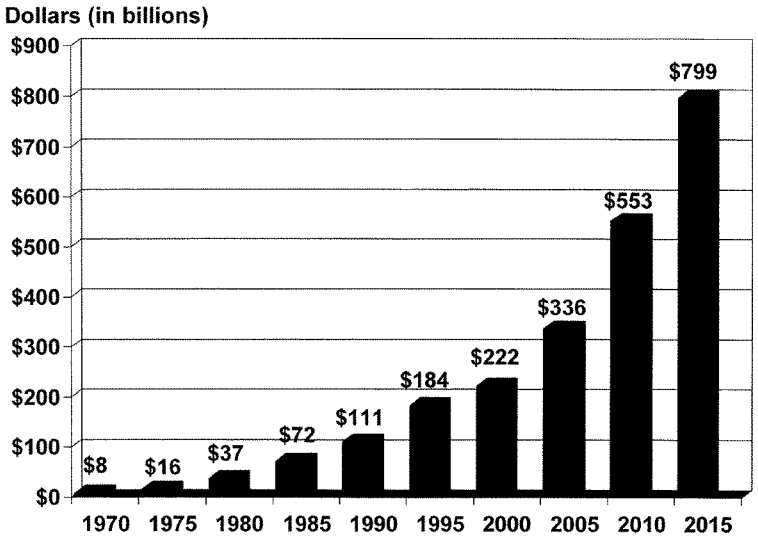
International Comparison of Spending on Health 1980 – 2004



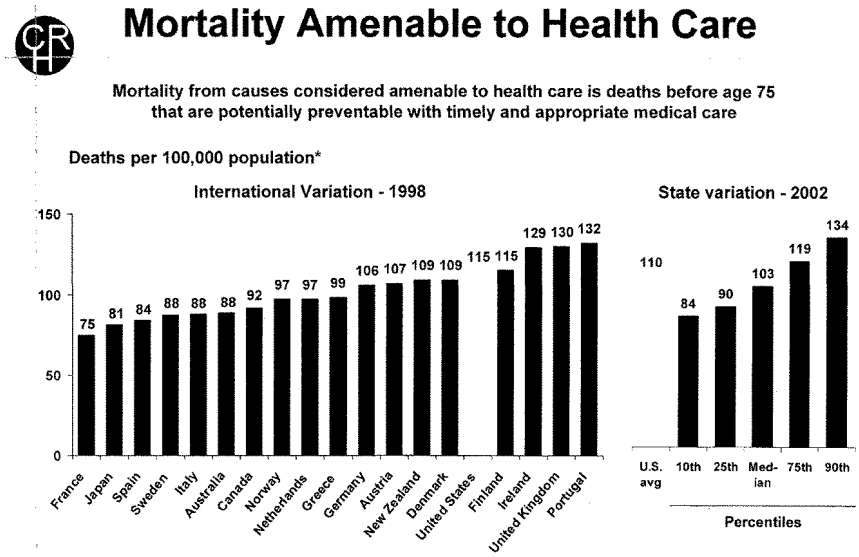
Data: OECD Health Data 2005 and 2006.

(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

Medicare Expenditures (1970 - 2015)

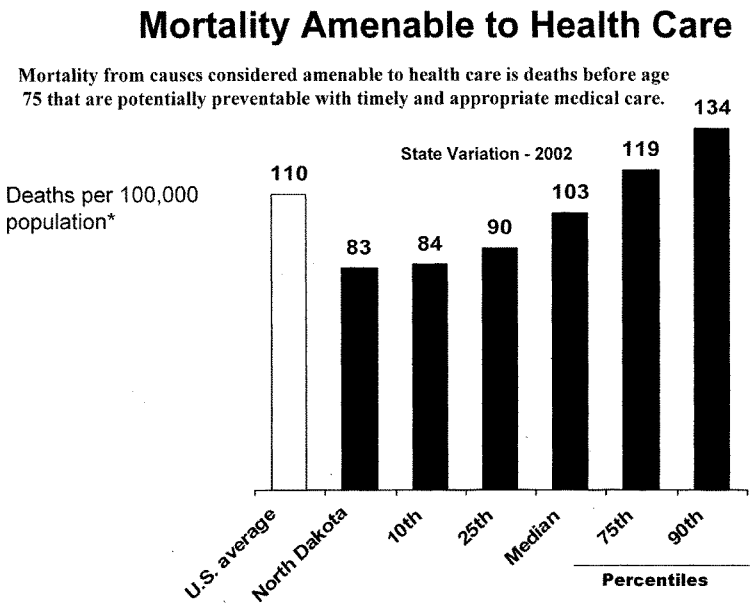


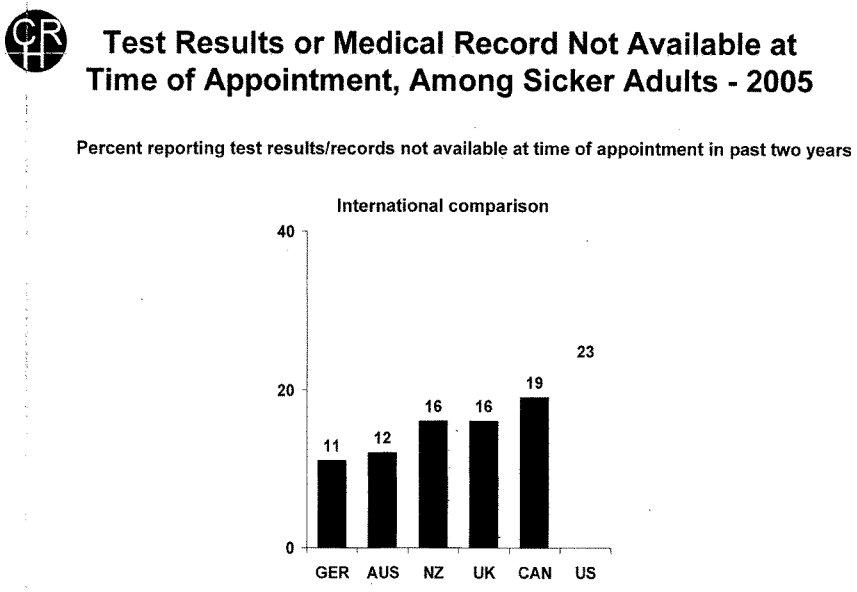
Note: Figures for 2010 and 2015 are projected
Source: 2007 Medicare Trustees' Report



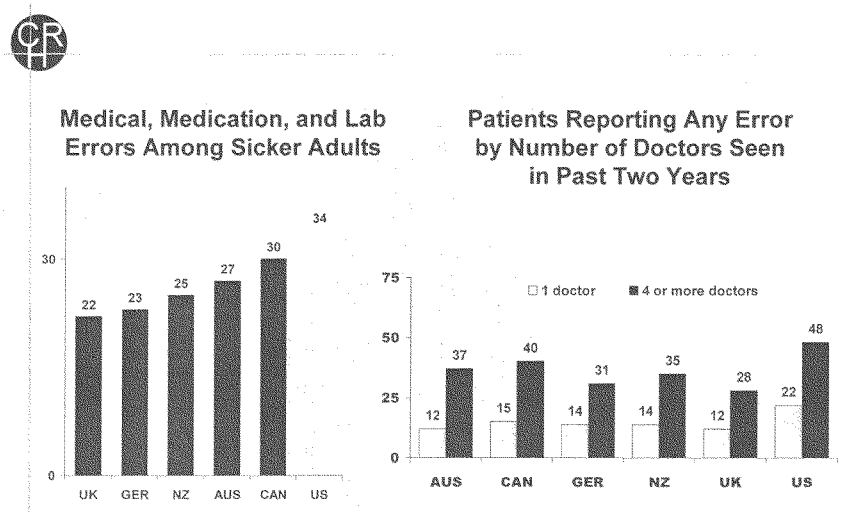
See Technical Appendix for list of conditions considered amenable to health care in the analysis.
Data: International estimates—World Health Organization, WHO mortality database (Nolte and McKee 2003);
State estimates—K. Hempstead, Rutgers University using Nolte and McKee methodology.

LONG, HEALTHY & PRODUCTIVE LIVES





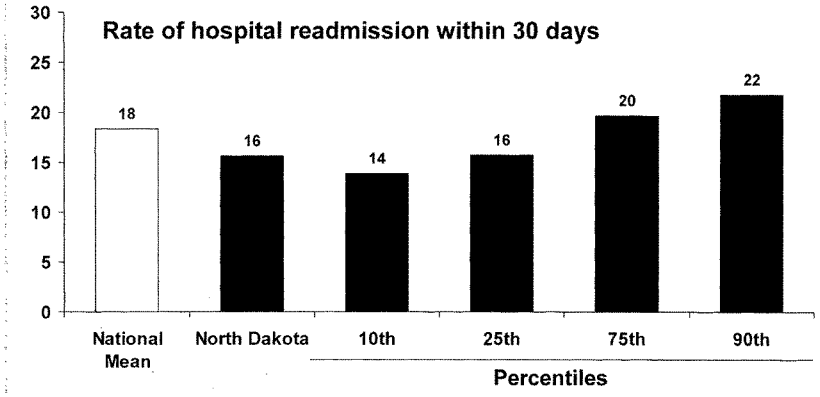
GER = Germany; AUS = Australia; NZ = New Zealand; UK = United Kingdom; CAN = Canada; US = United States.
Data: Analysis of 2005 Commonwealth Fund International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.



UK = United Kingdom; GER = Germany; NZ = New Zealand; AUS = Australia; CAN = Canada; US = United States. International Health Policy Survey of Sicker Adults; Schoen et al. 2005a.

2005 Commonwealth Fund International Health Policy Survey

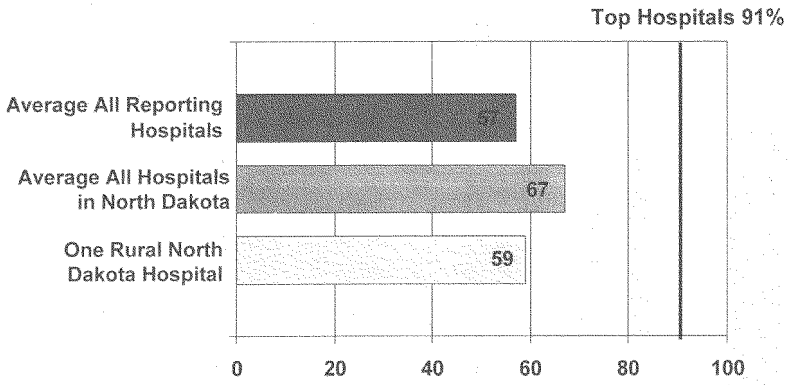
Medicare Hospital 30-Day Readmission Rates, by Regions



Data: G. Anderson and R. Herbert, Johns Hopkins University analysis of 2003 Medicare Standard Analytical Files 5% Inpatient Data

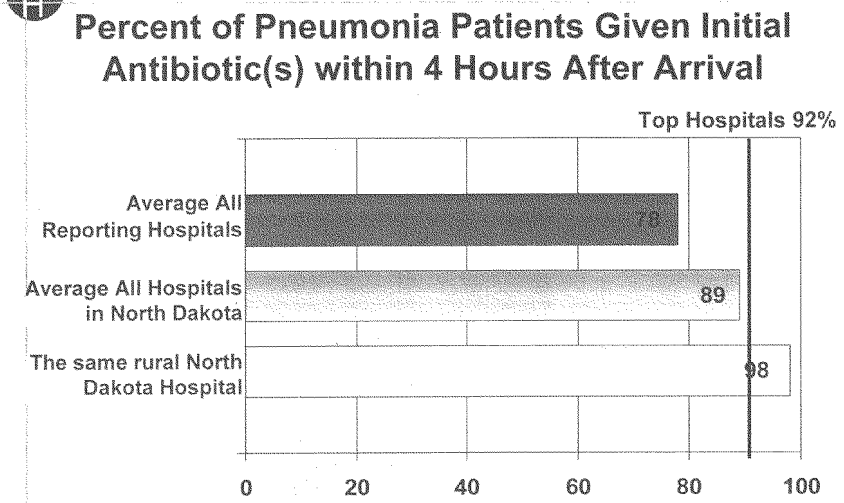
(Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2006)

Percent of Heart Failure Patients Given Discharge Instructions

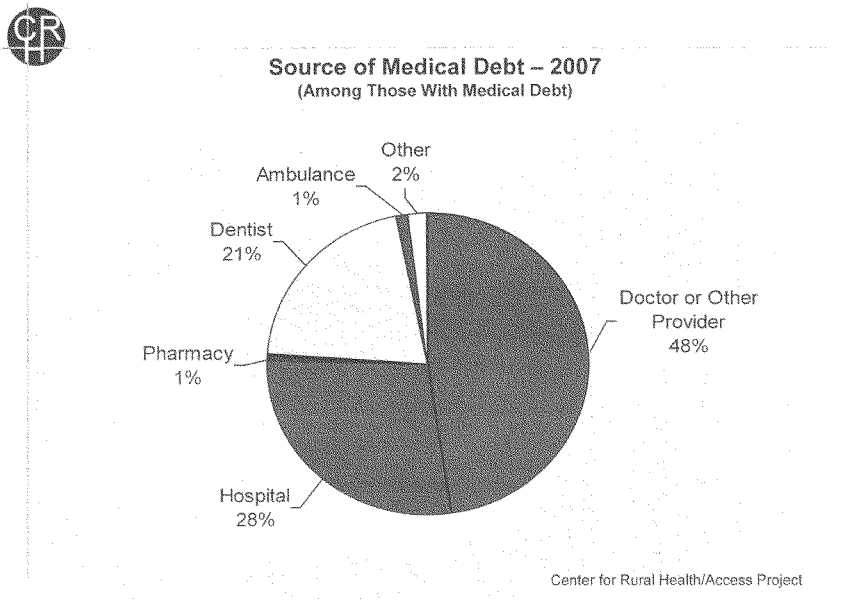


Top Hospitals represents the top 10% of hospitals nationwide.
Top hospitals achieved a 91% rate or better

(http://www.hospitalcompare.hhs.gov)



(http://www.hospitalcompare.hhs.gov)

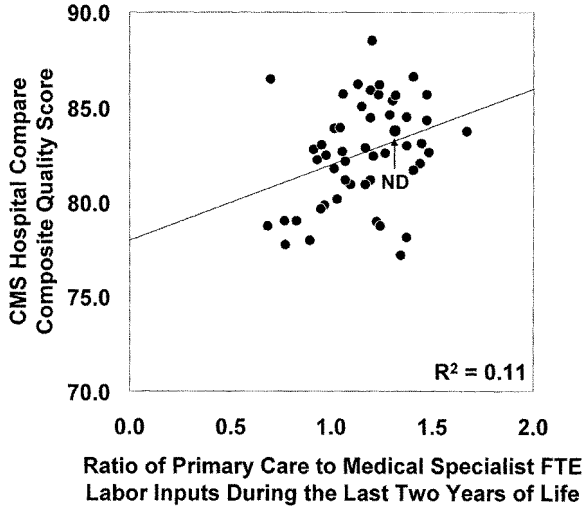


Primary Care

- Health is better in areas where there are more primary care services.
- People who receive primary care are healthier.
- Costs of care are lower in areas where there are more primary care services.

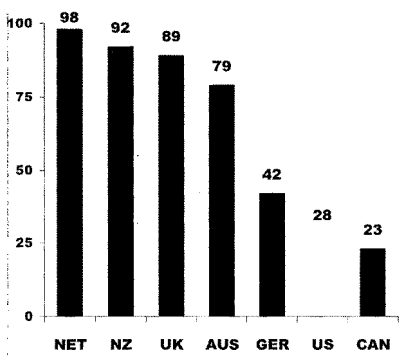
(Starfield, et al. 2005)

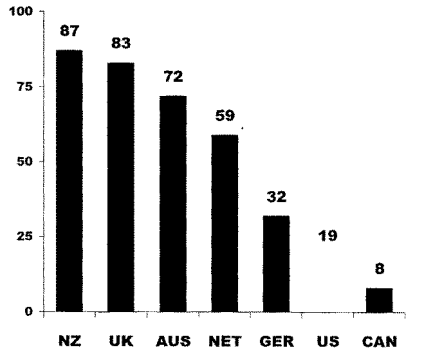
The Relationship Between the Ratio of Primary Care to Medical Specialist Physician Labor Inputs (Deaths Occurring 2000-03) and CMS hospital compare composite quality score



(Dartmouth)

Where are We on IT?
Only 28% of U.S. Primary Care Physicians Have Electronic Medical Records; Only 19% Have Advanced IT Capacity

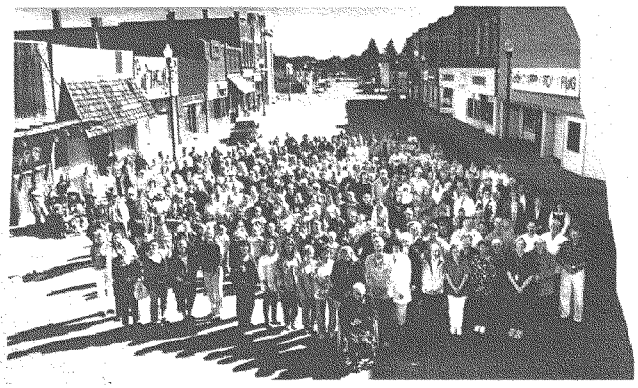


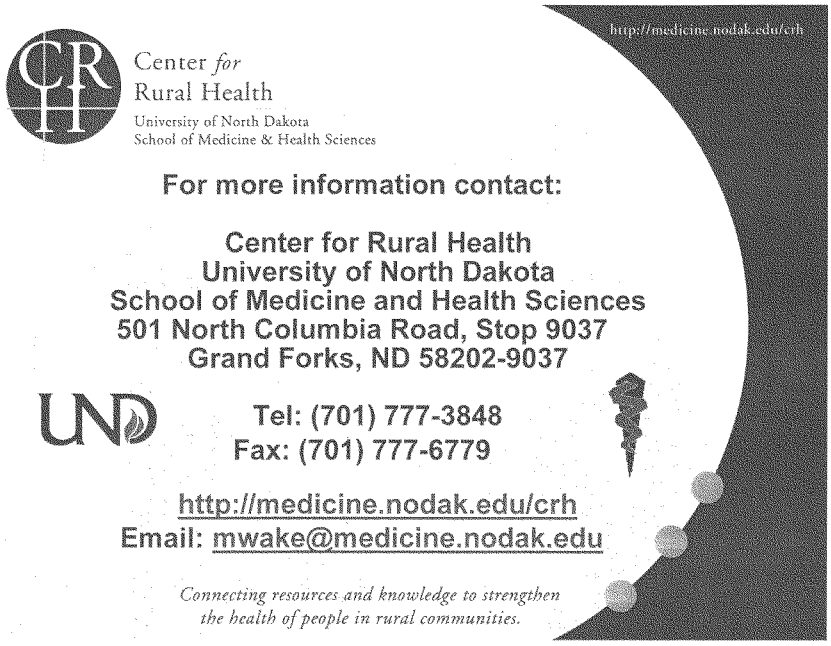


*Count of 14: EMR, EMR access other doctors, outside office, patient; routine use electronic ordering tests, prescriptions, access test results, access hospital records; computer for reminders, Rx alerts, prompt tests results; easy to list diagnosis, medications, patients due for care.

Source: 2006 Commonwealth Fund International Health Policy Survey of Primary Care Physicians

... help everyone, to the extent possible, lead long, healthy, and productive lives.





The CHAIRMAN. Thank you, Mary Wakefield. You know, we're very lucky to have somebody of her quality. I'll tell you, Mary Wakefield is somebody that is respected around the country, has served on MedPAC board nationally, and in these other positions, which tells you something about the respect she's held in nationally, and we're very fortunate to have you from North Dakota. So thank you, Mary Wakefield.

We're joined at the witness table as well by Janis Cheney. She's the state director of AARP. Most recently, AARP has joined forces with the Business Round Table and the Service Employee International Union to push health care reform and economic securities as a national priority. Now, you think about an unusual coalition. The Business Round Table and Service Employee International Union, that's an unusual coalition joined with AARP. Janis Cheney offers the insight of a consumer trying to afford health care as well as an advocate for system change. The Divided We Fail campaign has a number of, I think, intriguing ideas for reform, and I welcome your testimony. Good to have you here.

STATEMENT OF JANIS CHENEY, STATE DIRECTOR, AARP NORTH DAKOTA, BISMARCK, NORTH DAKOTA

Ms. CHENEY. Thank you very much, Senator Conrad. I am delighted to be here and appreciate the opportunity to discuss the challenges of rising health care costs.

Health care costs have risen dramatically in the past few decades. Since 1975, total health care spending as a percentage of gross domestic product in the United States has doubled, and it now comprises one-sixth of the U.S. economy, or about $2.2 trillion. Some of this information echoes what the Senator and Dr. Wake-

field have provided as well. By 2016 some projections show total health spending almost doubling to 4.1 trillion and consuming one-fifth of the nation's GDP. A report published by the McKinsey Global Institute in January found that the United States spends a greater percentage of its national wealth on health care than any other country in the world. According to McKinsey, the overriding cost of high U.S. health care costs is the double failure of the American system to hold down demand-side pressure from patients and supply side pressures from hospitals and clinics, doctors, pharmaceutical companies, and insurers.

Health care costs cannot be measured merely by the impact on the general economy, however. The implications of ever-escalating health care costs are far-reaching. For instance, employees, large and small, are grappling with whether and to what extent they can afford to provide health care insurance to their workers and retirees. Over the past several years, employer-sponsored insurance coverage rates have been falling. In 2000, 66 percent of non-elderly Americans were insured through the workplace, but by 2004, only 61 percent were covered by employer-sponsored insurance. Half of this decline was the result of employers no longer offering health coverage, while a quarter of the decline was due to employees' inability to afford their share of the premium. The decline in employer-sponsored insurance is most severe for small employers who are finding it difficult to even offer health insurance.

Health care costs cause American businesses to be at a competitive disadvantage with their global competitors because providing health insurance adds to the cost of goods and services. For instance, as of 2005, health insurance was calculated to add between 1100 and 1500 dollars to the price of each automobile manufactured by General Motors, a cost not borne by its foreign competitors.

Public programs are also grappling with rising health care costs. Peter——

The CHAIRMAN. Janis, can I just stop you on that last point and just tell you, I have had, as you can imagine, all the auto makers in to see me because of the energy legislation before Congress, and they all tell me their latest calculation is that there is close to $2,000 of health care costs in every automobile. And they told us unless we find a way to take that competitive disadvantage away—because all of their competitors don't have that cost; right? You know, the Japanese, the Germans, the Italians. All the other auto makers have some other health care system and it's not on the employer, it's not on the manufacturer. And they've come and seen me in the last 3 weeks and said if a way is not found to avoid these health care costs, and, of course, the legacy cost of all their retired employees they're responsible for, if there's not a way to fix this, they don't think they can be competitive. Now, that was a stunning admission by a major sector of the American economy.

Ms. CHENEY. Thank you for the updated figures.

Public programs are also grappling with rising health care costs. Peter Orszag, director of the Congressional Budget Office, has stated that if health care costs continue growing at the same rate over the next four decades as they did over the past four decades, Federal spending on Medicare and Medicaid alone would rise to about

20 percent of GDP by 2050, roughly the share of the economy now accounted for by the entire Federal budget. This has led Orszag to comment that this nation does not face an aging problem, but a health care problem.

And individual Americans are some of the hardest hit. One in four Americans have problems paying medical bills. Millions go bankrupt every year because of unaffordable medical bills. Retail prescription prices have increased three times faster than the cost of living in recent years. More than 44 million Americans are uninsured, with middle class families the fastest growing segment. About 8.2 percent of North Dakotans are uninsured, 51,920, nearly the population of Bismarck.

Real people are struggling to make ends meet while still having access to health coverage. AARP has, as part of our Divided We Fail campaign, heard some of these stories from North Dakota and across the nation. We've heard from a 52-year-old divorced single mom raising a son alone. She works in a part-time job that offers no benefits and is unable to find reasonably priced coverage even though she says she maintains a healthy life-style. There is a story from a self-employed couple. The wife's diagnosis of thyroid cancer 9 years ago made her uninsurable until they were able to find a high risk pool. Even with this safety net protection, they are paying upwards of $1,000 a month each, with a $5,000 deductible. Because nothing is covered until they spend $5,000, the couple tends to put off basic preventive and screening services.

There is no single answer to controlling health care costs, and the necessary steps will involve not just government and policymakers, but many players, including patients, providers, pharmaceutical companies, and trade groups. Getting these players together to agree to work on focused strategies for controlling health care costs is one reason why AARP, along with the Business Round Table and the Service Employees International Union formed Divided We Fail. Accomplishing our goal of affordable quality health care and financial security for all Americans will require the efforts of us all. The issue is not whether but how solutions can be found. The growth in health care costs demands that players come together to find the solutions and make the hard decisions.

AARP recognizes that changes cannot be made all at once. They must be phased in over a number of years. We have identified a number of key transitions which must occur in our health care system.

The next steps or building blocks for Divided We Fail is to identify the solutions to the specific policy and behavior changes we believe will be necessary to drive each key transition. For example, health technology and greater use of evidence-based research can help bring down health care costs by making the health care system more efficient. Others will have different solutions, and we are encouraging all those with a stake in the outcome to join the debate and bring their ideas to the table.

Ultimately, the President and Congress must act. First, by reaching agreement on the need to put the critical health care building blocks into place, and then further action to achieve comprehensive health care reform. AARP's attention will be devoted to making

sure that health care is at the top of the agenda of all the candidates in the 2008 election.

Senator Conrad, we commend you for holding this hearing today to draw attention to rising health care costs and the need to transform the entire health care system. Addressing health care costs overall will not only help the citizens of North Dakota, but across the nation.

AARP stands ready to work with you and your colleagues to enact meaningful health care reforms.

The CHAIRMAN. Thank you very much. I appreciate that testimony.

We'll next hear from Candace Abernathey. I want to thank Candace for coming to share her story with us today. She's a consumer who has dealt with the red tape and inefficiencies of our current health care system. In 1990 she had health insurance and was diagnosed with cancer. As the bills were mounting and her health was getting worse, she lost her coverage. Her story, I think, illustrates very well at least some of the problems with the health care system and why we need to fix it. I want to thank you, Candace, and commend you for your courage in coming to testify today. Thank you.

STATEMENT OF CANDACE ABERNATHEY, PATIENT, MINOT, NORTH DAKOTA

Ms. ABERNATHEY. Thank you, Senator Conrad, for the privilege of letting me testify here today.

In June 1990, my world was turned upside down by a simple bruise. Unfortunately, that bruise was a signal of far worse to come and I was soon bleeding profusely from my mouth. I was immediately referred to the Mayo Clinic. Fortunately, my husband was a Boeing employee and we had health insurance. Mayo ran test after test, prescribed medication after medication and still I had no firm diagnosis. I was told to go home, spend quality time with my children and enter hospice care when the time came.

On top of the death sentence, the bills started coming in from Mayo Clinic and in from Trinity. Our co-pay was high, and my husband had no idea how we were going to pay.

My health just kept getting worse, and I was soon back in the hospital receiving blood transfusions, the one thing that was keeping me alive. While I was lying there, my husband marched into my room and informed me that he couldn't afford the medical bills and he wanted out. He also wanted my children, but, fortunately, the Court didn't see it that way and did not agree. I had no choice but to turn to the State of North Dakota for TANF and Food Stamp assistance.

I was so ill, I was so lost, I was upset, and I never even thought about the possibility that my coverage through Boeing would end with the divorce. When my grandmother questioned me about that, I called Boeing and learned that my ex-husband had terminated the coverage not only for me but for my children. I then had the option of their COBRA plan as long as I could pay the premiums of $380 a month. That was like $3 million a month to me. But, fortunately, my grandmother paid 6 months of premiums and that allowed me time to get on state assistance.

By this time, it was obvious that a bone marrow transplant was my only hope. If I only had Medicaid, there would be no facility that would accept me. Thankfully, Social Services chose to continue paying the COBRA premiums as it would be cheaper in the long run.

I was already floundering in medical bills. I was becoming more lost, confused, and scared. My health just continued to deteriorate. I was spot bleeding in my brain, which caused huge headaches and migraines and temporary blindness. I had pleurisy in my lungs and my heart. I was bleeding faster than they could replace the blood.

Finally, a referral was made to the University of Washington hospital, but I could not go without approval for the procedure from my insurance company and they were giving me the runaround. They denied it, saying that it was experimental. I had to involve the family's attorney in order to budge them. And then when the Fred Hutchinson Cancer Center had an opening for me, the insurance company again denied it. I can't tell you how scared I was. Something, I'm still not sure what, changed their decision again.

I was so very sick. I was told I was probably not going to live more than a couple weeks. But they started me on Cytoxan chemotherapy. In this case, the treatment was as sickening as the disease I had, but finally on the 45th day of treatment, my blood counts started returning. As they increased, I lost the fluid around my heart and both my lungs. My bleeding slowly stopped. For the first time in over a year I could lay flat on a bed and sleep.

After the bone marrow transplant on March 31, 1991, I was put on cyclosporine, an anti-rejection medication. The cost of this drug was $800 a day. And that was just one of the 25 medications that I was on.

I finally felt like I had a new lease on life and I returned to Minot with my children. At this point, the State was still covering my insurance premiums. As I grew stronger, I moved back to Washington state and started working as a social worker. I was working. I was making my way. But I still had to file bankruptcy because of the mountain of medical bills I had.

Then in 2004, the chronic grafts versus host disease was affecting my skin, my mouth, my liver, and my memory. Co-workers noticed that I was becoming very forgetful. After 7 years of employment, my supervisor asked me to resign. I went out on long-term disability, which pays me $240 a month.

I returned to Minot to be close to family and because I thought it would be cheaper to live here than there. Because I still had children in the home, I was thankfully able to return to the TANF program, and Medicaid continued paying my medical premiums.

Am I well now? No. The impact of the massive doses of chemotherapy is really showing up. I'm losing the sight in my left eye and will likely be blind in both eyes. My teeth are gradually crumbling and I need to guard against chipping at all times. The grafts versus host disease continues to take its toll. In addition, because none of the over 1,000 blood transfusions I had was filtered, my body is being attacked by the extra iron, causing constant pain in my arms and legs. I will likely need a liver transplant.

And the latest blow is my youngest child left my household. What does that mean for my continued assistance through the

State? It means everything. As of July 31, I lost Medicaid coverage. I lost every kind of assistance.

I'm completely terrified as I cannot qualify for Medicaid help again until I have a disability determination from Social Security. I applied for disability in 2005 and I was denied at the initial application and the reconsideration level. I am now awaiting an administrative law judge hearing, which, thankfully, you, Senator Conrad, were able to expedite for me.

With only $240 a month income, I am struggling to keep a roof over my head, to keep my utilities on, put food on the table. Poor health, high medical bills, and now the uncertainty of whether I will be able to get any medical help for at least a time keeps me up at night.

I don't know what the answer is to making our health care system better for average people with serious illnesses, but I do know that something has got to be done, and soon. Too many people don't have insurance that are forced into bankruptcy, like me, in order to afford the health care they need to live.

Thank you for letting me be here.

[The prepared statement of Ms. Abernathey follows:]

Thank you, Senator Conrad, for the privilege of testifying at this hearing.

In June of 1990, my world was turned upside down by a simple bruise. Unfortunately, that bruise was the signal of far worse to come and I was soon bleeding profusely from my mouth. I was immediately referred to the Mayo Clinic.

Fortunately, my husband was a Boeing employee and we had health insurance. Mayo ran test after test; prescribed medication after medication; and still I had no firm diagnosis. I was told to go home, spend quality time with my children and enter hospice care when the time came.

On top of this death sentence, the bills started coming in from Mayo Clinic and from Trinity. Our co-pay was high and my husband had no idea how we were going to pay.

My health just kept getting worse and I was soon back in the hospital receiving blood transfusions, the one thing that was keeping me alive. While I was lying there, my husband marched into my room and informed me that he couldn't afford the medical bills and he wanted out. He also wanted my children, but fortunately, the court did not agree.

I had no choice but to turn to the state of North Dakota for TANF and Food Stamp assistance. I was so ill, so lost, so upset that I never even thought about the possibility that my coverage through Boeing would end with the divorce.

When my grandmother questioned me about that, I called Boeing and learned that my ex-husband had terminated the coverage not only for me, but for our children. I then had the option of their COBRA plan as long as I could pay the premiums of $380 a month. That was like $3 million to me. Fortunately, my grandmother paid six months of premiums and that allowed me time to get on state assistance.

By this time, it was obvious that a bone marrow transplant was my only hope. If I only had Medicaid, there would be no facility that would accept me. Thankfully, Social Services chose to continue paying the COBRA premiums as it would be cheaper in the long run.

I was already floundering in medical bills. I was becoming more lost, confused, and scared. My health just continued deteriorating. I was spot bleeding in my brain, which caused huge headaches and temporary blindness. I had pleurisy in my lungs and my heart. I was bleeding faster than they could replace the blood.

Finally, a referral was made to the University of Washington hospital but I could not go without approval for the procedure from my insurance company and they were giving me the run-around. They denied it, saying it was experimental. I had to involve the family's attorney in order to budge them.

And, then, when the Fred Hutchinson Cancer Center had an opening for me, the insurance company again denied it. I can't tell you how scared I was. Something, I'm still not sure what, changed their decision again.

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After the bone marrow transplant on March 31, 1991, I was put on cyclosporine, an anti-rejection medication. The cost of this drug was $800 a day. And, that was just one of 25 different medications that I was on.

I finally felt like I had a new lease on life and I returned to Minot and my children. At this point, the state was still covering my insurance premiums. As I grew stronger, I moved back to Washington state and started working as a social worker.

I was working. I was making my way, but I still had to file bankruptcy because of the mountain of medical bills I had.

Then, in 2004, the chronic grafts vs. host disease was affecting my skin, my mouth, my liver, and my memory. Co-workers noticed that I was becoming very forgetful. After 7 years of employment, my supervisor asked me to resign. I went out on long-term disability which pays me $240 a month.

I returned to Minot to be close to family and because I thought it would be cheaper to live here. Because I still had children in the home, I was, thankfully, able to return to the TANF program, and Medicaid continued paying my medical premiums.

Am I well now? No, the impact of the massive doses of chemotherapy is really showing up. I am losing the sight in my left eye and will likely be blind in both eyes. My teeth are gradually crumbling, and I need to guard against chipping at all times. The grafts vs. host disease continues to take its toll. In addition, because none of the over one thousand blood transfusions I had was filtered, my body is being attacked by the extra iron, causing constant pain in my arms and legs. I will likely need a liver transplant.

And, the latest blow? My youngest child just left my household. What does that mean for my continued assistance through the state? It means everything. As of July 31, I lost Medicaid coverage. I lost every kind of assistance.

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I don't know what the answer is to making our health system better for average people with serious illnesses, but I do know that something has got to be done. And soon. Too many people don't have insurance or are forced into bankruptcy, like me, in order to afford the health care they need to live.

The CHAIRMAN. Well, Candace, thank you. That is unbelievably powerful testimony and we salute your courage in going through all this. I don't know how many people could haveten through all that you have been through. That says a lot about your strength of character.

But a person shouldn't have to be swimming against the stream of our health care system when confronted with those life threatening challenges. And that's really what we're here to talk about. Because I think all of us know none of us can predict when we or a family member might face something like this. We just learned of a family member of ours, my wife's brother's wife, sister-in-law, just diagnosed with ovarian cancer. Just had an operation and is in a desperate struggle for her life. And, you know, thank God they have coverage. But you had coverage and lost that coverage and then had all these struggles on top of the struggle to defeat the illness.

So, you know, I very much wanted to have Candace here today because that puts a face on the reality of what this all means, you know. Sometimes we're very removed from the reality of what these issues are about and how they affect real people's real lives. And I think you put a face on what this could mean to any one of us. And there's nobody sitting here that can be certain that we won't have some terrible diagnosis in the near future. We don't know that. So again, Candace, thank you for your courage.

I'd like to also welcome John MacMartin. John's the president of the Minot Area Chamber of Commerce.

Businesses are also struggling. As I have indicated, this friend of mine that stopped me, that friend of mine seen me walking down the street, he had just gotten his health care premium, 18 percent increase, and came down the street. Now, he is somebody that provides insurance, has over a hundred employees, wants to provide

insurance, but, you know, he's caught in a squeeze, too. How does he stay competitive when some of his competitors don't provide health insurance and he does?

John, I know some of your membership faces these struggles as well. So it's an important benefit to potential employees, current employees, but we know that businesses are finding it more and more difficult to afford these benefits. We're delighted to have you here to speak to those issues. John MacMartin.

STATEMENT OF L. JOHN MACMARTIN, PRESIDENT, MINOT AREA CHAMBER OF COMMERCE, MINOT, NORTH DAKOTA

Mr. MACMARTIN. Senator Conrad, members of the Budget Committee. I am pleased to be here today to represent the Chamber and to provide a brief general overview and comments on health care costs and the challenges and options for reform.

The Minot Chamber is a private not-for-profit business organization in which membership is voluntary and is composed of roughly 700 members. I have served as the president for the last 17 years. During that time, the Minot business community has faced a number of critical issues, including reform of workers compensation, the Base Realignment and Closure Commission, and the Northwest Area Water Supply, to name just a few. As we've recruited new members, talked with individual members and surveyed our membership, the issue that is routinely brought up is health care; more importantly, affordable insurance. That is not to say that insurance companies are not offering coverage, but many small businesses are unable to find a group insurance program for which they qualify. As such, those business owners cannot afford the insurance premiums on their own. Not being able to join a large group, individuals that are sole proprietors may have real large deductibles, 2,500 to 5,000 dollars. Some businesses choose simply to go naked.

The CHAIRMAN. What do you mean by that, John?

Mr. MACMARTIN. Not have any insurance at all.

The CHAIRMAN. That's good to explain that.

Mr. MACMARTIN. Yes.

The CHAIRMAN. This is a congressional record.

Mr. MACMARTIN. Somebody might wonder which business that is.

The issues of health care and health insurance bring up a myriad of topics. I believe that the business community wants to see health care reform. I believe that the reform has to remain employer based and it needs to involve the end user, whether that is a sole proprietor of a business or the employees of that business. I believe further that the current situation has the end user removed too far from the choice for health care providers and for the payment of the services received.

In business, usually the more often something is purchased, the price will reflect a downward trend. In health care, I'm not sure that that situation follows, except, perhaps, in areas where insurance does not cover the procedure. I would offer the case of RK surgery and elective cosmetic surgery where prices have fallen in response to patients choosing their own provider and also choosing the prices that they want to pay. In most insurance models, the patient is removed from both the pricing model and the choice of pro-

vider. As such, the market system of supply and demand, as seen in RK surgery and elective cosmetic surgery, is not occurring.

Health care is and will remain a critical issue facing small business. I thank you for the opportunity to appear here today and provide these brief comments to the committee. I would interject, given more time, more specific individual data could be obtained, and perhaps with the chairman's indulgence, we could be allowed to revise and extend our remarks in the record.

The CHAIRMAN. You've been watching the House. Revise and extend, they love that in the House of Representatives. You know, in the Senate, the senators just talk on and on and on and have no time limit, for the most part. But in the House, they're usually strictly limited to 2 minutes, so they always want to revise and extend. And we'll certainly grant you that privilege here today.

Mr. MACMARTIN. Thank you.

[The prepared statement of Mr. MacMartin follows:]

The Honorable Senator Kent Conrad, Chairman
United Sates Senate Budget Committee
August 7, 2007

Mr. Chairman and members of the Senate Budget Committee, I am John MacMartin the President of the Minot Area Chamber of Commerce and I am pleased to be here today to represent the Chamber and provide brief comments on Health Care Costs and the Challenges and Options for Reform.

The Minot Chamber is a private not-for-profit business organization, in which membership is voluntary and is composed of 700 members. I have served as the President of the Minot Chamber for the last 17 years. During that time, the Minot business community has faced a number of critical issues including the reform of workers compensation, the Base Realignment and Closure Commission and the Northwest Area Water Supply to name just a few. As we have recruited new members, talked with individual members and surveyed the membership, the issue that is routinely brought up is health care: more importantly affordable insurance. That is not to say that insurance companies are not offering coverage, but many small businesses are unable to find a group insurance program for which they qualify. As such, those business owners simply cannot afford the insurance premiums on their own.

The issues of health care and health insurance bring a myriad of topics. I believe that the business community wants to see health care reform. I believe that reform has to remain employer based and it needs to involve the end user whether that is a sole proprietor of a business or the employees of small businesses. I further believe that the current situation has the end user

removed too far from the choice for health care and the payment for services received.

In business, usually the more often something is purchased; the price will reflect a downward trend. In health care I am not sure that situation follows except in areas where insurance does not cover the procedure. I would offer the case of RK surgery for eyes and elective cosmetic surgery where prices have fallen in response to patients choosing providers who offered the procedures at lower prices. In most insurance models, the patient is removed from both the pricing model and the choice of the provider. As such the market system of supply and demand, as seen in RK surgery and elective cosmetic surgery is not occurring.

Health care is and will remain a critical issue facing small business. I thank you for the opportunity to appear today and provide these brief comments to the Committee and will continue to provide information to you at your request.

The CHAIRMAN. Our final formal witness is Terry Hoff, the president and CEO of Trinity Hospital, somebody that I have grown to know and respect very much and who has been of great help to me in our struggles to get more fair reimbursement for our hospitals. Not generally well known, but our hospitals typically get one-half as much in reimbursement under Medicare as more urban hospitals for treating the very same illnesses. This puts our hospitals in a very, very tough squeeze.

Terry is in an interesting situation because not only is he the region's largest employer, spending almost $13 million a year on health care for its employees, but is also a business that's feeling the pinch of the health care crisis. I've indicated they're getting squeezed on the reimbursement side. They're not getting reimbursed what other hospitals would get if they were in a more urban setting. They also are getting squeezed by uncompensated care. And so it takes a real management challenge. It is a real management challenge to face all these kind of cost cutting pressures.

Terry, welcome. Good to have you here. Please proceed.

STATEMENT OF TERRY G. HOFF, CHIEF EXECUTIVE OFFICER AND PRESIDENT, TRINITY HEALTH, MINOT, NORTH DAKOTA

Mr. HOFF. Thank you, Mr. Chairman. I appreciate the opportunity to speak to you today.

I would just comment about Trinity Health. Trinity Health actually operates two hospitals, 22 clinics, two nursing homes, and two pharmacies. We have over 140 health care providers providing care to the citizens in our area. We have 2,800 employees, a population service area of 140,000 people, covering 20,000 square miles. We also have referral agreements with ten critical access hospitals in North Central and Northwest North Dakota. We provide 315,000 clinic visits annually, 137,000 outpatient visits, including 25,000 emergency room visits, 10,600 inpatient days, and 98,000 nursing home days.

As you indicated, and other witnesses have indicated, North Dakota is the best in the Nation for quality, and Trinity consistently ranks at or on the top of all of those CMS quality indicators.

I bring two perspectives, one as an employer as providing health care and health care benefits, but also as a provider of health care.

If I could, I'd address the employer portion first. We do have a health insurance plan and it is self-funded. It did not go up 18 percent a year for the last 3 years, but our costs have increased from 9.5 million to 12.8 million from 2004 to 2007.

We have done several multiple things to make changes. We've changed the plan design, we've increased deductibles. A few years ago we even developed an HMO in an attempt to control the cost of our own health insurance premiums. In addition to the health insurance premium, we also participate with Workers Safety Insurance program. We offer employee discounts for using our health care facilities. And we have an employee sick leave. The sum of those totals approximately $1.9 million.

We've focused on trying to keep our work force healthy. One of our better programs is what we call Health in Motion, where employees can participate in a wellness program. They meet individually with our exercise physiologists and they establish goals, up to six goals. And then they target improvement in those goals, and then after a year they're remeasured again. And if they make a sufficient progress toward those individuals goals, then we reimburse them up to 70 percent of their membership in the YMCA for that exercise program. That program cost us approximately $70,000 in the last year.

And one thing that I'm particularly proud of now to improve our own employees' health and others is that we just announced that we will be going to a tobacco-free environment on all our campuses, starting September 15, the day of the Great American Smoke Out.

Speaking as a provider, health care payment has changed a lot over the years. Eight years ago, our board of directors concluded that the community of Minot could not support two full service community hospitals, so they set in motion a plan which resulted in the acquisition of UniMed Medical Center in 2001. And in 2001, the combination of the two facilities resulted in approximately a $2 million loss on operating margin. Since that time, our operating margin has increased every year to the year 2004. And after 2004, which was the peak year, it's been declining once again and our margin has decreased down to a break even for fiscal year 2007.

And the question is why is that happening. There's multiple issues that are playing onto that. First of all is driving costs. Nursing salaries alone increased 41 percent over the last 5 years. Our

total payroll went from $100 million to $140 million over that same timeframe. Our drug costs increased 67 percent since 2003. That's up $4.8 million. You mentioned earlier charity care. Charity care nearly tripled from $560,000 to $1.4 million. And the other part of the problem is the payment system. Medicare, Medicaid, and Blue Cross Blue Shield of North Dakota are not keeping up with the rate of inflation in health care. Our Medicare payments decreased from 52 cents on the dollar to 43 cents on the dollar over the last 4 years. Medicaid decreased from 45 cents to 37 cents. And Blue Cross decreased from 61 cents to 52 cents on the dollar.

We've taken some actions to mitigate some of these things. Relating to charity care, we have a full-time resource coordinator that assists the uninsured and underinsured to find private or public sources of funds to help pay the bills, including drug costs. That person saved those people more than $200,000 last year. We support the free clinic in Minot with supplies, equipment, and ancillary testing services. The clinic is staffed by volunteers.

We have also been working to create a healthier community. We do continuous education about health and chronic disease like diabetes, back pain, and heart. And we do screening events. I am proud to say we did prostate screening at the fair last month, which was co-sponsored by yourself and the Cancer and Research Prevention Foundation. We screened over a thousand men during that 9-day event.

The CHAIRMAN. What were the results; do you know?

Mr. HOFF. I'm not sure I can tell you because it might be a secret. No. Actually, we were surprised. We did find over 70 of the men with elevated PSAs, and that's a pretty high percentage, actually, for a random screening like that. So 70 men will be referred to their physician for further action.

The CHAIRMAN. That's great. You found 70 people that we may have stopped from having something more serious.

Mr. HOFF. And, finally, in our Garrison community clinic, our provider there is sponsoring a Reduce Obesity campaign for the Garrison clinic, which just was started this summer and will conclude by late fall.

We also formed a partnership with the YMCA in Minot. We made a significant investment with the Y in new facilities to create a healthier community. We have our exercise physiologist there. They do prescreening for people who are new members. They help individuals develop their own exercise routines through the Y. And also we use their facilities for our sports acceleration.

One of the things I wanted to mention briefly is we have, in the last 2 years, invested significantly in electronic health care records. We will soon be in the top 15 percent of the hospitals electronically in the health care records.

North Dakota's health care system is in an extremely fragile state. We have declining reimbursement, increasing costs, an aging population, work force shortages, and expensive technologies. We would be in crisis if it was not for the hard work and efforts of yourself. We do appreciate the work you've done for rural health care and critical access payment, Section 508 for urban hospitals, and we know that it was a lot of work and that torch was carried by yourself. Solutions are not easy. And with health care reform

mentioned frequently, we're concerned that the remedy is not simply reducing payments to providers for their same services. Thank you very much.

[The prepared statement of Mr. Hoff follows:]

Statement of Terry G. Hoff, Chief Executive Officer and President

Trinity Health, Minot, ND

An Examination of Health Care Costs:

Challenges and Opportunities for Reform" before the Committee on the Budget, United States Senate

August 7, 2007

During the early 1920s, Lutheran pastors from across the Northwest Territory gathered in Minot, ND, to sketch out plans for a hospital "Consecrated to Christian Service in the Name of The Father, Son and Holy Ghost," hence, the name "Trinity." It quickly grew to become the region's premier healthcare provider. Today, Trinity Health keeps faith with that tradition of caring and compassion. As a nonprofit, fully-integrated healthcare system, our network of doctors, hospitals, nursing homes, clinics and other facilities has been recognized for its dedication to quality care and science-based medicine. Trinity Health is governed by a community-based board of directors who voluntarily donate their time and talents.

A full-service community-based organization, Trinity Health is the region's largest employer with more than 2,800 employees and is the third largest healthcare organization in ND. Responding to decreasing reimbursements and escalating costs, Trinity acquired longtime competitor UniMed Medical Center in 2001 and has since moved to consolidate services to maximize efficiency of community resources. This consolidation was a reflection of industry cost pressures continually forcing the highest levels of efficiency.

Trinity's footprint encompasses most of northwest ND, a service area of about 20,000 square miles where more than 140,000 people call home. Trinity operates facilities in 10 communities (see **Appendix A**) across the region, demonstrating its commitment to rural medicine. For example, Trinity operates a clinic as well as a Critical Access Hospital and nursing home in Kenmare, ND.

Trinity serves as a tertiary care center for hospitals and providers throughout central and western ND, where patients needing advanced or specialty services are referred for care. For example, as a Level II Trauma Center and home to one of only two helicopter ambulances in the state, area patients with severe injuries are typically transferred to Trinity for definitive care. Additionally, a number of hospitals in the region are Critical Access Hospitals and have a relationship with Trinity Hospitals as their designated referral link. For a full list of services, see **Appendix B**.

There are nearly 140 medical providers representing 43 specialties that are employed by Trinity and comprise Trinity Medical Group. Members serve as faculty and preceptors for UND's School of Medicine in Minot. For a list of specialties in the Medical Group, see **Appendix C**.

Trinity partners with other rural medical providers through informal and formal relationships, including joint ventures with hospitals and nursing homes in the region in an effort to recruit physicians and provide medical services in these communities.

Quality of Care

The quality of medical care in ND overall is reputed to be of the very best. In fact, ND was ranked best in the nation in the quality of hospital health care in the sixth annual *HealthGrades Hospital Quality in America Study*. Researchers evaluated each of the country's nearly 5,000 hospitals, measuring them on 26 common procedures and conditions (September 2003). Trinity Hospitals' quality indicators have compared very favorably in national and state comparisons; during the past two years, Trinity has led its peer hospitals nearly every quarter in Appropriate Care Measures, a compendium of indicators used in CMS' Core Measures.

While Trinity Health supports the efforts to improve healthcare quality and promote the widespread use of evidence-based best practices, the resources we allocate to gather and report data in compliance with federal mandates is becoming onerous. More than 10 full-time-equivalents are currently assigned in Trinity Hospitals to manage the quality reporting requirements, and that number is expected to double and even triple under the proposed reporting requirements.

Health Insurance: Benefit vs. Burden

As the region's largest employer, offering employees cost-effective health insurance is certainly a growing challenge. Trinity Health's self-funded health insurance plan contains an employer- and employee-share component (contribution per month):

	2007	
SINGLE		
Employee	76.12	24.8%
Trinity	306.50	75.2%
SINGLE + DEPENDENT		
Employee	150.39	28.9%
Trinity	520.30	71.1%
FAMILY		
Employee	249.82	33.0%
Trinity	756.57	67.0%

As illustrated above, Trinity Health pays about 75% of the employee's premium for the Single contract, while other options vary depending on coverage. With the increasing cost of health insurance Trinity, as every other employer must, balances this financial burden with its effect on our employee recruitment and retention. The only way these increasing costs can be mitigated is through either modifying contract design or increasing premium cost.

Total maximum costs assumed by the organization in fiscal year 2007 were over $12.8 million, whereas total premiums paid by employees were approximately $3,130,000. These costs have increased more than 25% over the past four years. At this rate of increase, it soon may become a benefit which Trinity cannot sustain.

	2004	2005	2006	2007
Avg. # Contracts	1,649	1,664	1,703	1,712
Avg. # Members	3,785	3,806	3,894	3,879
Avg. Pd/Contract/Mo	$337.08	$391.36	$428.75	$460.39
Aggregate Stop-Loss	$8,636,477	$ 9,113,215	$ 9,734,009	$11,594,308
Administrative Ser. Agree	$ 552,735	$ 583,246	$ 622,977	$ 742,036
Stop Loss Premium	$ 323,513	$ 373,981	$ 419,855	$ 473,057
Total	**$9,512,725**	**$10,070,442**	**$10,776,841**	**$12,809,401**

Trinity has tried various contract designs over the past several years, and years ago even participated in the development of an HMO which ultimately failed after just a short time. Currently the Plan's design is that of a self-funded contract with a $300 deductible ($600 per family); co-insurance is $1,000 per member ($2,000 per family) per year. Today, physician office visits are subject to a $20 co-pay. This contract has both in-network and out-of network components. The contract carries an individual stop-loss of $150,000/member/benefit period. With this type of design the vast majority of the stop-loss risk rests with the employer. Trinity strives to capture as much of the service possible, and in doing so provides appropriately designed coverage at the most affordable price.

One example of manipulating plan design to achieve maximum benefit is our recent change to the Pharmacy coverage. Trinity added a network component to that plan, which allow for discounts on in-network purchases.

Another benefit for employees at Trinity Health is paid sick-leave. Trinity's costs for employee sick-leave amounted to $1.3 million in 2007.

Workforce Safety & Insurance (WSI)

WSI is designed to ensure that employees who because of injury or occupational disease on- the- job or disabled on the job are provided with fixed monetary awards, and medical benefits. These laws also provide benefits for dependents of those workers who are killed because of work-related accidents or illnesses. Trinity Health's costs in 2006 exceeded $353,257.

Employee Discounts

In addition to providing healthcare coverage, one strategy aimed at enticing qualified candidates to consider employment with Trinity, and to keep our valued employees during increasing competitive pressure from healthcare and other industries, is to provide certain discounts on hospital services in addition to the health benefits paid for by Trinity Health. All discounts apply to the employee, their spouse and dependents:

1. There is a discount on the difference in charges between a private and a semi-private room after the health benefit payment.
2. There is up to a 50% discount on any hospital balance remaining after the health benefit payment has been made, if applicable, up to a limit of $ 300.00 per occurrence. This discount shall be limited to the hospitals in Minot and Kenmare only. Between 2003 and 2007, employees' discount on fees rose from $149,000 to $264,000, or nearly 44%.
3. There is up to a 20% discount on the purchase of glasses and or frames when purchased through an affiliated optical store; a second pair for the same person discounted 25%.
4. 10 % off prescription price if not covered by insurance plan.

To receive the available discounts, the employee must either pay their account in full or make arrangements for repayment through payroll deductions subject to the terms as established by the business office. Regardless of the service rendered the maximum discount may not exceed 20% of the total charges per occurrence.

Additionally, all employees, medical staff and/or students that are actively enrolled in Trinity Health's educational programs are entitled to a 10% discount at on-site cafeteria prices. Trini-Tots Daycare is operated within one of Trinity's facilities, Trinity Homes, and offers low-cost childcare for employees. The public is invited to use this program, too. Finally, discounted movie tickets and car wash coupons are available to all employees.

Promoting a Healthy Workplace

Trinity Health encourages employees to live healthy lifestyles. Trinity tries to influence healthy behavior through programs and financial incentives. Some examples include:

- Health in Motion is an employee wellness program which provides qualifying participants up to 70% savings in YMCA membership fees (2006 benefit was more than $70,000 in reimbursement). Members keep track of their exercise time/activities under the consultation of exercise physiologists, who help to develop goals to be measured. Participants have averaged meeting 5.32 goals out of a total possible 6, while meeting nearly 80% of the program's exercise requirement. Members have improved in cardiovascular, body fat, strength and flexibility measures.
- Serving as a model for other organizations in our area, Trinity is moving towards a Tobacco-free campus, inside and out, effective 11/15/07. Staff, patients and visitors will be restricted from using tobacco while on the premises.
- Annual influenza vaccines are offered employees at no charge to minimize their risk during its active season, at a cost to the organization of $13,000 last year.

Profitability of Healthcare

Despite consolidating healthcare organizations in Minot six years ago, today's financial picture resembles that of a pre-consolidation environment: the organization's operating margin shows minimal growth. In 2001, more than a $2 million annual loss was recorded between the two organizations. In the first few post-consolidation years, consolidation of services and elimination of duplication achieved economies of scale, resulting in modest to average profits and enabling technology investments that were sorely needed. In the past couple of years, however, the system's ability to maintain an adequate profit margin has diminished.

	2001	2002	2003	2004	2005	2006	2007
Operating Margin	-1.11%	0.12%	1.75%	2.33%	2.17%	0.88%	-0.87%

Some of the factors influencing the net income include escalating drug costs, rising materials and other technology costs, and necessary investments in wages

and benefits to recruit and/or retain quality staff. While these strategies are essential to maintaining strong healthcare services into the future, they are opposed by federal policies which further reduce payments to providers on one front or another.

Drug costs

One of the most volatile expenses we face in our hospital's operation is the cost of pharmaceuticals. Since 2003, our costs for drugs have risen more than 67% - which results in more than $4.8 million increase in expenses over the past few years!

Compensation and Workforce

To remain competitive in an expanding workforce marketplace, Trinity has had to significantly increase wages for employees. For example, Trinity's nursing salaries have increased 41% over the past five years, and that rate of increase shows no sign of slowing down. Total payroll costs have increased from just over $100 million in 2002, to more than $140 million in 2007. As a percentage of total costs, payroll hovers in the 56% range.

While we compete at a national level for physicians and other key healthcare professionals, we get lower reimbursement from Medicare and other payors for the same services. Recruiting physicians and other healthcare professionals to this region of the country requires more than an attractive organization – it takes a significant investment in resources and wages, at rates equal to or even higher than many other markets. In fiscal year 2007, recruitment costs for physicians alone were $2.2 million, compared to 2004's $594,000.

Trinity Health partners with Minot State University to educate nurses, technicians and other candidates for healthcare careers. Last year, Trinity paid $130,000 in nursing scholarships. Unfortunately, the supply of graduates willing to work in this region is not adequate to satisfy openings in the organization.

For an integrated delivery system like Trinity Health, reductions to any component, whether it be physicians, or hospitals, or home health services, or outpatient tests, serve to negatively impact the organization's ability to achieve its mission.

Trinity Health began its conversion to an electronic medical record across the enterprise: clinics, nursing homes, and hospitals. Over the next few years, this

investment in technology to improve the quality of care and access to care will amount to more than $25 million. The amount of change to an organization that must occur during a massive conversion like this, in terms of how care is delivered, is phenomenal.

Health Education

A vital part of Trinity's mission is to help educate the public about living healthier lives. Physicians and other providers regularly offer community presentations on topics like diabetes, arthritis, menopause and other subjects of interest. Another important function of Trinity's community education is providing health screenings to help promote early detection and prevention. Just a few weeks ago, Trinity partnered with Senator Conrad and the Cancer and Research Prevention Foundation to conduct a prostate screening clinic at the North Dakota State Fair. This event resulted in testing more than one thousand men for elevated prostate-specific antigen. This effort netted seventy higher-than-normal blood specimens, and may lead to early detection of prostate cancer for some of these patients. Screenings like this one are typically offered for free or at a reduced charge as part of Trinity's mission.

Other examples of Trinity-sponsored outreach within the region include a Reduce Obesity campaign in Garrison, Heart Health screenings in a number of communities, health fairs and screenings in Cando and many other communities, cholesterol screenings during the regional Ag Expo, and so on.

For about eight years, Trinity operated a Wellness Center to promote healthy lifestyles and the importance of exercise to good health. In 1996, Trinity closed that facility and began an innovative partnership with the Minot Family YMCA. Today, Trinity Health and the YMCA are still partners in health; Trinity occupies space in the YMCA and runs its exercise Physiology program and sports performance out of that facility. Together, Trinity and the YMCA bring other events to the region, including sports tournaments and marathons.

Inadequate Coverage -Assistance

The proportion of senior citizens to the general population in ND is higher than in the rest of the country, which is one reason our residents are struggling with rising healthcare costs while living with fixed incomes. At the same time, providers like Trinity are also struggling with the reimbursement rates offered by our major payors, Medicare and Medicaid, since this population has become a higher

percentage of our total patient base. Overall, payments from these payors have not kept up with inflation.

Trinity Health employs one full-time person to work with the uninsured and underinsured patients applying for public and private insurance programs and helps patients seek assistance paying for their prescription drugs. These efforts helped our patients save more than $200,000 last year alone.

In one recent case, a transient was involved in a serious accident requiring hospitalization and considerable rehabilitation. His income was not low enough to qualify for federal healthcare programs, but he didn't have the means with which to pay for these services out-of-pocket. His care resulted in a write-off amounting to well over $200,000. This is not an isolated case; rather this scenario is repeated often.

People with no means to pay can qualify for Trinity's charity care. Each year, Trinity writes off around $1.4 million for services performed in the hospital and clinics.

For the past few years, a group of volunteers have operated a Free Clinic which serves the uninsured who may not have the ability to pay for care. Trinity helped the clinic to get established through donations of equipment and supplies. Support for the free clinic continues today, with ongoing contributions of equipment, services and personnel. For example, last year Trinity Hospitals' laboratory donated more than $26,000 worth of lab services.

Conclusion

While Trinity Health is a non-profit, community organization, it still must maintain modern facilities, utilize current medical technology, and retain a high quality workforce. So while no person receives any share of its profits, these obligations require a return on investment at a sufficient level to continue to maintain services. We are committed to provide the needed medical services for people living in this region, even though some of them have a negative financial impact to the organization. For example, our Level II Trauma Center, kidney dialysis clinics, and the only helicopter ambulance in western ND are all a financial drain but vital to the quality of life in our region.

Regulatory mandates and the quest for improving quality in healthcare are placing heavy burdens on providers. For example, the billing and coding complexity brought by reclassification of DRGs from today's 538 to an expected 745, will place an enormous challenge on staff training. Additionally, the proposed 1.2% payment decrease, supposedly to reflect a case-mix adjustment, illustrates the difficult and increasingly complex environment we are subjected to.

CMS' quality indicators, expected to balloon from 10 to a projected 1000 in three years, will place a huge financial and staffing burden on healthcare providers. We all support improving quality, but the current approach actually detracts from quality at the bedside due to the additional resources that must be dedicated in that effort rather than directed towards patient care.

ND's healthcare system is in an extremely fragile state, with declining reimbursements, increasing costs and the burdens of complicated regulations, an aging population and a workforce shortage. With "healthcare reform" mentioned frequently, providers are carefully watching to ensure the remedy is not simply to reduce their payments.

Trinity Health: Minot Area Facilities **Appendix A**

Minot:
Trinity Hospital
Trinity Hospital-St. Joseph's
Trinity Homes
Health Center-East
Health Center-West
Health Center-Town & Country
Health Center-3rd Street
Health Center-5th Avenue
Health Center-Centennial
Health Center-Medical Arts
Health Center-Riverside
Regional Eyecare-Williams Center
CancerCare Center, Town & Country Center
B & B Northwest Drug
KeyCare Pharmacy
KeyCare Medical
KeyCare Optical

Outreach
Trinity Community Clinics:
Belcourt (KDU)
Garrison
Kenmare
Mohall
New Town (2)
Parshall
Velva
Westhope
Williston (2)

Formal Affiliations
Cando Hospital
Tioga Hospital
UND Minot Center for Family Medicine

Joint Venture Partners
St. Andrew's Clinic Bottineau
Mountrail County Medical Center – Stanley
Minot YMCA

Trinity Hospitals: Services **Appendix B**

Adult and Adolescent Addiction Services / Mental Health Services
Anesthesia
CancerCare Center
Cardiopulmonary
Dietary/Nutrition Education
Emergency/Trauma (verified Level II)
NorthStar Criticair Helicopter Ambulance
Home Health / Hospice
IV Therapy
Wound Care
Kidney Dialysis (Minot & Belcourt clinics)
Laboratory / EKG Services
    Outreach Laboratory Services
Orthopedics
    Sports Medicine
    Exercise Physiology
Neurodiagnostics
Occupational Therapy
Outpatient Physical Therapy
Pediatrics
Newborn Nursery
Neonatal Intensive Care Unit (NICU)
Physical Therapy-Inpatient
Pharmacy
    Inpatient
    Retail (2)
Radiology Services
    Breast Imaging / Mobile Mammography Unit
    Cardiac Cath
CT-scanner
MRI
Ultrasound

Nuclear Medicine
RehabCare Center-Inpatient Unit
Sleep Center
Social Services
Speech Pathology
Surgery
Ambulatory Surgery
Same Day Surgery
GI Same Day Surgery
Women's Health Center
    Labor & Delivery
    Work Injury Management Program

Additional Community Services
B&B Northwest Pharmacy
Community Resource Coordinator
Convenient Care Clinic
EMS Education & Outreach
Oral Facial Surgery
Pain Management Center
Plastic Surgery
Pacemaker Clinic
Protime Clinic
School of Radiology Technology

Trinity Medical Group: Specialties **Appendix C**

Addiction Services
Allergy/Immunology
Anesthesiology & Critical Care Medicine
Audiology
Cardiology
Cardiovascular & Thoracic Surgery
Convenient Care Clinic
Dermatology
Emergency Medicine / Family Medicine
Family Medicine
Family Practice
Gastroenterology
General Practice
General, Laparoscopic & Vascular Surgery
Hematology/Oncology
Hospitalist
Internal Medicine
Low Vision
Mental Health Therapy
MidWifery
Neonatology
Nephrology
Neurology
Neuropsychology
Neurosurgery
Obstetrics & Gynecology
Occupational Medicine/ Family Medicine
Ophthalmology
Optometry
Oral & Facial Surgery
Orthopedic Surgery
Otolaryngology/ENT
Pathology
Pediatrics
Physical Medicine & Rehabilitation
Plastic & Reconstructive Surgery
Podiatry
Psychiatry/Adult & Child
Psychiatry
Pulmonary Medicine
Radiation Oncology
Radiology
Rheumatology
Sports Medicine
Urology

The CHAIRMAN. Thank you very much. Really five excellent witnesses. I think this lays out very well, in the brief time that we have, the extraordinary challenges that we confront.

I would like to ask each of you to answer this question. In Washington, there is, I think, almost unanimous agreement that we're on a course that is unsustainable. I think that was very clear from the witnesses here. We've got a train wreck going on here. So what do we do about it? I've talked about some ideas in terms of health IT and in terms of better coordination of care, in terms of identifying most effective practices. But there's a fundamental underlying question, and that is how do we structure the basic system. And let me give it to you in this kind of summary profile.

There are really three basic options. One is to have a single care system. That would be like Canada has, like most of the industrialized countries have. A system that is coordinated by the Federal Government with all that implies. That's one possibility. A second possibility is an employer mandate, requiring employers to provide health care for their employees. And where people are not employed or where the businesses cannot afford to provide the insurance, that there is government support to fill in the difference. A third possibility, just embraced by the state of Massachusetts is for an employee mandate. That is that all of us would be required to

carry health insurance. And, you know, you could get it at your employer, you could get it somewhere else. But there would be a requirement that we have it, and there would be assistance for those that can't afford it on their own. Those are the three basic structures of providing health care coverage. And there are arguments pro and con about each one.

I would just be interested to the extent you have an opinion—if you don't have an opinion, that's not a problem—but if you have an opinion on those three basic approaches, I'd be interested in it. I know the committee would. Mary?

Dr. WAKEFIELD. I think without a doubt there is a role for government, State and Federal Government, in terms of assuring coverage for vulnerable populations. Employers and even employees, vehicles for folks who are over age 65 don't work very well. And so there's clearly a role for Medicare, and I think that's almost a given. There's also a role for Medicaid. Maximizing efficiency and ensuring that we're aligning payment with high quality care, so that we're not paying for services that don't buy the consumer anything is really important. And the government, I think, can use its leverage to realign payment policies so that we are paying for high quality care consistently.

I'll just give you a personal example. My mother had gone in to have a carpal tunnel surgery done on one hand. Well, whoops, it was the wrong hand. Medicare paid twice on one hand to have carpal tunnel surgery done and then done on the other. A couple of years later at a different hospital she went in and had an injection under fluoro done in one of her hips. Whoops, Medicare paid again, it was a wrong hip, different provider, different facility.

So the point I'm making is that government has a role for vulnerable populations like folks over age 65, like Medicaid. But we need to be using those Federal dollars and the strength of that program with all the muscle behind it to ensure that the care that people are getting through those programs is efficient care and effective care. So that role doesn't, I don't think, go away.

With regard to the employee mandates, I agree with Mr. MacMartin that employees need to have some skin in the game where they can. There have to be private sector pieces to this and employees ought not be immune from some of the costs of their care. Now, the other piece of that is that a big part of their most expensive care is actually not so negotiable. It's care that they get inside a hospital, which is often not an option. You got to be there, you have to be there. And what we're starting to see is a little bit of trickle down of bad debt with some of our hospitals now incurring bad debt because those bills aren't being paid as consistently as they have been historically for the big ticket items. Depends on the structure of the insurance policy. But we're going to have to watch that very carefully in terms of some of the new planned features.

The employee mandate in Massachusetts, they're really the ones that are leading the charge, but there are about six or seven other states now that are doing some variations on that theme. I think that's absolutely worth experimenting. And it gets it to the point about really experimentation. We need to try different models right now. I don't think we've got a lot of time. I think ultimately we

could well default into what a lot of people are very afraid of, and that might be one big payer system, because that always seems to be kind of the end game in some people's mind. If we don't take care of this problem on the front end, business can't afford it, big business can't afford it, and somebody eventually has to accept the responsibility.

So you often hear that, well, we might default to just an all-government, one single payer program. I don't think we're there yet. I think we absolutely need private sector approaches. Some experimentation at the state level is really important. Massachusetts, I think, is a great idea, because it builds on an orientation we already have. If you're driving a car, you've got to have insurance. You generally have to have insurance on your house if you've got a mortgage on it, on your farm, et cetera, et cetera. So the model, the concept, I think is an important one to look at.

The CHAIRMAN. I want to say this, I've always been intrigued by the German system. Maybe it's because I carry a German name and am part German. But I've always been intrigued by the German system, which is the vast majority of people, like in our country, are insured at their place of employment. And they have large purchasing pools that purchase insurance which gives them leverage in getting a good deal. And as I understand it, where the business can't afford it, or for those people who are not employed and can't afford their own insurance, that's where government steps in. Government provides assistance to very small businesses that can't afford health insurance. They provide assistance to low profit businesses that can't provide it or they're in a competitive position that doesn't allow them to provide it. They help those who are not employed, who are disabled, elderly, et cetera. I've always been intrigued with that approach.

Janis, do you have a——

Ms. CHENEY. I think that I certainly don't have an answer for how to structure the basic system, but I think that you've touched on the point, and as has Dr. Wakefield and others at the table, that there is a role for government, there is a role for the private sector, there is a role for business and the individuals as well. And that is really the genesis of AARP's Divided We Fail movement. AARP representing consumers, nearly 39 million people now nationwide, and their families. I think that is an important consideration. AARP is not in this just to look out for the interests of our members but all of our members' families. And we recognize that this issue is larger than just Medicare and the senior population. It affects every single one of us and we have to find a solution that will work for every single one of us.

So, you know, I mentioned in my comments relative to key transitions that we see as being necessary to finding some of these solutions, the health promotion and healthy behaviors elements that you spoke of are something that AARP has been committed to for a long time. Quality procedures and the health IT is something that the association has worked on. Coordinating care. I guess personally from my experience with cancer and health issues with my children, that kind of coordination has really been missing, and if I weren't a fairly astute recipient of health care with some resources to access, friends and other kind of information, things

might have taken different turns at different places. Absolutely the individual has a role, government, and business.

And the other piece that I think AARP is stressing so strongly is that all of those voices have to be at the table. Everyone has got to realize I'm not going to get the ideal system that's going to just take care of me. We all have to give a little. And that conversation has got to go across party lines and across employer and employee lines and really start building common understanding that we can then use to structure a system that is going to work for everyone.

The CHAIRMAN. Candace, any thoughts on what kind of a system we should have?

Ms. ABERNATHEY. I have some thoughts, but as you know, obesity has a high cost on our health care. And I, for one, used to weigh 350 pounds and I had a gastric bypass surgery. After I had gastric bypass surgery and lost 180 pounds, borderline diabetes was gone, all of my health care problems as far as related to the obesity was gone. But yet insurance companies don't want to get involved with gastric bypass surgeries, and Medicaid doesn't want to get involved with gastric bypass surgeries, which seems to eliminate a lot of the health care problems that go along with the obesity.

As far as the government being involved, you know, they had to remove a lot of my intestines for surgery and I don't absorb the way I used to. My doctors say, OK, they did labs and said Candy doesn't absorb medication the way she used to before this, so now we have to give her two instead of one. Well, the Federal Government says, no, she only gets one, only 30 per month, one per day. But the doctors say, well, she needs two because Candy has got this situation. Doesn't matter, this is what she gets.

As far as when I was an employee for the department of social and health services in Washington, every year my premiums went up, my health care premiums went up, but I only got one cost of living allowance the whole time I worked there. You know, I was there for 7 years, and I thought, wait a minute now, my paycheck is lower. I'm paying more for this but my paycheck is smaller and I even got a cost of living increase on this. So I don't know.

The CHAIRMAN. I have so many people, you know, from elderly people to people who are working, who are seeing more and more of their paycheck go for health care to employers who are saying, you know, they're getting squeezed. If there was ever a circumstance in which I think there's a general recognition we got a big problem, this is it.

John, any thoughts on structuring?

Mr. MACMARTIN. I don't know that I can choose any one of the three today, Senator Conrad. When we say like Canada or some of the European nations, I think we all see many health care professionals that flock to the United States so that they can practice under the freedom of the system we have, and correspondingly we all read horror stories about perhaps foreign health care professionals that we've trained that go back to their home country and set up clinics that lure people there. So I'm not sure that an all-government system is the answer. Mandates always scare employees, and especially employers.

Perhaps it isn't the right analogy, but North Dakota for a time has toyed with requiring ethanol in every gas station, but when you apply that broadly across North Dakota—and I know you drive through a lot of North Dakota—there's lots of places that have only one gas station, and that gas station has only one pump and it's regular. And to put in a second tank with all the EPA would close the station down, you know. So mandates by themselves may not be there. And you know this, and you've expressed this before, what works in urban America doesn't work in rural America. It is going to be some combination. But to say one of those three today would work, I can't do that—

The CHAIRMAN. OK. Terry.

Mr. HOFF. Thank you, Senator. I guess I'd probably look at a combination of employer and employee type situation. I don't know that I can pick one. From the provider perspective, the fear we have is the increased burden of bureaucracy of whatever it is. Just recently, the new notice requirements for discharging Medicare patients, a small thing, but it's like a ten-page document that you're handing out to every patient three times. So that part is a mentionable thing. I think they have issues like Candace where we have a lot of coverage for a lot of people but there are still people who fall through the cracks, and we need to make some solutions for those problems.

And, also, I think that if you're going to talk about insurance, one of the things we need to do is change the payment mechanism, particularly for physicians. Because certain specialists are awarded, rewarded way out of proportion to particularly primary care. And for us in Minot, North Dakota, and the state of North Dakota, it's becoming nearly impossible to recruit primary care physicians because there just aren't any.

The CHAIRMAN. I really see that. I've got a brother-in-law that's a family practice doctor and, you know, he's really seriously contemplating getting out of it. He said just trying to get the money from the insurance companies, trying to get the money from Medicare, trying to get the money, he's got so many people chasing money that he's owed. And, you know, he's in his fifties, very able guy, and lots of patients, very popular guy. And he said, "Kent, I sat down and figured out what I'm actually making at the end of the day. I've got a lot money coming in but I got so much money going out." He said, "I could make a lot more money doing something else." And I'm hearing this with increasing frequency for family practice doctors.

Mr. HOFF. We have right now in the western part of the state two family practice doctors who will be leaving their practice next spring and going to radiology residency. Among other things, they get paid a heck of a lot more.

The CHAIRMAN. Mary's husband's a family practice doc. What's he telling you?

Dr. WAKEFIELD. That he's going to stay in Grand Forks.

Mr. HOFF. He's not available to come out and take over these practices?

Dr. WAKEFIELD. I'm sure he'd be happy to help, Terry.

Mr. HOFF. I think the other thing I could comment to, as John mentioned, is one of the problems we're facing, and as you know

for the record, the fixes for Washington, D.C. or New York or Florida are not the same as the fixes for North Dakota.

The CHAIRMAN. Well, we have seen that repeatedly, this one size does not fit all. That's very, very clear. We live in a totally different culture, a totally different economic reality.

And I tell you, I've just had the director of Health and Human Services come to see me as we were writing this budget, and he showed me results of investigations in Florida of fraud and corruption that is just unbelievable. Shopping center filled with little offices with agencies that were billing Medicare on the average of a million and a half dollars a year. You go up in the middle of the day and knock on the door, nobody is there because nothing is going on there. They're not providing any services, they're not doing anything. But they have a mill where they're producing bills, and it's a giant fraudulent operation. It's not one company like that, it's 80. And they've made kind of a boutique out of a shopping center where they're running these fraudulent operations. I tell you, that's so outrageous. This is the kind of scam——

A number of years ago we held a hearing here, a budget hearing, in North Dakota, and we found out about a wound kit scam that was going on out of Pennsylvania, and they were billing Medicare hundreds of million of dollars a year and it was a phony deal, and they were actually coming to providers and bribing them, offering them bribes to get them to take their wound kits that cost three times as much as what a wound kit should cost. We discovered that in a hearing here in North Dakota and were able to shut down at least part of that operation as a result.

I know that we're actually past our time, which I apologize for, and we'll end on this note. I would just ask each of you, in a sentence or two, if you could send one message that would get heard by the budget committee, by the finance committee, by the Congress, what would it be? In a sentence or two, what would you most want them to know or to act upon?

Dr. WAKEFIELD. There's a lot of efficiency in North Dakota. There's a lot of inefficiency in the health care delivery system. And, frankly, you can find some of it in the state, I'm certain, too. But there is a tremendous amount of inefficiency. I think this is not just about putting more money into health care delivery systems. It's about making sure that the money we're spending right now is spent wisely. You made a couple comments to that very point, part of what I was trying to illustrate, in terms of using the power of the Federal Government to ensure that dollars are spent not just as a payer but as a wise purchaser——

The CHAIRMAN. Let me tell you, some of the Presidential candidates have come to me and asked me on the budgetary front about putting more money into health care, and I say to them, I just don't think that's the answer. I mean, just putting more money in. One in every six dollars in this economy right now is going into health care. I think we've got to find a way to make things run more efficiently and effectively before we pour more money. I mean, I just don't see how that's going to work.

Janis?

Ms. CHENEY. I think the message I might have, and echoing AARP's perspective in the Divided We Fail campaign, would be to

set aside some of the personal and perhaps political interests and to really sit down and listen to each other, listen to constituents and to employers, to providers, to employees, and start hammering out some things that will move us forward. Because certainly we have enough money in this country, and resources to take care of our citizens. And certainly there are things we can learn from our States, other countries. The Medicare system works very efficiently, for example. And so let's take some of those bright people that are there and really start focusing in on this problem. As I indicated, that would be AARP's perspective over the next months, up to and past the 2008 election, would be to really try to make sure that every single candidate accepts some responsibility for addressing health care in a serious way.

The CHAIRMAN. Candace, if you had a message that you wanted people to hear.

Ms. ABERNATHEY. A lot of us aren't able to work anymore due to no fault of our own. And we're on low fixed incomes. Even senior citizens are on low fixed incomes, you know. There should be some kind of coverage that we could rely on. Just because I'm not a mom anymore, my kids are over a certain age now, where it's like I don't matter anymore. Yes, I do matter still. I still am a mom. I just don't have the small children anymore, but I'm still a mother to three children, one who will be serving in Iraq starting next month, you know.

And if I do get approved for social security disability, well, then I find out from social services that my co-pay will be $400 a month. I can't afford $400 a month. So something has to be done for people who are, you know, getting social security disability. That $400 a month, that's just impossible. That's my co-pay before I get any help from Medicaid to help me with my prescriptions that I have to have, and my oncology appointments, my liver doctor appointments. I mean, all those appointments I have to go through. Recognize that I am still important. I may be a single adult now, but I still need medical coverage. And people still need to be able to get it at an affordable rate. It needs to be affordable.

The CHAIRMAN. OK. John.

Mr. MACMARTIN. I would say please make sure that small business is involved. I know, and I appreciate, comments that you made from the auto industry and the problems that they're facing, but please make sure we talk to small business, mom and pop on Main Street, because that's where the bulk of our businesses are. And I think the other issue is we as patients or consumers of health care are being told to become smarter and engage the doctor. I think we have to be involved as that end consumer in all aspects of it, including the pricing, the insurance, and what is done there.

The CHAIRMAN. OK. Terry.

Mr. HOFF. Senator, as a provider, I just can't say that you shouldn't put money into the system.

The CHAIRMAN. I knew that would get your attention.

Mr. HOFF. But, you know, I guess the thing is that when I say that, half in jest, is that health care costs are increasing a lot, but a lot of that is really good stuff. I mean, some of the drugs that are really expensive, they do a lot of good things. I think the mes-

sage is that health care is a huge, huge industry and there's a lot of money in it and there are some bad guys in that system. And my message would be go after the bad guys and leave the guys that are trying to do the job day in and day out honestly and fairly, let us be.

The CHAIRMAN. Yeah. We have a pretty good idea where some of those bad guys are, too. The thing that the secretary has just shown me on Medicare fraud in Florida, it's really just outrageous. I just gave them in the budget another $200 million to go after these guys. And I think that's in all of our interests. When I say don't put more money in the system, I'm talking collectively. To me, it's very clear that those parts of the country that have been unfairly reimbursed, they need an increase. I was just at Dickinson hospital today. They are in very serious financial trouble, and in part because they have been unfairly reimbursed, like most of the hospitals in North Dakota. Unfairly reimbursed. Well, there are other hospitals that have been overreimbursed, you know. And there are other parts of the health care system where we see fraud and abuse and corruption and that's got to be taken on. That's got to be taken on in a very tough way. And we're going to endeavor to do that in this budget that I've helped write for this year.

Let me just conclude by thanking these witnesses, thank each and every one of you. I think you've made a real contribution to the committee. I want to thank all the people that were here in the audience as well. I certainly appreciate your attendance. This is, as I indicated, an official hearing of the Senate Budget Committee, will go as part of the record.

We are focusing now on a series of hearings on health care. We have just held one in Washington that was extremely interesting on a proposal by Senator Wyden and Senator Bennett, a bipartisan proposal. And the next hearing is going to be on this question of what is the basic structure, and we're going to listen to a lot of people who are very knowledgeable about that. Then we're going to be talking about comparative effectiveness and what can be done to seize on the opportunities there. And then we're going to talk about the use of information technology to improve effectiveness and efficiency. So we have an ambitious schedule of hearings in Washington and some of them will be in other parts of the country as well, as we struggle to fashion a policy that makes the most sense for the country.

With that, I declare this hearing to be adjourned.

[Whereupon, at 5:31 p.m., the hearing was adjourned.]

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