PRESIDENT'S 2003 BUDGET PROPOSALS FEATURING HHS SECRETARY THOMPSON

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

SECOND SESSION

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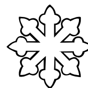

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PRESIDENT'S 2003 BUDGET PROPOSALS FEATURING HHS SECRETARY THOMPSON

WEDNESDAY, FEBRUARY 6, 2002

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS
Washington, DC.

The Committee met, pursuant to notice, at 10:12 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
January 29, 2002
No. FC–11

CONTACT: (202) 225–1721

Thomas Announces a Hearing Featuring HHS Secretary Thompson on the President's 2003 Budget Proposals

Congressman Bill Thomas (R-CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on the President's fiscal year 2003 budget for the U.S. Department of Health and Human Services. **The hearing will take place on Wednesday, February 6, 2002, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the Honorable Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services (HHS). However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On January 29, 2002, President George W. Bush will deliver his State of the Union address, in which he is expected to outline several legislative initiatives. The details of these proposals are expected to be released on February 4, 2002, when the President is scheduled to submit his fiscal year 2003 budget to the Congress. The budget for HHS is expected to include initiatives aimed at: strengthening and improving Medicare; assisting individuals who lack health insurance; reforming managed care; ensuring medical records confidentiality; and reauthorizing and improving Temporary Assistance for Needy Families, and related programs.

In announcing the hearing, Chairman Thomas stated: "The Committee looks forward to Secretary Thompson's appearance. This hearing will help lay the groundwork for the coming year's legislative business. The Committee will examine measures to secure a drug benefit, strengthen Medicare, protect consumers in managed care, reduce the number of uninsured, and guard sensitive personal medical information," Thomas said.

"In addition, we will work to build on the tremendous successes of welfare reform. Earnings for low-income parents have risen, child poverty is down sharply, and welfare caseloads have been cut in half. We need to press on with the work-focused approach taken since 1996 and resist efforts to turn back the clock to pre-reform policies discouraging work and promoting dependence."

FOCUS OF THE HEARING:

The focus of the hearing is to review the President's fiscal year 2003 budget proposals for the U.S. Department of Health and Human Services.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Due to the change in House mail policy, any person or organization wishing to submit a written statement for the printed record of the hearing should send it electronically to "*hearingclerks.waysandmeans@mail.house.gov*", along with a fax copy to 202/225-2610 by the close of business, Wednesday, February 20, 2002. Those filing written statements who wish to have their statements distributed to the press and interested public at the hearing should deliver their 200 copies to the full Committee in room 1102 Longworth House Office Building, in an open and searchable package 48 hours before the hearing. The U.S. Capitol Police will refuse unopened and unsearchable deliveries to all House Office Building.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. Due to the change in House mail policy, all statements and any accompanying exhibits for printing must be submitted electronically to "*hearingclerks.waysandmeans@mail.house.gov*", along with a fax copy to 202/225-2610, in Word Perfect or MS Word format and MUST NOT exceed a total of 10 pages including attachments. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov/*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman THOMAS. Good morning, and welcome to the Committee's second hearing on the President's fiscal year 2003 budget. This morning we will hear from U.S. Department of Health and

Human Services (HHS) Secretary Governor Tommy Thompson. The President's budget, as we said yesterday, lays out three clear and concise priorities: Win the war, protect our homeland, and revive the economy. These, to a very good extent, relate to the tragic events of September 11th. Almost 8 million Americans are now unemployed, many of them without access to affordable health insurance. This House addressed that issue last year. The Senate's failure to act on stimulus means the unemployed are still waiting.

The President's budget includes $90 billion in refundable and advancable health care tax credits for the unemployed and other uninsured.

As the first of the baby boomers approach retirement age, this budget takes steps toward providing retirement security. Medicare clearly forms a part of a secure retirement, but Medicare, in its basic form, is 35 years old. The most obvious wrinkle on the face of Medicare is the lack of a Medicare prescription drug benefit, and that needs to be addressed. In fact, it is overdue in being addressed. No one designing a modern health program for seniors today would exclude prescription drugs. In fact, the House has acted last Congress on a prescription drug program. We plan to act in this Congress. The difficulty has been in getting the Senate to act so we can move together a bill to the President's desk.

Given the realities on terrorism and the recession, I commend the President for not reducing the resources he proposed last year for prescription drugs and Medicare reform. That $190 billion was placed on the table in a period of surplus. The $190 billion in today's budget is placed in a very clouded atmosphere of significant additional resources, demands, and I underscore, I commend the President for that effort.

All of our seniors and disabled citizens deserve a comprehensive prescription drug benefit in a modernized Medicare Program. The President's proposal to provide immediate relief to seniors through a prescription drug card is a good interim step. I underscore "interim." It will lay the groundwork for Medicare and develop an infrastructure for a fully funded prescription drug benefit and for seniors to learn how to use it. It is a bridge to a more comprehensive drug benefit program, and I hope that bridge is of short duration.

Modernization of Medicare must also include a rationalization of how health care provider services are paid for. Our government-run payment systems are fundamentally flawed, whether it is how we pay private health plans in Medicare or physicians serving our beneficiaries.

Mr. Secretary, you have been a strong leader on the issue of health and welfare, both now in your current capacity as Secretary and previously as Governor of Wisconsin. We look forward to working with you. You have already made significant changes in the administrative structure. I know you need additional assistance. We do need to reauthorize the Temporary Assistance to Needy Families, or the TANF program. That law has been a resounding success, and we need to move forward in this area as well.

The President's budget, I think, has started a constructive dialog on many important issues. We look forward to continuing the dialog and hearing your testimony, but more importantly, we need to

figure out how to structurally make the changes and how budgetarily to finance the very real reforms that need to be made. Nothing is more fundamental than providing prescription drugs for our seniors. And so, prior to hearing from you, Mr. Secretary I would ask the gentleman from New York, Ranking Member, if he has any comments.

[The opening statement of Chairman Thomas follows:]

Opening Statement of the Hon. Bill Thomas, a Representative in Congress from the State of California, and Chairman, Committee on Ways and Means

Good morning, and welcome to the Committee's second hearing on the President's fiscal year 2003 budget. This morning we will hear from Health and Human Services Secretary Tommy Thompson.

The President's budget lays out three clear and concise priorities: win the war, protect our homeland, and revive the economy. These, to a great extent, relate to the tragic events of September 11th. Almost eight million Americans are now unemployed, many of them without access to affordable health insurance. This House addressed that issue last year. The Senate's failure to act on stimulus means the unemployed are still waiting.

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In fact, the House acted during the last Congress on a prescription drug program. We plan to act in this Congress. The difficulty has been in getting the Senate to act, so we can together move a bill to the President's desk.

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And now, prior to hearing from you, Mr. Secretary, I would ask the gentleman from New York, the ranking member, if he has any comments.

Mr. RANGEL. Thank you, Mr. Chairman. Let me agree with you that we are pleased to have the Secretary to come before us and to provide the leadership as we try to protect the health care for our aged and those people that, for no reason of their own will, have to be relying on federally supported assistance and welfare. And I agree with the Chairman that all we are doing is having dialog. We realize we are in a war, we are in a recession. The luxury we had in talking about surpluses are no longer before us, and so to a large degree, we have got to determine the priorities of the Congress and the Administration. I do hope that any ideas that the Democrats have in welfare that—led by Mr. Cardin and in health care, led by Mr. Stark, we will have an opportunity perhaps, even outside of the Committee, to at least have a review by the Administration so that when the President talks about bipartisanship, he truly means we work together in trying to reach a conclusion and to further that goal. Then with the permission of the Chair and the Committee at this time, I would like to yield to Mr. Stark.

Mr. STARK. Thank you, and thank you, Chairman Thomas. Thank you, Mr. Secretary for being with us today. The unfortunate thing about the budget that you have got to work with is that there is not much there. As far as domestic spending is concerned, it is long on rhetoric and very short on dollars to get the job done. The Medicare trust fund will disappear in the year ahead, and we will go well into the Social Security trust fund. So much for the Medicare and Social Security lock boxes, which we all voted for time and time again. We are just, I gather, ignoring those.

We hear rhetoric about reforming Medicare, and it is clear that the Republican policy is to privatize Medicare—turn it into a voucher system—as it is a Republican policy to privatize Social Security and instead invest those funds in the private sector as payback, I suppose, to the help they receive from Enron.

So much for doing anything to protect the average senior, either in health care or in Social Security. There is some opportunity to expand the uninsured program. We can probably do it better not using the Tax Code, which often is not the best way. There are a series of items that I think we could work together on, to fine-tune some of the problems that we have with Medicare.

Obviously, the physician payment formula needs some work. It was put together when we were in the majority, and you all were in the White House. We made some mistakes. I think we should fix those. Even though we don't have the money to do what is right, we can change those formulas and improve the status quo.

And there are some other items. Indeed, the Senate has a bill that we sent over on regulatory reform and modernization, things that should help you and help—I still say Health Care Financing Administration (HCFA)—do their jobs better. We have to stay away from the budget discussion, because the drug benefit isn't meaningful, and the seniors understand that. They can count the benefits with their shoes and socks on, and they are not going to be flim-flammed into thinking they are getting a benefit when they are just getting a pat on the head.

So regarding the budget, as we say in Oakland, California, there is no “there” there, but let’s deal with what we can.

I know that your testimony, Mr. Secretary, does deal with TANF and some of the welfare issues which we normally don’t get to put a large audience when we deal with welfare issues in this Committee. I would like to, if I may, yield briefly to Mr. Cardin.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Hon. Fortney Pete Stark, a Representative in Congress from the State of California

First I’d like to thank Secretary Thompson for being with us today to help illuminate the details of President Bush’s health care priorities since one cannot read the budget documents and ascertain much in that regard.

Unfortunately, this budget is like much of what we’ve seen out of the Bush Administration with regard to domestic spending priorities: it is long on rhetoric and short on policy and dollars to get the job done.

So much for a Social Security or Medicare lock-box. This budget spends both of these trust funds for the foreseeable future just to run the government. This is hardly sound budgeting. We know we’ve got an explosion of Social Security and Medicare beneficiaries at the end of the decade—we should be saving for those costs—not blowing the bank now.

We all know that dedicating $190 billion over 10 years for a Medicare prescription drug benefit doesn’t come close to providing the necessary funding. To create a meaningful prescription drug benefit—one that provides each Medicare beneficiary with even a decent prescription drug benefit—would probably cost at least $500 billion over that timeframe.

We also know that the $190 billion allocated in the President’s budget doesn’t all go to prescription drug benefit. $77 billion of these funds are optional money to the states should they choose to expand prescription drug benefits in Medicaid to seniors between 100–150% of poverty. There is no requirement that the states spend any of this money and actually provide drug coverage for anyone. The only two other prescription drug proposals highlighted in the President’s budget are a waiver program, described as a budget neutral way for states to expand drug coverage, and the President’s phony prescription drug discount card. In fact, much of the remaining funds seem to go to Administration efforts to “reform” Medicare by turning it into a voucher system in which government funds are protected and the financial burdens on seniors increase.

The President claims to want to help the uninsured get health insurance. Unfortunately, he has proposed a tax credit which simply won’t accomplish that goal.

These tax credits begin phasing out for individuals at $15,000 income and families with $25,000 in annual income. The subsidy level of $1000/$3000 will not cover half the cost of a standard health insurance plan ($2600 individual/$7000 family). For families with incomes below $25,000, they would have to spend some 10–15% of their gross incomes to be able to afford a policy under this proposal—and that is only if they are healthy enough to qualify for coverage. Those costs are too high for a family making decisions about paying the mortgage, or putting dinner on the table, not to mention buying a health insurance policy.

Expanding health insurance for the uninsured is a goal I hope all of us share. I would advocate building on existing government programs as a much more effective method of expanding coverage and urge you to remain open to such alternatives this year.

There are many other components of the President’s health care budget which I haven’t touched on. But, I think I will close with my belief that the presentation of a budget is really a list of priorities. It is clear from the President’s 2003 Budget that providing a prescription drug benefit to seniors ranks far below providing tax breaks to the wealthy. It is obvious that steps for expanding access to health insurance will be small. Clearly, it will be up to Congress to come up with policies in both of these arenas if we are to see real advancements in the near future.

I look forward to hearing from the Secretary with his thoughts on these matters.

Chairman THOMAS. The gentleman’s time has expired.

The Chair would indicate that the Chair was extremely generous in the first hearing. Many Members on both sides, going 8, 10 and 12 minutes. To the degree that we can discipline ourselves to the rules in terms of 5 minutes, which includes questioning, and to the extent possible, the response of the witness, I believe we can move along. And with that, I would indicate——

Mr. RANGEL. Mr. Chairman——

Chairman THOMAS. The gentleman from Maryland is recognized.

Mr. RANGEL. Mr. Chairman, just a courtesy to have an exchange, so I can—what you are saying, and just inquire as to whether or not this strict support of the rules would include the Chair, because in honesty, you do have a tendency to comment on everything that the Members have to say, which I do, too, if I had the chance, and it would help us to discipline ourselves if there—if we can see you set an example.

Mr. MCCRERY. Mr. Chairman, if I might be recognized.

Chairman THOMAS. The gentleman from Louisiana.

Mr. MCCRERY. I was a Member of this Committee when we were in the minority, and it has always been a rule on this Committee that the Chair has wide latitude on his comments; he, the Chair of the Committee. And I would hope that would be maintained regardless of which party is in control of the Committee.

Mr. RANGEL. And I respect that.

Mr. MCCRERY. And I respect the Chairman's ability to run this Committee, and I think he has the right as Chairman to comment as he pleases.

Mr. RANGEL. I respect that. I support that. I respect majority rule. I was only trying to set a tone of fairness and equity, but you certainly can do what you think you can get away with.

Chairman THOMAS. And what the Chair indicated was that normally when the Ranking Member makes a statement out of courtesy, he is not clocked either, if the gentleman will notice the apparatus that determines the time available.

Mr. RANGEL. You have been very kind, Mr. Chairman.

Chairman THOMAS. The gentleman from New York handed off to the gentleman from California. The Chair continued to allow it to go forward. The gentleman from California handed off to the gentleman from Maryland. Now, at some point, the relay is going to end, and I made that point, and then to recognize you for your generous intervention, the Chair said he would recognize the gentleman from Maryland for a brief statement. The point is, when you are given a privilege, you don't abuse it, and frankly, the Chair believes that what was occurring was an attempt to abuse the privilege, and the Chair will exercise every power and prerogative to the Chair when privileges are abused. The gentleman from Maryland wish to make a comment?

Mr. CARDIN. Thank you, Mr. Chairman, and Secretary Thompson, I want to welcome you here, and thank you for your leadership on TANF. I am the Ranking Member, as you know, on the Human Resources Subcommittee. I look forward to working with you on TANF reauthorization. I am an optimist, and I think that the structure that you have brought forward gives us latitude to reach a bipartisan agreement on TANF, and I thank you for the leadership within the Bush Administration on this area.

I particularly want to compliment you on trying to update the illegitimacy fund to make it a constructive fund to help American families with technical assistance and eliminating the discrimination on two-parent families today. I think they are both improvements. But as you said in your statement, but even with those notable programs, much more needs to be done, and I agree with you.

So it is time to take it to the next level. You suggest that we add to the TANF legislation child's well-being. I would suggest that you broaden that to poverty reduction, and the reason I say that is that we have been reducing the number of people on welfare much faster than American families have got now poverty.

Still, now one in six children live in poverty, and you and I know we need to do a lot better than that. So I would suggest that as we work toward reauthorization, look at ways that can help people get out of poverty, like the current restrictions on vocational training need to be eased up, and the work support programs, such as child care and wage supplements for low-income families also need to be reviewed. So we need to do more in resources. If we don't adjust the basic—there is a 22-percent reduction, and I look forward to working with you. I think with your leadership, we can work out a bipartisan agreement, but it is going to take some more money. Thank you, Mr. Chairman.

Chairman THOMAS. You are welcome. The Committee rules have been that the Chair and the Ranking Member make opening statements. All other Members can submit written statements, and the Chair will apologize to the Chair of the Health Subcommittee and to the Chair of the Welfare Committee who chose not to abuse the privilege, and the Chair appreciates that.

And now, Mr. Secretary, once again it is a privilege to have you before us. Your job is indeed a daunting one. There are never enough resources, and unfortunately we haven't been so creative as perhaps all of us would like in addressing a very serious concern. But utilizing the resources you have with the staff, very capable staff that you have surrounded yourself with, we look forward to hearing your plans for the upcoming budget year.

You have a written statement, I assume. It will be made a part of the record, and with that you may address us in any way you see fit. And I believe you need to turn that mirophone on.

STATEMENT OF THE HON. TOMMY G. THOMPSON, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. THOMPSON. Thank you, Mr. Chairman, and good morning. Good morning, Mr. Chairman, Congressman Rangel, Members of the Committee. Mr. Chairman, thank you for your friendship and support in my first year as HHS Secretary. Your counsel and consideration have been both helpful and generous, and I appreciate them very much.

Mr. Rangel, we may be an opposite sides of the aisle, but we are on the same side when it comes to caring about the health and well-being of every American. Thank you for your leadership, and good work.

It is good to be with all the Members of this Committee again. They had the opportunity to discuss the President's Fiscal Year 2003 Budget for the Department of Health and Human Services.

Mr. Chairman, when I first appeared before you a year ago to describe President Bush's ambitious agenda, I told you that I accepted this job, because I wanted to help secure the safety and welfare of the American people. Health security is the ultimate goal of our efforts, and I believe that we are reaching that goal to a degree never before in our history.

First, Mr. Chairman, let me review a few of our most notable accomplishments. We responded quickly and effectively to the terrorist attacks of 9–11 and the anthrax attacks that followed. We made tremendous progress in providing health care to lower income Americans. We provided 1400 waivers and State plan amendments, expanding eligibility to about 1.8 million people, over 300,000 in the State of California and over 600,000 in the State of New York, and we enhanced benefits to 4½ million individuals in America.

We have also committed substantial resources to community health centers. Last year, I also committed to you to change the way the Centers for Medicare and Medicaid Services (CMS) work, and we are working every day to ensure you and this Committee that the agency is run in the most efficient way possible, in the most responsible way possible to this Committee and other Members of Congress.

I applaud your work, Mr. Chairman and the Committees in the areas of regulatory relief and contractor reform issues. The President and I would urge your colleagues in the Senate to move those important issues forward as well.

In addition, we launched a prevention initiative. We got a new emphasis on organ donation and dramatically increased, with your help and on a bipartisan basis, I might add, funding for the National Institutes of Health. We strengthened the health and well-being of American families, seniors and the traditionally underserved populations. Our progress was substantial, but of course it was not complete.

So this year the work goes on as we propose a balanced and responsible approach to ensuring a safe and healthy Nation. At the same time, this is a budget about priorities. As the President said in his State of the Union message, our Nation has no higher immediate priorities than defeating international terrorism, defending our homeland and restoring economic growth. So we must choose our priorities carefully, and I believe the President is doing just that.

The President is providing unprecedented resources to prepare for bioterrorist attacks against us, and he recognizes that securing the safety and welfare of our country goes beyond preparing for bioterrorism and protecting our borders. It goes to the heart and the health of every American.

Mr. Chairman, the total HHS request for fiscal year 2003 is $488 billion, almost a quarter of all Federal spending. This is an increase of $29 billion, or 6½ percent over the comparable fiscal year 2002 budget. The discretionary component of the HHS budget totals $64 billion in budget authority. An increase of $2.4 billion, or 3.9 percent.

Today, Mr. Chairman, I would like to focus on two groups of Americans whose well being is of particular concern to all of us as

public servants, those who are struggling with continued dependence on welfare, including the children and the young people, as well as those older Americans who deserve a strong improved Medicare system.

First, I will discuss the President's bold proposals for the continued reform of the welfare system. As you know, welfare reform has always been one of my greatest concerns. In Wisconsin, we devoted substantial resources to helping individuals get the training, health insurance, child care and other services they needed to go from welfare to work. Welfare reform has worked beyond expectations, resulting in millions moving from the shackles of Aid to Families with Dependent Children (AFDC) to the independence of work. Nearly 7 million fewer individuals now are on welfare today than in 1996, and 2.8 million fewer children are in poverty because of welfare reform.

In New York City, where employment loss is perhaps one of the greatest concerns, there still were more than 53,000 job placements for welfare recipients, from September through December of last year. While the number of TANF recipients increased briefly due to the terrorist attacks of September 11th, by December there were about 15,000 fewer individuals on the TANF roles than in August. In fact, in December, there were fewer individuals in New York City on welfare than at any time since 1965, but we are not done. There is a clear and important next step to welfare reform. The budget boldly takes that next step, and I applaud the President for keeping us moving forward in this historic endeavor.

The next step requires to work with States to help those families that have left welfare, to climb the economic ladder and become more secure in the workforce, as Mr. Cardin has just indicated. And while doing so, we must not leave behind those that are still in our caseloads. Our budget also provides $16½ billion for block grant funding. It provides supplement grants to address historical disparities in welfare spending among States and strengthens work participation requirements.

It also provides $100 million in broad demonstration authority, focused primarily on encouraging stronger and healthier families. Next, we will be submitting a proposal to create a matching State grant program to strengthen families and reduce out-of-wedlock births.

While this represents level funding for the TANF grant, in reality, it provides money that States can spend on helping workers remain in the work force. States will be able to apply the savings gained from caseload reduction to new programs that help workers thrive in the work force. We are giving States the flexibility they need to creatively mix effective education and job training programs with work, as well as money to strengthen families and reduce illegitimacy. We hope to work closely with all of you in Congress to more closely shape the next step in welfare reform. In doing so, however, we cannot get away from the foundation of welfare reform success, and that foundation is work.

Work must remain at the core of TANF, for work is the only way to climb out of poverty and become self sufficient, and we must continue to make sure that work pays for families, providing the proper child care and the proper health care programs.

President Bush's budget helps in this regard by providing another $350 million in Medicaid benefits for those in the transition from welfare to work. I appreciate this Committee's tremendous effort and want to recognize Mr. Herger's as well as Mr. Cardin's bipartisan leadership, in particular, in support of all of our initiatives to help America's families. Your support was very evident recently as you advanced the President's safe and stable families program, Mr. Herger, through the legislative process.

The President's 2003 budget would increase funding for the safe and stable families for this program to $505 million, fully supporting the increased authorization included in this new law which was supported on a bipartisan basis in this Committee. These additional funds will be used to help move children to adoption more quickly so that they become part of a safe and stable family, as well as enhanced preventive efforts to help families in crisis.

Our budget framework includes resources for a number of additional programs targeted at protecting our most vulnerable and at-risk children. The budget provides nearly $5 billion for foster care, nearly $2 billion for adoption assistance, and $43 million in adoption incentive funds.

As we provide funding for programs and policies that will enable adults to transition from welfare to work and to be able to help ensure them a healthy start in life for disadvantaged young people, we must not neglect our obligations to those on the other end of life's horizon, our Nation's seniors. The President's budget lays a firm foundation for meeting those obligations, now and in the future, through a stronger Medicare Program.

Right now, Medicare covers only 53 percent of the average senior's annual Medicare expenses, and the program's benefit package has not kept pace with advances in medication and treatment. So the budget dedicates $190 billion over 10 years for immediate improvements in comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection and better private options for all beneficiaries.

I know that some Members of Congress are concerned that the $190 billion over 10 years is not enough, but we believe this, amount is sufficient. The President and I will work with this Committee and Congress to achieve that goal this year.

Last year President Bush proposed a framework for modernizing and improving the Medicare Program that built on many of the ideas that had been developed in this Committee and by other Members of Congress. Let me assure you the President remains committed to that framework and to bring the Medicare Program up to date by providing prescription drug coverage and other improvements.

The President and I are absolutely committed to providing immediate assistance to seniors who currently have to pay the highest prices for prescription drugs, and the policies we have announced in the budget establish a framework necessary for a Medicare prescription drug benefit. This budget proposes transitional drug coverage for low-income seniors to help them with high drug costs. The Federal Government will help States provide comprehensive drug coverage up to 150 percent of poverty, about $17,000 for a family of two.

This policy would eventually expand drug coverage for up to 3 million beneficiaries who do not now have prescription drug assistance. It would be a mistake to address this issue in a vacuum, however, which is why we propose that this program should be integrated into the full benefit as quickly as possible. But we don't need to wait to help now the most needy seniors.

As you know, last year the President proposed the creation of a new prescription drug card to reduce the costs of prescription drugs for seniors. This year HHS will continue working to implement a Medicare endorsed prescription drug card, which will give beneficiaries immediate access to drug discounts, hopefully up to 25 percent and other valuable pharmacy services.

In addition, I announced several weeks ago a model drug waiver program called Pharmacy Plus, to allow States to reduce drug expenditures for Medicare beneficiaries and disabled individuals with family income up to 200 percent of the Federal poverty level, making it easier for States to take similar steps to help their senior citizens who need help the most is a goal we all must make.

The bottom line is that we need to enact a prescription drug benefit this year, but it would be a mistake to address prescription drugs in a vacuum. We must also make it part of a comprehensive strengthening of Medicare, and I know you are for that, Mr. Chairman, and I applaud you, securing the viability of this popular program for our baby boomers and future generations. We simply can't put the problems facing Medicare off any longer. As I said a few moments ago, now is the time to act.

The budget also includes an increase in funding to stabilize the Medicare+Choice program by realigning payment rates more closely with overall spending. Over 500,000 seniors lost coverage last year, because Medicare+Choice plans left the program. Today, about 5 million seniors choose to receive quality health care through Medicare+Choice. Many seniors like this option, and we must preserve it. And some of these initiatives are immediate and tangible help to seniors, but let me make it clear. These are not substitutes for a comprehensive reform and a prescription drug benefit. Ultimately we must work together on these broader issues, and I look forward to you, Mr. Chairman, and other Members, to join you in this important task.

Mr. Chairman, I know many Members of this Committee have expressed concerns about Medicare payment systems, including hospitals and physician payments. The President's budget demonstrates that the Administration is willing to work with you and Congress to address this issue. We agree that changes should be made and believe that we must approach significant changes carefully and consider all the provider payments, but let me be clear: If increasing physician payments is on the table, then we think adjusting other provider payments should be as well.

I look forward to working with you, Mr. Chairman, and you, Mr. Stark and your colleagues on this issue.

Finally, Mr. Chairman, the President's budget includes $89 billion in new health credits to help American families buy health insurance. The program will support purchase of health insurance, as well as affordable expansions in State and Federal programs and will provide the States the kind of flexibility they need to set up

State-sponsored purchasing pools to harness the economics of group purchasing.

The budget I bring before you today contains many different elements of a single proposal, but binds them together as the desire to ensure a safe and healthy America and to improve the lives of the American citizens, while fostering the discipline the state of our economy demands. All of our proposals, from increasing access to health care for seniors and all Americans, to protecting the Nation against bioterrorism, to investing in biomedical research to supporting healthier communities, are put forward with the single goal of building a safe and healthy country.

I know this is a goal that we all share, and with your support, we are committed to achieving it more fully in the year 2003. Thank you again, Mr. Chairman, for letting me come before you today. I look forward to answering your questions.

Chairman THOMAS. Thank you very much, Mr. Secretary. And I appreciate the comments and your remarks about being willing to work with us, because frankly we have some difficulty with the math, as it has been presented to us.

[The prepared statement of Secretary Thompson follows:]

Statement of the Hon. Tommy G. Thompson, Secretary, U.S. Department of Health and Human Services

Good morning, Mr. Chairman and members of the Committee. I am honored to appear before you today to discuss the President's FY 2003 budget for the Department of Health and Human Services (HHS). I am confident that a review of the full details of our budget will demonstrate that we are proposing a balanced and responsible approach to ensuring a safe and healthy America.

The budget I present to you today fulfills the promises the President has made and proposes creative and innovative solutions for meeting the challenges that now face our nation. Our budget supports the development and well-being of America's families; increases access to health care; strengthens Medicare with a prescription drug benefit and other improvements; and increases support for bioterrorism research and preparedness, and supports the President's Management Agenda through a number of management reform initiatives within the Department. The President's budget also includes a $4 billion increase for biomedical research at the National Institutes of Health (NIH). This final installment of the President's five-year doubling is largest year-to-year dollar increase that NIH has ever received.

Mr. Chairman, the total HHS request for FY 2003 is $488.8 billion in outlays. This is an increase of $29.2 billion, or 6.3 percent over the comparable FY 2002 budget. The discretionary component of the HHS budget totals $64.0 billion in budget authority, an increase of $2.4 billion, or 3.9 percent. This committee has jurisdiction over much of this budget. Allow me to highlight several important aspects of the HHS budget.

STRENGTHENING AMERICA'S FAMILIES

President Bush has said that American families are the bedrock of American society and the primary source of strength and health for both individuals and communities. Our budget includes a number of new initiatives that support this principle by targeting resources to strengthen our nation's families. We look forward to working with the Committee in considering the next phase of welfare reform and other elements of the President's proposals to help America's low-income families succeed.

Temporary Assistance for Needy Families

As a former governor, I can tell you that the Temporary Assistance for Needy Families program—or TANF—has been a truly remarkable example of a successful Federal-State partnership. States were given tremendous flexibility to reform their welfare programs and as a result, millions of families have been able to end their dependency on welfare and achieve self-sufficiency.

Since 1996, welfare dependency has plummeted. As of September of 2001, the number of families receiving assistance, which represents the welfare caseload, was 2,103,000 and the number of individuals receiving assistance was 5,343,000. This means the welfare caseload and the number of individuals receiving cash assistance

declined 52 percent and 56 percent, respectively, since the enactment of TANF. Between January and September of last year national caseloads actually declined about 2 percent, and while the July to September statistics indicate a slight increase, the figures are still well below the previous year's caseload levels. The general trend suggests the national caseloads are not rising but, instead, have stabilized.

In New York City, where we are understandably most concerned about job opportunities, they have achieved more than 53,000 job placements for welfare recipients from September through December 2001. While the number of TANF recipients increased briefly directly because of the tragedy on September 11, by December there were about 15,000 fewer TANF recipients on the rolls than there were in August. Indeed, in December the City had its lowest number of persons on welfare since 1965.

- Some other positive outcomes we have seen since the law's passage include:
- Employment among single mothers has grown to unprecedented levels.
- Child poverty rates are at their lowest level since 1978. Overall child poverty rates declined from 20.5 percent in 1996 to 16.2 percent in 2000. The poverty rate among African American children declined from 39.9 percent to 30.9 percent—the lowest level on record. The poverty rate among Hispanic children declined from 40.3 percent to 28.0 percent—the largest four-year drop on record.
- The rate of births to unwed mothers has not increased.

But even with this notable progress, much remains to be done, and States still face many challenges. Last year, I held eight listening sessions throughout the country to discuss the state of their TANF systems and understand the new challenges they are facing. The states overwhelmingly support this program. While keeping the basic structure and purpose of the program, States, administrators, recipients, employers, and advocates have provided valuable insight into where we could make the program even more responsive to the needs of families.

In the near future, we plan to unveil our reauthorization proposal to build on current successes of the program. Our reauthorization proposal embraces the needs of families by maintaining the program's overall funding and basic structure, while focusing increased efforts on building stronger families through work and job advancement and adding child well-being as an overarching goal of TANF.

Our budget proposes $16.5 billion each year for block grants to States and Tribes; $319 million a year to restore supplemental grants; $2 billion over five years for a more accessible Contingency Fund; and a $100 million a year initiative for research, demonstration and technical assistance primarily to promote child well-being through strengthening family formation and healthy marriages. In addition, our proposal will call for modification of the bonus for high performance to reward significant achievement in promoting employment of program participants.

We maintain State flexibility, but include important changes to improve the effectiveness of the program. We will also expect States to engage all families they serve and help them make progress toward their highest degree of self-sufficiency—even those cases that may appear hard to employ. We will eliminate the separate two-parent work participation rates and give States more flexibility in designing productive self-sufficiency activities while ensuring that the participation rate requirements are meaningful. We will also ask States to set performance goals for their TANF programs and report on their progress toward meeting these goals.

I look forward to working with the Committee on reauthorization of this hallmark program. I am confident that together we will witness even greater achievements under the TANF program.

<u>Other Programs Supporting TANF Goals</u>

The President's budget also includes funding for several other programs at the State and community level that work to support the goals of TANF. The Job Opportunities for Low-Income Individuals program (JOLI), provides grants to non-profit organizations to create new employment and business opportunities for TANF recipients and other low-income individuals. Our budget provides $5.5 million to continue this valuable program. The Individual Development Account (IDA) demonstration program similarly seeks to increase the economic self-sufficiency of low-income families by testing policies that promote savings for post-secondary education, home ownership, and micro-enterprise development. The President's budget calls for almost $25 million to support IDAs. More broadly, the Social Services Block Grant (SSBG) provides a flexible source of funding for States to help families achieve or maintain self-sufficiency and provide an array of social services to vulnerable families. The President's budget request for SSBG is $1.7 billion.

Child Care

Child Care has played an important role in the success of welfare reform by providing parents the support they need to work. The President's budget recognizes this critical link and maintains a high level of commitment to childcare. Continuing the substantial increase in funding the Congress has provided over the last several years, the President's budget includes a total of $4.8 billion in childcare funding in conjunction with our request to reauthorize the mandatory and discretionary funding provided under the Child Care Development Block Grant and the Child Care Entitlement. States will also continue to have significant flexibility under the TANF program and under the Social Services Block Grant program to address the needs of their low-income working families. These additional funding opportunities have substantially increased the amount of resources dedicated to child care needs. For example, in FY 2000 States transferred $2 billion in TANF funds to the Child Care and Development Block Grant.

Child Support Enforcement

The Child Support Enforcement program offers another vital connection to families' ability to achieve self-sufficiency and financial stability. The President's budget proposes to increase child support collections and direct more of the support collected to families transitioning from welfare—goals this Committee has supported vigorously. Under our proposal, the Federal government would share in the cost of expanded State efforts to pass through child support collections to families receiving TANF. Pass through payments enhance a family's potential for achieving self-sufficiency while also creating incentives for non-custodial parents to pay support and custodial parents to cooperate in securing support. Similarly, States would be given the option to adopt simplified distribution rules that ease State administration but, more importantly, benefit families that have transitioned from welfare by directing support otherwise retained by the State and Federal governments to these families.

Overall collections would be increased by expanding our successful program for denying passports to parents owing $2,500 in past-due support, requiring States to update support awards in TANF cases every three years, and authorizing States to offset certain Social Security Administration payments when they determine such action would be appropriate to collect unpaid support. Our child support legislative package would also impose a minimal annual processing fee in any case where the State has been successful in collecting support on behalf of a family that has never received assistance.

Promoting Responsible Fatherhood

Helping custodial parents, generally mothers, collect support is an important part of our efforts to assist America's families, but we cannot ignore the critical role fathers play in the lives of their children and families. Our budget includes a request for $20 million to begin an initiative to promote responsible fatherhood by providing competitive grants to organizations that work to strengthen the role that fathers play in their children and families' lives. Faith and community-based organizations and Indian tribes will be encouraged to compete for these grants. These funds will be used to support programs that effectively encourage responsible fatherhood and parenting skills and to fund programs that promote successful parenting and healthy marriages. We appreciate the support shown by Representative Herger in introducing the President's proposal last September and look forward to working with the Committee on its enactment.

Compassion Capital Fund

The President has been a leader in recognizing the important role that charitable organizations play in delivering services to the public, and we are proposing steps to increase Federal support for these groups. Specifically, our budget seeks $70 million in additional funds for the Compassion Capital Fund, for a total of $100 million. These new funds will be used to expand the number of public and private partnerships engaged in this critical effort and strengthen our ability to identify those successful models for providing social services by charitable organizations. Our budget also includes $1.6 million to continue the Department's Center for Faith-Based and Community Initiatives established under the President's Executive Order.

Promoting Safe and Stable Families

I appreciate this Committee's tremendous support for our efforts to help American families, most recently your work shepherding through to enactment the President's initiative to reauthorize and expand the Promoting Safe and Stable Families Program. The President's budget would increase the funding level for this program to $505 million, fully supporting the increased authorization included in the new law. These additional funds will be used to help promote and support adoption so that

children can become part of a safe and stable family, as well as for increased preventive efforts to help families in crisis.

Our budget also supports the new authority for funding the mentoring children of prisoners initiative included in the legislation and advanced by the President in last year's budget. The budget requests $25 million for grants to provide a range of activities to mentor children of prisoners.

This landmark legislation also authorized a new program to provide vouchers to youth who are aging out of foster care so that they can obtain the education and training they need to lead productive lives. The President's budget includes $60 million for these vouchers, bringing the total request for the Foster Care Independence Program to $200 million.

Child Welfare/Foster Care/Adoption

Our budget framework includes resources for a number of additional programs targeted to protecting our most vulnerable and at-risk children. Foster Care, Adoption Assistance, Adoption Incentives and Child Welfare Services are designed to enhance the capacity of families to raise children in a nurturing, safe environment. The President's budget provides resources to help States provide safe and appropriate care for children who need placement outside their homes, and to provide funds to States to assist in providing financial and medical assistance for adopted children with special needs who cannot be reunited with their families, and to reward States for increasing their number of adoptions. At the same time, the budget also supports Child Welfare Services programs with the goal of keeping families together when possible and in the best interest of the child.

The budget provides nearly $4.9 billion for Foster Care, $1.6 billion for Adoption Assistance, and $43 million in Adoption Incentive funds. In addition, the President's budget seeks almost $300 million in funding for child welfare services and training. Together, these funds will support improvements in the healthy development, safety, and well being of the children and youth in our nation.

Abstinence Education

The President's Budget proposes to reauthorize $50 million in mandatory funding for Abstinence Education grants to States. These resources complement Abstinence Education grants to community-based organizations ($73 million). Both grants will continue to support the message, through mentoring, counseling and adult supervision, that abstinence from sexual activity is the only sure way for teens to avoid out of wedlock pregnancies and sexually transmitted diseases.

Repatriation

Finally, our commitment to supporting America's families does not stop at our borders. The President's budget seeks $1 million in funding for the Repatriation program to assist U.S. citizens and their dependents returning from foreign countries under extreme circumstances.

STRENGTHENING MEDICARE

The FY 2003 budget dedicates $190 billion over ten years for immediate targeted improvements and comprehensive Medicare modernization, including a subsidized prescription drug benefit, better insurance protection, and better private options for all beneficiaries. Last year, President Bush proposed a framework for modernizing and improving the Medicare program that built on many of the ideas that had been developed in this Committee and by other Members of Congress. That framework includes the principles that:

- All seniors should have the option of a subsidized prescription drug benefit as part of modernized Medicare.
- Modernized Medicare should provide better coverage for preventive care and serious illness.
- Today's beneficiaries and those approaching retirement should have the option of keeping the traditional plan with no changes.
- Medicare should make available better health insurance options, like those available to all Federal employees.
- Medicare legislation should strengthen the program's long-term financial security.
- The management of the government Medicare plan should be strengthened to improve care for seniors.
- Medicare's regulations and administrative procedures should be updated and streamlined, while instances of fraud and abuse should be reduced.
- Medicare should encourage high-quality health care for all seniors.

The improvements the President and I have proposed include not only a subsidized drug benefit as part of modernized Medicare, but also providing better cov-

erage for preventive care and serious illness. The program's lack of drug coverage is just one example of its outdated benefits and it will have even more difficulty giving beneficiaries modern and appropriate treatment for their health problems in the future. We propose that preventive benefits have zero co-insurance and be excluded from the deductible. We must make these improvements to more effectively address the health needs of seniors today and for the future.

Let me assure you, the President remains committed to framework he introduced last summer, and to bringing the Medicare program up to date by providing prescription drug coverage and other improvements. We cannot wait: it is time to act. Recognizing that there is no time to waste, the President's Budget also includes a series of targeted immediate improvements to Medicare.

As you know, last year the President proposed the creation of a new Medicare-endorsed prescription drug card program to reduce the cost of prescription drugs for seniors. This year, HHS will continue working to implement the drug card, which will give beneficiaries immediate access to manufacturer discounts on their medicines and other valuable pharmacy services. The President is absolutely committed to providing immediate assistance to seniors who currently have to pay for prescription drugs.

Assistance, however, will not come only through the prescription drug card program. The budget proposes several new initiatives to improve Medicare's benefits and address cost. This budget proposes additional federal assistance for comprehensive drug coverage to low-income Medicare beneficiaries up to 150% of poverty—about $17,000 for a family of two. This policy would eventually expand drug coverage for up to 3 million beneficiaries who currently do not have prescription drug assistance, and it will be integrated with the Medicare drug benefit that is offered to all seniors once that is in place. This policy helps to establish the framework necessary for a Medicare prescription drug benefit and is essentially a provision that is in all of the major drug benefit proposals to be debated before Congress. That is, the policy provides new Federal support for comprehensive coverage of low-income seniors up to 150 percent of poverty. And in all the proposals, the Federal government would work with the states to provide this coverage, just as we are proposing with this policy.

In addition, last week, I announced a model drug waiver program—Pharmacy Plus—to allow States to reduce drug expenditures for seniors and certain individuals with disabilities with family incomes up to 200 percent of the federal poverty level. This program is being done administratively. The Illinois initiative illustrates how we can expand coverage to Medicare beneficiaries in partnership with the federal government. The program we approved last week will give an estimated 368,000 low-income seniors new drug coverage. The model application I have announced is easy to understand and use, and the Centers for Medicare and Medicaid Services is working with numerous States—at least 12—that have already expressed interest in this program. Making it easier for states to take similar steps to help their citizens who need help the most is the goal I believe we all share.

The President's budget also includes an increase in funding to stabilize and increase choice in Medicare+Choice program by aligning payment rates more closely with overall Medicare spending and paying incentives for new types of plans to participate. Over 500,000 seniors lost coverage last year because Medicare+Choice plans left the program. Today close to 5 million seniors choose to receive quality health care through the Medicare+Choice program. Because it provides access to drug coverage and other innovative benefits, it is an option many seniors like, and an option we must preserve. The President's budget also proposes the addition of two new Medigap plans to the existing 10 plans. These new plans will include prescription drug assistance and protect seniors from high out-of-pocket costs.

Some of these initiatives give immediate and tangible help to seniors. But, let me make clear: these are not substitutes for comprehensive reform and a universal drug benefit in Medicare. They are immediate steps we want to take to improve the program in conjunction with comprehensive reform, so that beneficiaries will not have to wait to begin to see benefit improvements. I want to pledge today to work with each and every member of this Committee to fulfill our promise of health care security for America's seniors—now and in the future.

EXPANDING ACCESS TO HEALTHCARE

President Bush and I also are proposing to improve the health of the American people by taking important steps to fund health care for the uninsured and create new tax supports to help purchase health insurance. The President is proposing to combine new tax provisions to help more Americans purchase health insurance with affordable expansions of federal and state programs. Beginning in 2003, advance credits will be available to individuals and families to directly reduce their monthly

premium payments for health insurance. We propose to allow States, if they choose, to use pooling arrangements to give these citizens even better options for their premium dollars. These initiatives will go a long way in improving the well being of our citizens and the quality health care they receive.

The President's budget also will increase and expand the number of Community Health Centers, which provide family oriented preventive and primary health care to over 11 million patients through a network of over 3,400 health sites. About 40 percent of the patients treated at health centers have no insurance coverage, and many others have difficulty affording the care their insurance does cover. The FY 2003 budget will increase and expand the number of health center sites by 1,200 and serve an additional 6.1 million patients by 2006. We propose to increase funding for these Community Health Centers by $114 million.

PROTECTING THE NATION AGAINST BIOTERRORISM

Mr. Chairman, as you may know, the Department of Health and Human Services is the lead federal agency in countering bioterrorism. And while this Committee's primary jurisdiction does not include bioterrorism, I know all Members share my concern that we must better protect our homeland from bioterrorism attacks. So, if the Committee would permit, I would like to briefly touch on what this budget proposes with respect to bioterrorism.

The President's FY 2003 budget request for bioterrorism is $4.3 billion, an increase of $1.3 billion, or 45 percent, $3.9 billion excluding emergency funding provided through a supplemental appropriation, and it underscores his commitment to providing the Department with the necessary resources to protect the American people from any biological or chemical attack. Our budget funds a wide variety of bioterrorism prevention, identification, and response activities that are administered through the Centers for Disease Control and Prevention (CDC), the National Institutes of Health (NIH,), the Office of the Secretary, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Food and Drug Administration (FDA).

The President believes, as do I, that state and local preparedness must be a primary focus of our nation's bioterrorism protection efforts. We have requested $1.5 billion, an increase of $406 million, for planning and physical improvements to regional and local hospitals. Additionally, our budget provides critical resources to state and local organizations to improve laboratory capacity, enhance epidemiological expertise in the identification, surveillance and containment of bioterrorism-related diseases, improve electronic communication and distance learning. The FY2003 budget also continues to provide $65 million in grants to states for the implementation of distribution systems for pharmaceuticals deployed by the National Pharmaceutical Stockpile

Our nation's hospitals, for example, must be capable of handling the large number of patients that could result from a mass-casualty incident, such as a bioterrorist attack. The President's FY 2003 budget provides $591 million for hospital preparedness and infrastructure to enhance biological and chemical preparedness plans focused on hospital surge capacity and support a newly expanded focus on cooperative training between public health agencies and state and local hospitals. Our request will upgrade the capacity of hospitals, outpatient facilities, emergency medical services systems and poison control centers to care for victims of bioterrorism.

IMPROVING MANAGEMENT AND PERFORMANCE OF HHS PROGRAMS

I am committed to being proactive in preparing the nation for potential threats of bioterrorism and supporting research that will enable Americans to live healthier and safer lives. And, I am excited about beginning the next phase of Welfare reform and strengthening our Medicare and Medicaid programs. Ensuring that HHS resources are managed properly and effectively is also a challenge I take very seriously.

For any organization to succeed, it must never stop asking how it can do things better, and I am committed to supporting the President's vision for a government that is citizen-centered, results oriented, and actively promotes innovation through competition. HHS is committed to improving management within the Department and has established its own vision of a unified HHS—One Department free of unnecessary layers, collectively strong to serve the American people. The FY 2003 budget supports the President's Management Agenda.

The Department will improve program performance and service delivery to our citizens by more strategically managing its human capital and ensuring that resources are directed to national priorities. HHS will reduce duplication of effort by consolidating administrative management functions and eliminating management layers to speed decision-making. The Department plans to reduce the number of

personnel offices from 40 to 4; centralize the public affairs and legislative affairs functions; and consolidate construction funding, leasing, and other facilities management activities. These management efficiencies will result in an estimated savings of 700 full time equivalent positions, allowing the Department to redeploy staff and other resources to line programs.

HHS continues to be at the forefront of the Government-wide effort to integrate budget and performance. We were one of the first Departments to add tables to its GPRA Annual Performance Reports that provide summary tables that associate resource dollars and performance measures HHS-wide. Although we work in a challenging environment where health outcomes may not be apparent for several years, and the Federal dollar may be just one input to complex programs, HHS is committed to demonstrating to citizens the value they receive for the tax dollars they pay.

By expanding our information technology and by establishing a single corporate Information Technology Enterprise system, HHS can build a strong foundation to re-engineer the way we do business and can provide better government services at reduced costs. By consolidating and modernizing existing financial management systems our Unified Financial Management System (UFMS) will provide a consistent, standardized system for departmental accounting and financial management. This "One Department" approach to financial management and information technology emphasizes the use of resources on an enterprise basis with a common infrastructure, thereby reducing errors and enhancing accountability. The use of cost accounting will aid in the evaluation of HHS program effectiveness, and the impacts of funding level changes on our programs.

HHS is also committed to providing the highest possible standard of services and will use competitive sourcing as a management tool to study the efficiency and performance of our programs, while minimizing costs overall. The program will be linked to performance reviews to identify those programs and program components where outsourcing can have the greatest impact. Further, the incorporation of performance-based contracting will improve efficiency and performance at a savings to the taxpayer.

GOVERNMENT PERFORMANCE AND RESULTS ACT

HHS is committed to continual improvement in the performance and management of its programs and the Administration's efforts to provide results-oriented, citizen-centered government. The budget request for FY 2003 is accompanied by annual performance plans and reports required by the Government Performance and Results Act (GPRA). The performance measures cover the wide range of program activities essential to carrying out the HHS mission. Some notable FY 2001 achievements include:

- Reducing Erroneous Medicare Payments: CMS has continued to reduce the payment error rate, cutting improper payments from 7.97 percent in FY 1999 to 6.8 percent in FY 2000 and exceeding its targets in both years. CMS, with the assistance of the Office of the Inspector General, is committed to further reducing the error rate to 5 percent by FY 2002.
- Moving Families Toward Self-sufficiency: ACF reported that 42.9 percent of adult recipients of TANF were employed by FY 1999. This is a primary indicator of success in moving families toward self-sufficiency. It improves on the FY 1998 baseline of 38.7 percent and exceeds the target of 42 percent.
- Families Benefiting from Child Support Enforcement: The Child Support Enforcement program broke new records nationwide in FY 2001 by collecting $18.9 billion, one billion over FY 2000 levels. In one such initiative in FY 2000, the government collected a record $1.4 billion in overdue child support from Federal income tax refunds, and more than 1.42 million families benefited from these collections.

These are just a few of the dozens of impressive success stories found in the 13 performance plans and reports. GPRA has been and will continue to be an important part of our effort to improve the management and performance of our programs.

WORKING TOGETHER TO ENSURE A SAFE AND HEALTHY AMERICA

Mr. Chairman, the budget I bring before you today contains many different elements of a single proposal; what binds these fundamental elements together is the desire to and to improve the lives of the American people. All of our proposals, from building upon the successes of welfare reform, to protecting the nation against bioterrorism; from increasing access to healthcare, to strengthening Medicare, are put forward with the simple goal of ensuring a safe and healthy America. I know this is a goal we all share, and with your support, we are committed to achieving it.

Chairman THOMAS. As you know, I complimented you for maintaining the Administration's position of $190 billion through two budget years that look significantly different. However, the budget that the House and the Senate were working on had about $300 billion earmarked for this particular area, Medicare reform and prescription drugs. And what I will request of you is I will provide a written question to you, and so you need not respond now and take the Committee's time up now. But the question will run along these lines: You have in the budget $190 billion for Medicare reform and prescription drugs. You have outlined a program for low-income seniors that costs in ball park of $75 to $80 billion. You have some modest savers in the budget of about 5½ billion, but the Medicare+Choice increase that you outlined is about 6.5 percent which is somewhere in the vicinity of $3.7 to $4 billion. When you look at the group that recommends changes to Medicare to us, MedPAC, or the Medicare Payment Advisory Commission, we have before us squarely the physician payment problem, both in terms of formula and the dollar amounts which require a substantial cut over 5 percent. If we are going to reinstate that, the ball park budgetary figures that I am now getting is somewhere in the vicinity of $80 billion.

The hospital recommendation was a full market basket update for rural and disproportionate share hospitals. There is some, then, pressure to go across the board with that kind of a recommendation, just for rural and dish, it is about $6 billion.

There was a recommendation of increased payments to dialysis facilities at about $3 billion. We still have that $15 billion home health sword hanging over our head that we need to deal with. I have outlined, just in those areas of providers, about $100 billion in payments.

This Committee, and indeed this House, has shown its willingness to make tough decisions, but what we believe is that as you are willing to work with us, decisions that are very difficult in terms of payment adjustments between areas of providers and new program initiatives, like drugs for seniors, are going to require us linking our arms and working together. And what this Chair would very much like is in response to the very specific questions I will be asking you, where at all possible, specific answers back as to a range of decisions that the Administration would be willing to stand with the House on, both in terms of provider payments and for areas of adjustment. And I would hope that there would be a short turnaround on that so that we can begin to construct the kind of increases in payments, adjustments in other areas and initiatives in new programs that not only seniors and disabled, but indeed all Americans need.

Mr. THOMPSON. Mr. Chairman, I appreciate that, and I will be looking forward to your letter. We will get a very quick response to it. There is no question that this Administration wants to work with you. I would like to point out quickly that the $77 billion for Immediate Helping hand for prescription drugs is, we anticipate would only be $7.7 billion. We expect that after 3 years, it would

be phased out and would be pushed into the comprehensive Medicare drug benefit, and therefore you would not use the balance.

We also believe that all the provider payment issues should be on the table. I know Mr. Stark mentioned it. You have mentioned it to me several times. I think that we are willing to work with you. We are willing to look at it across the board. There needs to be some changes. The law needs to be changed. We can only implement the laws as they currently exist, and we want to work with you, Mr. Chairman, and we certainly will, and we think that we can come up with a comprehensive package that will do what you want and what the Administration wants on a bipartisan basis.

Chairman THOMAS. Thank you, Mr. Secretary. And I do appreciate your willingness to get it to me quick. My goal would also that it be specific, and to the degree quickness denies specificity, I will wait. But I would like to have a very specific response.

The gentleman from California wish to be recognized?

Mr. THOMPSON. I am confident that if it is not specific, I will hear directly from you, Mr. Chairman.

Chairman THOMAS. Thank you, Mr. Secretary.

[The questions and responses follow:]

U.S. House of Representatives
Washington, DC 20515
February 8, 2002

The Honorable Tommy Thompson
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Mitchell E. Daniels
Director
Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Dear Secretary Thompson and Director Daniels:

Thank you for testifying at the Ways and Means Committee this week. We appreciate your hard work in developing the President's budget in this difficult time for our Nation.

As we stated in the hearings, we commend the President for not reducing the resources he devoted to prescription drugs and Medicare modernization last year, notwithstanding the new realities of the war on terrorism and an economic downturn, which has produced short-term budget deficits. We share your commitment to ensuring that our seniors and disabled beneficiaries receive the highest quality of care for a price our taxpayers can afford.

The President's budget provides $190 billion over 10 years for prescription drugs and Medicare modernization, of which $77 billion is reserved for low-income drug assistance. The budget proposes spending increases for private plans in Medicare of $4.1 billion. It also proposes several modest savings proposals—competitive bidding for durable medical equipment, Medigap reform, Medicare Secondary Payer and Graduate Medical Education reform—which collectively total $6.5 billion. Hence, there is $116 billion remaining for prescription drugs for all non-low income beneficiaries and Medicare modernization. Although we believe $116 billion is insufficient for a comprehensive prescription drug benefit, we assume you share our belief that none of this money is intended for provider payment increases.

The Administration's budget includes a statement that any provider payment adjustments must be budget neutral in both the short and long-term. However, the Medicare Payment Advisory Commission (MedPAC), a non-partisan advisory Committee of Medicare experts, recently recommended provider payment changes that could collectively total more than $174 billion over 10 years. The MedPAC recommendation for reforming the physician sustainable growth rate alone would cost $128 billion according to the CMS actuary. Clearly, we are not suggesting that we could afford, or that we should implement every MedPAC recommendation. How-

ever, MedPAC has identified serious problems, such as significant and successive payment cuts to physicians, which are unsustainable and require reform.

Does the Administration believe Congress should address any of the problems identified by the MedPAC (see attached list) with respect to hospitals, home health agencies, physicians, skilled nursing facilities and dialysis facilities? Please identify which provider problems you believe merit Congressional action and which do not. Since the budget calls for budget neutral payment adjustments, please provide a specific list of Medicare savings recommendations, which can finance appropriate provider payment changes.

Given the short legislative year, and our intention to act on Medicare legislation this spring, we would appreciate a prompt and detailed response to these requests.

Best regards,

Bill Thomas
Chairman,
Committee on Ways and Means

Nancy L. Johnson
Chairman,
Subcommittee on Health
Committee on Ways and Means

Enclosure: MedPAC Recommendations

Medicare Payment Advisory Commission Recommendations	**10 yrs billions of dollars**
Physicians	
• The Congress should repeal the sustainable growth rate and replace it with the Medicare Economic Index. The Secretary should revise the physician productivity offset from −1.5% to −0.5% to reflect the productivity of all costs rather than just labor. The resulting update for 2003 is 2.5%	[1] $127.7
Hospitals	
• The Congress should phase out the difference in the inpatient national rates between hospitals in MSAs > 1 million and hospitals in all other areas starting in 2003. In the first year, the update for hospitals in MSAs < 1 million and rural areas should be increased 0.55%	* 15
Rural Hospitals	
• The Congress should revise the Medicare Disproportionate Share payment formulas so that the payments for rural and small urban hospitals are capped at 10% rather than 5.25%	[2] 1.8
Skilled Nursing Facilities	
• If refinement of skilled nursing payment system is adopted by the Secretary as planned, Congress should fold-in the resource utilization group (RUG) add-on payments into the skilled nursing rates	[3] 10
Home Health Agencies	
• The Congress should update home health payments by market basket for FY 2003. (Current law is mb-1.1%.) The Congress should retain the 10% bonus payments for rural home health agencies	
• The Congress should eliminate the 15% adjustment to home health payments, which otherwise would result in a 4% to 7% reduction in payments	*2
Dialysis Facilities	[4] 17
• The Congress should update dialysis payments by 2.4% in 2003	*0.5
TOTAL	**174**

[1] Office of the Actuary, Centers for Medicare and Medicaid Services (CMS), February 7, 2002.
[2] Medicare Payment Advisory Commission, February 7, 2002.
[3] CMS, Health Care Industry Market Update, February 6, 2002.
[4] Congressional Budget Office (CBO), January 2002.
* Estimates based on BBRA, BIPA and discussions with CBO, February 6, 2002.

U.S. Department of Health and Human Services, and
Office of Management and Budget
Washington, DC 20201
March 14, 2002

Hon. Bill Thomas
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Hon. Nancy L. Johnson
Chairman
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives
Washington, D.C. 20515

Dear Chairman Thomas and Chairman Johnson:

Thank you for your letter to the two of us regarding the President's budget and the ways Congress could adjust Medicare payments to health care providers in a budget-neutral fashion. We know you share the Administration's dedication to better meeting the health care needs of elderly and disabled Americans, and appreciate your longstanding interest in and untiring dedication to these important issues.

President Bush believes that the Nation has a moral obligation to fulfill Medicare's promise of health care for America's seniors and people with disabilities. Medicare has provided this security to millions of Americans since 1965. However, as Medicare's lack of prescription drug coverage demonstrates, Medicare is not keeping up with rapid changes in the way health care is delivered or with benefits available in the private health insurance market.

To ensure that Medicare continues to provide our Nation's elderly and disabled secure access to modern health care, the President's Fiscal Year (FY) 2003 Budget renews his commitment to comprehensive Medicare modernization with integrated prescription drug coverage. His proposal is based on the framework for bipartisan legislation that he proposed in July 2001. Specifically, the President's budget proposes to invest $190 billion in Medicare to modernize the program by improving health insurance plan options that include prescription drug coverage. We agree with you completely that all of the new funding should be used for the President's top priority of improving the coverage options available to beneficiaries, including prescription drugs, and not for increasing payments to fee-for-service Medicare providers.

The President's top three goals for improving Medicare include quickly phasing in assistance with drug costs for Medicare beneficiaries, sustaining and enhancing the options available to beneficiaries in Medicare+Choice,, and strengthening and modernizing the Medicare Program. This includes transitioning low-income prescription drug assistance into a drug benefit that serves all Medicare beneficiaries and adding new plan options for beneficiaries and updating the benefit package. Many of these improvements, such as full implementation of a prescription drug benefit, will take several years to set up. The needed improvements identified in the President's budget can begin to take effect sooner by building on existing programs.

We agree with you that the current administrative pricing system creates extremely complex provider payment systems that do not always function smoothly or equitably. In our view, these problems further underscore the need for the President's priority of fundamental modernization of the Medicare program. We believe the primary focus of the Congress should be on strengthening and modernizing Medicare, not on revamping outdated, overly complex payment systems.

While we appreciate the work the Medicare Payment Advisory Commission (MedPAC) has put into developing their proposals, we do not believe these ideas are the appropriate starting point for a discussion of Medicare provider payments.

We have no compelling evidence that there is a problem with the overall adequacy of provider payments, although we recognize that recent short-term adjustments have been substantial in the system Medicare uses to pay physicians. For example, while home health services are vitally important to the Medicare program, home health spending is expected to rise by over 42 percent this year and 12 percent next year, and this includes the adjustment to payments already scheduled in current law. And although certain provider payments may benefit from adjustment, we believe such adjustments can be accomplished without draining new funds that are even more urgently needed for improving Medicare benefits.

In the context of moving forward on our shared goal of modernizing and strengthening Medicare, the Administration is willing to work with Congress to consider limited modifications to provider payment systems in order to address payment issues. Most importantly, as we all consider changes to payment systems, we need to be cautious and recall that any increases in spending will be borne, in part, by beneficiaries in the form of higher premiums and coinsurance payments.

Therefore, while the President's Budget did not contemplate any particular provider payment changes, we are willing to consider limited adjustments to payment systems and to work with you to develop a comprehensive package that is budget neutral across providers. We will not support any package of provider payment changes unless it is budget neutral in the short- and long-term. To this end, we recognize that some provisions in law that, in the past, have restrained growth in payments are about to expire, and extension of these provisions is one potential way to ensure a budget-neutral package of reforms.

We believe it is possible to develop a fiscally responsible package of provider payment adjustments that remain budget neutral. We are happy to begin to work with you to provide technical support for such a package if you desire. Enclosed is some additional information on various provider issues that we hope will be useful in our continuing discussions of these issues.

We look forward to working with you to advance the priorities of a prescription drug benefit, a strengthened Medicare+Choice program, and a modernized Medicare program, while also pursuing the issues surrounding modifications to provider payment systems.

Sincerely,

Tommy G. Thompson
Secretary

Mitchell E. Daniels, Jr.
Director

Administration's Views on Various Provider Payment Issues

Physician Payment Update

The current system for updating Medicare's payment for physician services was originally established in law in 1989, and has been adjusted a number of times since then, eventually resulting in the Sustainable Growth Rate (SGR) system that is used today. In general, Congress' goal for the payment system was to restrain unsustainable growth in physician payment under Medicare. The system has been working precisely as designed. Between 1997 and 2001, Medicare physician spending increased from 17.6 percent to 20.5 percent of total Medicare fee-for-service spending. Moreover, physician spending continued to increase, growing 5.3 percent in 1999, 10.7 percent in 2000, and 11.2 percent in 2001, far outpacing inflation in the broader economy.

Last year, a number of factors combined to cause the physician payment formula, as set in law, to produce a negative update. First, there has been a downturn in the economy, which affected the SGR because it is tied to estimates of the nation's Gross Domestic Product growth per capita. Second, actual cumulative Medicare spending for physicians' services in prior years was higher than expected. Third, information on services that were not previously included in the measurement of actual expenditures was now included. Had this information been captured in the measurements originally, spending increases would have been 5.9 percent in 2000, and 9.7 percent in 2001, rather than the respective 10.7 and 11.2-percent increases mentioned above. Counting these previously uncounted actual expenditures, as required by law, contributed to this year's negative update to physician payments. However, despite the negative update, overall Medicare physician spending is not projected to decrease this year. In fact, as the Congressional Budget Office (CBO) noted before Congress two weeks ago, program spending increases by 5.9 percent in 2002.

While a formula that produces these payment fluctuations year-to-year should be reviewed, the underlying system is sound and effective. As CBO Director Dan Crippen concluded in his testimony before Congress:

"In considering whether to change the current system for setting Medicare physician payments, the Congress confronts the prospect of reductions in the fees paid per service for the next several years. MedPAC's recommendation would increase the Federal government's spending for physicians' services under Medicare by $126 billion over the next 10 years. In contrast, other approaches might have the potential to lessen the volatility in the update without dismantling the mechanism for

linking physician fees to total spending for physicians services or growth in the economy.Changes that increase Medicare payments to physicians will increase Federal spending. Incorporating higher fees for physicians' services into Medicare spending as currently projected would add to the already substantial long-range costs of the program and to the fiscal challenge to the nation posed by the aging of the baby boomers. Raising fees would also increase the premium that beneficiaries must pay for Part B of Medicare (the Supplementary Medical Insurance program). Inevitably, over the long run, higher spending by Medicare for physicians' services will require reduced spending elsewhere in the budget, higher taxes, or larger deficits."

We believe that considerations of sustainability and of our other urgent priorities in Medicare argue strongly that, if changes in the physician payment system are undertaken this year, they should be undertaken carefully and implemented in a way that does not significantly worsen Medicare's long-term budgetary outlook. The Administration supports reforms in physician payment that lessen volatility, and further believes that any short-term payment problems can be addressed at a much lower cost than the MedPAC recommendation implies.

Home Health

The President's budget also assumes no further delay in the implementation of the "15-percent reduction" in home health interim payment system (IPS) limits. As you may know, this reduction is somewhat of a misnomer. It does not translate into an across-the-board, direct cut in Medicare payment rates for home health services, as many have described it. Rather, the 15 percent reduction is a decrease in the payment caps under the old IPS. The actual percentage reduction in payments that will result from lowering the limits is much less. In fact, the CMS actuary estimates that the 15 percent reduction will only reduce payments to home health agencies by about 7 percent, not 15 percent. Further, after the PPS rates are reduced by 7 percent, we would apply the home health update (currently estimated to be 2.1 percent), leading to a net reduction of approximately 4.9 percent.

Home health spending is expected to rise by 42 percent for FY 2002. Even if the 15 percent adjustment occurs, we estimate that home health spending would increase 12 percent in FY 2003, 8.3 percent in FY 2004, and 7.8 percent in FY 2005. Therefore, we do not support a repeal of the 15 percent adjustment in the caps.

Skilled Nursing Facilities

Prior to the enactment of the Balanced Budget Act 1997 (BBA), many nursing home companies were expanding rapidly, taking on significant debt, and leveraging themselves heavily for acquisitions of new homes and allowing their debt-to-equity ratios to escalate steeply. That strategy backfired on many of the industry's biggest companies when the nursing home industry came under financial pressure resulting from the implementation of the Prospective Payment System for skilled nursing facilities (SNFs) and other Balanced Budget Act 1997 provisions. As a result, Congress passed two laws to provide some relief. The Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, and SCHIP Benefits linprovement and Protection Act of 2000 (BIIPA) required three Medicare payment "add-ons:" a 4-percent increase in per diem rates; a 16.66-percent increase in the nursing component of each Resource Utilization Group; and a 20-percent increase for certain categories of high-cost, medically complex patients. The first two add-ons expire on October 1, 2002. The third will expire when FIRS implements a case-mix refinement rule. The Administration is currently moving forward in its development of this refinement rule.

The President's budget proposal reiterates the administration's commitment to paying SNFs fairly and appropriately for the delivery of services to Medicare beneficiaries. CMS recently explored the fairness and appropriateness of Medicare SNF payments in the February 6, 2002, *Health Care Industry Market Update—Nursing Facilities.* While we surely want to avoid overpaying any of our providers, we also must be sensitive to their funding needs in order to maintain high quality services. We are willing to continue to review the substantive justification for modifying SNF payments with the Committee.

Hospital Updates

Under the President's budget assumption, inpatient hospital payments for FY 2003 would follow current law and be updated by the market basket, which accounts for inflation in the factors that contribute to the costs to provide hospital services, minus 0.55 percentage points. Under current law, the update beyond FY 2003 would be equal to the full market basket. Since the inception of the inpatient prospective payment system (PPS), hospitals have received a full market basket update only once in FY 2001. Since FY 1984 hospitals have received on average ap-

proximately 60 percent of the market basket forecasted increase. Even so, since the early 1990's, the Medicare PPS inpatient margin has risen sharply from 1.3 percent in FY 1993 to a historical high of 16.0 percent in FY 1997. Although there was a decrease in FY 1999 to a 12.4 percent margin, the Medicare inpatient hospital margins have begun to increase again. In addition, since the early 1990's, there has been a significant drop in the number of hospitals with negative inpatient margins. In FY 1991, 61.2 percent of hospitals had negative inpatient margins compared to approximately 25 percent in FY 1999.

The stabilization of overall hospital margins in recent years suggests that, overall, the restrictions on market basket increases of recent years have not resulted in inadequate hospital payments. Reasonable and modest limits on hospital market basket updates would appear to provide adequate reimbursement for hospitals. Modest limits below full market basket updates could be linked to continued careful review of Medicare hospital margin data to ensure that margin problems do not worsen, and certain hospital types that show clear evidence of negative and declining Medicare margins could be monitored closely for special consideration. The Administration believes that the savings from such measured changes in hospital payment updates could be more than adequate to finance reasonable net increases in total payments to physicians.

There are market updates for other providers that were established in the Balanced Budget Act 1997. To help restrain spending growth, you could also consider extending market basket update reductions to the calculations for other prospective payment systems.

We are prepared to provide further technical guidance to the Committee whenever it is requested.

Mr. STARK. Thank you, Mr. Chairman. In an effort to get back in the good graces, I will ask three quick questions, Mr. Secretary, and then you can take as long as you want to answer them. Then we will see how that works.

First of all, I have a question about the issue of providing medical services to low-income pregnant women. It is my understanding that under the rules laid down by President Clinton that are still in effect, that it is possible now to cover pregnant women under the children's health insurance program or other programs. Therefore, it would be not necessary to define a fetus as an unborn child and enter into that argument area that will only separate many of us on issues other than health care.

The second issue is that you state that Medicare+Choice is underpaid, and that is very popular with the Medicare+Choice lobbyists. The facts that I look at are that Medicare+Choice payments have increased 25 percent since 1997, while Medicare has only gone up in costs of 21 percent per capita under the total cost of Medicare. The U.S. General Accounting Office (GAO) tells us in its latest study that HMOs or Health Maintenance Organizations, Medicare+Choice plans, are overpaid as opposed to traditional Medicare.

So in the face of lower increase in per capita and the GAO's study that we are already overpaying them, I would be curious to know why you think that they are underpaid.

My third question is an attempt to elicit from you your commitment, and this is prospective. It appears—and the Chairman will blame this on the democratically controlled Senate—but it does appear that there may not be a tax bill this year. If the Senate doesn't bring it up and if your budget mavens on your side of the aisle decide that that is an issue, there is $600 billion leftover in the budget. If that is the case—these are a lot of ifs—would you

commit your personal battle to get half of that, $300 billion, into Health and Human Services so that we could use it for Medicare drug benefit and TANF benefits? Those are my three questions.

Mr. THOMPSON. Well, Congressman Stark, let me tell you the last one. Sure I will fight for anything I can get into Department of Health and Human Services. There is a lot of assumptions there that have to fall into place.

Mr. STARK. I understand.

Mr. THOMPSON. But if there is $600 million, I think I would only fight for 25 percent because that is what we usually get, but I will fight for that very hard.

Mr. STARK. Start high. We will take it.

Mr. THOMPSON. We have got a lot of needs that we could use. The second question in regards to the unborn, there is an area that really pregnant women are not covered for prenatal care, and you know——

Mr. STARK. But they can be under current law.

Mr. THOMPSON. No, there is not. Under existing law, there is—unless the State applies for the waiver.

Mr. STARK. Right.

Mr. THOMPSON. If the State applies for the waiver. We thought it was easier, because this is a group of individuals that we really wanted to serve, and I didn't want to get into a pro-life and a pro-choice battle. I want to serve low-income women and give them the prenatal care because we, you and I and everybody on this Committee wants healthy babies. And I think that we can achieve that. I know it got turned around and got into this, and the rule is going to be out there.

We are going to have a chance to work on the rule. Hopefully we can mitigate some of the harshness, the rhetoric out there and be able to come up with a compromise that is going to be able to allow for low-income women to get prenatal care. That is my ultimate objective. I am pledged to that, I am passionate about it, and I want to accomplish that. There is a group of women out there that are not getting the coverage and they need it.

In regards to Medicare+Choice, according to all of our indications you look at it, there is only 14.2 percent of the Medicare population now being covered by Medicare+Choice. We lost coverage for 500,000 individuals last year, some in Milwaukee in the State of Wisconsin, a city that——

Mr. STARK. What happens to the county executive? Will he get covered with that modest pension he is going to get in Milwaukie?

Mr. THOMPSON. The executive did not qualify for this particular plan. He had his own health insurance plan, and knowing that you come from that area, Congressman Stark, you are fully familiar with it and so on. But it always appears from all of the indications that Medicare+Choice plans are the ones that are losing. That is why the President wanted to stabilize it; I wanted to stabilize it. That is why the additional money was placed in there. And I think that it is the right thing, because the people that are in Medicare+Choice plans really like them. We would like to be able to continue that choice, even though it is a declining amount. There are only 14.2 percent, as I indicated, of the population currently

covered by Medicare+Choice. Those are my answers, Mr. Chairman.

Chairman THOMAS. The gentleman's time has expired. Does the gentleman from Illinois wish to inquire?

Mr. CRANE. Yes. Thank you, Mr. Chairman. Mr. Secretary, let me start off by saying that I commend your efforts to move a prescription drug benefit and modernize the Medicare program. That said, I think we all recognize that this is the first year that the baby boom generation shows up in the 10-year budget window for Medicare. Your budget states that the part B deficit overwhelms the surplus and part A revenues, a shortfall that is projected to be $46 billion in fiscal year 2003 and $553 billion over the next 10 years. Given the Congressional Budget Office (CBO) and Office of Management and Budget (OMB) baselines for Medicare spending, it is clear that the program is expending tremendous revenues annually.

The budget also states that many payment policies need to be reformed, and you have proposed to do it in a budget-neutral manner. Frankly, I believe this program is in need of fundamental reforms. However in the absence of achieving fundamental reforms, how can we change those policies in order to keep up with the increase in health care expenditures in a budget-neutral manner?

Mr. THOMPSON. Basically, Congressman Crane, I agree with you. We have to—we have to make some structural changes in all of these programs, and that is what we want to do. We want to—we are going to answer the questions in written form by the Chairman, and we are going to come back with suggestions on how we might be able to modify them, and we also believe that we should put prescription drugs in. We are putting an additional $190 billion in to accomplish that. We are putting in Immediate Helping Hand by allowing States to get a 90/10 match for 100 to150 percent poverty, and we think that is very important, especially for that.

On the assumptions, we believe that our assumptions are correct. And we think the assumptions the Medicare expenditures on the baseline are going to be lower than what CBO has, and CBO, of course, as we all know, will correct those figures in March of this year, but as of right now, based upon our assumption, based upon our experts, which this Committee has used on a bipartisan basis in the past, we feel that our assumptions are very correct.

Mr. CRANE. Mr. Secretary, as regards temporary assistance for needy families, it is my understanding that caseloads have been reduced in excess of 50 percent over the last 5 years, which is certainly very good progress. According to your report in fiscal year 2000, work efforts among current welfare recipients were three times its 1996 levels. As you know, this Committee will work to reauthorize TANF this year, and I am confident that we will further reform the program in such manner as to reduce caseloads even further across all 50 States.

You are certainly an expert in this field, and my question to you is this: Given the aforementioned progress the States have made in reducing caseloads, and given the prospects by which caseloads will be reduced in the near future, do you believe that we need to send $16.7 billion to the States this year rather than staying level? Shouldn't the amount in the budget be going down each year?

Mr. THOMPSON. I really sincerely believe that we should have level funding, Congressman. I will tell you why. Fifty percent of the cases remaining are going to be the hardest to place. These are individuals that have a lack of education, a lot of those individuals have one or more drug problems, alcoholic problems. Several have not finished school. Several have not worked and you are going to spend more money on those particular cases, integrating them into the work force. That is point number one.

Point number two, you want to be able to use some of this money, and what we are asking for this Congress to give us is allowing the States more flexibility to use some of their excess dollars to put in to work assistance, to be able to help workers be able to go up the economic ladder, and that is expensive. It requires training. It requires education. It requires a lot of assistance in order to move people up the ladder, because these are individuals that have been poorly trained in the past or no training at all.

The third thing you want to do is you want to be able to be sure the money—up to 30 percent of the TANF grant can go into child care. We think this is a very important thing to provide for quality child care and be able for those children to be able to have a good start in life. To me, all of these things argue for level funding, and I know I argued with OMB for level funding. I know some people think there should be more money. Other people think there should be less. I think it is just right. I think what we need to do is continue to move forward, move to the next level, the next plateau, refine TANF, make it even better, and get more people off the roles. We must give people the opportunity to move up the economic ladder.

Mr. CRANE. Thank you, Mr. Secretary, and we look forward to working with you.

Chairman THOMAS. I thank the gentleman. The gentlewoman from Connecticut wish to inquire of the Chair of the Health Subcommittee?

Mrs. JOHNSON OF CONNECTICUT. I thank you very much. Welcome, and thank you for being here. Secretary Thompson, do you support privatizing Medicare?

Mr. THOMPSON. No.

Mrs. JOHNSON OF CONNECTICUT. I want that heard loud and clear. I am Chairman of the Health Subcommittee. I do not support privatizing Medicare, and I am sick and tired of this partisan divide that some are trying to create between those who want to privatize Medicare and those who don't. I don't know anyone who wants to privatize Medicare. We have an obligation. We have taken it on by law and we intend to fulfill it in Social Security and Medicare to provide retirement income security seniors and retirement health care security to seniors, and I know no one who supports privatizing Medicare, and I want the record to note that very clearly.

I do, though, want to make two comments, and one short question. First of all, I appreciate, Secretary Thompson, that you have acknowledged that this body, not the House, because we will bring forward another prescription drug bill. We are committed to that. Seniors need it, modern health care can't proceed without prescription coverage. We have done it once. We will do it again, and with

it will come some very significant modernization of the Medicare program and justice for a lot of our providers through the administrative reforms that we passed here already once.

So I believe we can make significant progress in the House on improving the quality of the Medicare Program, as well as including prescription drugs. I am less optimistic that the Senate will be able to act.

So I am very impressed that you have, through your budget, laid out the way we can, through the government, increase access to prescription drugs for our seniors, freeing up valuable Federal dollars so that we can subsidize senior prescription drugs to higher income people in higher cost parts of the State like Connecticut—of the Nation like Connecticut. And that through your effort to provide a discount card are going to really be able to move manufacturer discounts down to all seniors.

If you do that, you will help every senior significantly and low-income seniors tremendously, and I hope that we will move through the House and Senate a prescription drug bill that then can assure that this will become a Medicare benefit in 2 or 3 years, but since it takes two or 3 years for our plan to be implemented, I am very glad that I see in your budget this commitment to meeting seniors' needs now and that also in your budget, it is loud and clear the need to move forward on health care for the uninsured.

That much said, I do want to just correct a fact that was stated earlier by the Ranking Member, Mr. Stark, about the Medicare choice programs, because, again, you are committed in your budget to helping us fix the problems. Sixty-five percent of seniors in America that get the valuable benefits, I mean, if they weren't valuable, we wouldn't see so much complaining, would we?

Mr. THOMPSON. No.

Mrs. JOHNSON OF CONNECTICUT. Sixty-five percent of those seniors live in areas where Medicare choice plans have gotten a 14-percent increase since 1998 as opposed to the 21-percent increase that fee-for-service patients have received. No wonder these plans are having difficulty. These skewed results that my colleague referred to that makes it look like the choice plan has got more results from the artificial floor that the Senate and the House passed for rural counties.

So the money is going to areas where there are no people, and the areas where there are people, benefits from these programs are being starved. This is our only means, our only means as a Congress to help seniors deal with the challenge of multiple chronic illnesses. And managing those chronic illnesses is high on my agenda, so I am very glad to see you are so committed to helping us fix the Medicare+Choice plans.

As for my question, I will just refer to it because I am not going to give you time to answer it clearly, but I wanted to get these issues on the table.

My question is really the Chairman's question. It is unconscionable for the government to drive capable physicians out of practice, and we cut their reimbursements this year because we have an arbitrary formula in place that I was on the Committee when we passed it, and I am proud to say I opposed it, because it is the only

payment system that is tied to economic growth and it is the only payment that caps volume.

So if you are an internist and you see more seniors because we have more seniors and they are living longer, your reimbursement gets cut. It is absurd, but we are in this terrible position that to fix what is an absurd law that was passed when I was on the minority side of the Subcommittee, I might add, and opposed, I have got to get that in there, because it is so important, when—to fix that now under the current circumstances is going to be extraordinarily expensive, and that is only one of the very big payment problems we have.

But 2 years ago, 45 percent of our doctors felt Medicare was treating them unfairly, and 2 years later we are in very deep trouble in terms of the quality of care that is going to be available to our seniors if we don't act. So thank you for listening. We do have our work cut out for us and I look forward to working with you.

Mr. THOMPSON. Thank you very much, Congresswoman Johnson, and I thank you for your questions and your comments. I couldn't agree with you more, with your statement. There is no intention whatsoever to privatize Medicare or Social Security in this Administration or me personally. We certainly want to make sure Medicare+Choice is able to survive. As most people that have Medicare+Choice like it—would like to be able to continue it. I think it is the right thing to do. In regards to provider payments, I think we have to look at all of them. The physicians' payment is the only one, as you indicate, when the economy goes down, they get cut. When the economy goes up, they get an increase. It doesn't make much sense, and so hopefully we can change that. But we have to implement the law as it is written, and therefore we will work with you on a bipartisan basis and you specifically, Congresswoman Johnson, because you have taken the lead in this along with the Chairman, we want to be able to try and correct this, and we will do everything we possibly can to assist you.

Chairman THOMAS. I thank the gentlewoman. The gentleman from Pennsylvania, Mr. Coyne wish to inquire?

Mr. COYNE. Thank you, Mr. Chairman. Mr. Secretary, as you know, the State of Pennsylvania conducts the—administers the Program of All-Inclusive Care for the Elderly (PACE), which is a highly effective.

Mr. THOMPSON. Right.

Mr. COYNE. Pharmaceutical——

Mr. THOMPSON. It is one of the best ones, Congressman.

Mr. COYNE. And I am just wondering how the new program that is being proposed by your Administration at Health and Human Services is going to interface with the program that we have already in Pennsylvania.

Mr. THOMPSON. It would be extremely helpful to the State of Pennsylvania Congressman. Once the State pays 100 percent of the PACE Program, then for the 100 to 150 percent, the State of Pennsylvania would receive 90 percent payment and be able to expand their program, probably get some reimbursement dollars out of it. It would be very helpful to the State of Pennsylvania. It would be directly integrated. Pennsylvania would apply for the program, and they would certainly—it would certainly be granted because of the

PACE Program is one of real stars out there for prescription drug coverage as you know.

Mr. COYNE. So there would be no problem with the State applying to the Federal Government to go beyond the current——

Mr. THOMPSON. No. It is our intention that it would build upon the PACE Program and allow them to go the next step. It may even allow for the State of—the State of Pennsylvania to get some dollars.

Mr. COYNE. Thank you.

Mr. THOMPSON. Okay.

Chairman THOMAS. I thank the gentleman. The gentleman from New York, wish to inquire?

Mr. HOUGHTON. Thank you, Mr. Chairman. I am going to give you a Christmas present early. I am not going to ask you a question, but I do have several questions that I would like to refer to you, and I will put them in writing.

Mr. THOMPSON. Thank you.

Mr. HOUGHTON. I just wanted to say that, you know, we are dealing with probably the most difficult issues in our government, you know, the whole concentration on the budget and on terrorism and everything is absorbing our time. But what you are doing I think is extraordinary. You bring clarity of mind. You bring purpose. You are supporting the present. I think you are doing a great job. Thanks very much.

Mr. THOMPSON. Thank you, Congressman. That is the best question I have ever received in this Committee, and I thank you very much.

Chairman THOMAS. The gentleman's time has expired.

Mr. THOMPSON. I wish his question could keep going on, Mr. Chairman.

Chairman THOMAS. The gentleman from California, Chairman of the Human Resources Subcommittee, Mr. Herger wish to inquire?

Mr. HERGER. Thank you very much, Mr. Chairman. I would like to continue on that best question that you ever received. Mr. Secretary, I want to thank you for the work that you have done.

Mr. THOMPSON. Thank you.

Mr. HERGER. It is a pleasure as Chairman of the Human Resources Subcommittee to be working with you in reauthorizing welfare reform for the next 5 years. It is a pleasure to be able to work with a program that is probably arguably the most successful program in the last generation, one which is unlike the old AFDC welfare program where we saw caseloads increasing even during prosperous times of the 1980s. We have actually seen the caseload decrease by, as was pointed out, more than 50 percent, and even in your State, I understand, in Wisconsin, it has been reduced by even more than 90 percent, talking with you. I want to thank you for— and at the same time, I might mention the poverty levels have been going down.

Mr. THOMPSON. That's right.

Mr. HERGER. The poverty levels for children, have been decreased by more than 2 million during this period of the TANF, Temporary Assistance to Needy Families, reform. You have already answered—responded to one of the questions I had, and that is on the funding level.

Mr. THOMPSON. Yes.

Mr. HERGER. In responding to the gentleman from Illinois, there are many who talk—who mention to me that with the roles decreasing by more than 50 percent, shouldn't we be reducing the funding? And I believe you responded to that. You made the comment that we cannot do welfare reform on the cheap, yet we have others who would come to me and say we need to increase it by tens of billions of dollars, and it would seem to me that we are being very generous on maintaining the level of $16.5 billion spending, considering the roles have decreased by 52 percent.

But I would like to move to another area. Certainly two of the key reasons why I believe welfare reform has been so very successful, one has been that we are—we have begun to require work, and certainly in your State where you did experimentation with this prior even to the 1996 law, I am very interested in what your thoughts are for maintaining this work. And we have some who would propose that we slack off in our work requirements. Right now we have increased by three-fold 30 percent of those on welfare are working. Many, like myself, feel that should be increased, or should be more than 30 percent of those who are able-bodied and working. Some would like to, perhaps, go back to just education, and certainly, I have concerns on that, of doing anything.

That old adage that I heard growing up on the farm, "if it ain't broke, don't fix it." I certainly would think it would be a disaster if we were to fix something that is working. Certainly, we want to fine-tune and work and make it better. But I would like to begin by, just on this area of the work area, the other, the time limits I would like to get into, but just in the area of work, what are your responses to those who would like to see us move away from work, and how well do you feel this is working? What is the recommendation of the Administration?

Mr. THOMPSON. Thank you very much, Congressman. Let me quickly point out that I was head of the National Governors Organization when the first TANF bill was enacted, and we negotiated with Congress for $16.5 billion, and we asked that it not be cut for 5 years. And the Congress kept their commitment. I think the Governors kept their commitment, and it has been, I think, a very successful program. The only area where I disagree with you is that I think it is probably the biggest social change in 60 years rather than 25 years. That is the only change I would make to your statement, Mr. Herger.

In regards to work, I think it is absolutely essential. I think work has got to be a very viable component of any reauthorization of TANF. In the existing law, 50 percent was supposed to be in a work capacity, but every time a State reduced the caseload down by 1 percent, the work requirement was reduced by 1 percent.

So now we are down to about 5 percent instead of 50 percent. It is about 5 percent that are required to work in America, pursuant to a law, because the caseloads have been reduced. In my own State of Wisconsin, we don't have any work requirement pursuant to the Federal level. We have a State requirement that requires it. I absolutely think it is important. I think it is the only way to get out of poverty. I think there has to be more, but also I think we can now move to the next step and use some adjustments to allow

for education and for training to be able to continue up the economic ladder, and I fully want to work with you and the Members of this Committee in order to accomplish the next step. I really feel passionately about this, and I think it is great for individuals. It is great for children, and I think it can be even a better program if we work together to accomplish that.

Mr. HERGER. Thank you, Mr. Secretary.

Chairman THOMAS. I thank the Chairman. The gentleman from Michigan, Mr. Levin, wish to inquire?

Mr. LEVIN. Well, thank you, and we are glad you are here.

Mr. THOMPSON. Thank you, Mr. Levin.

Mr. LEVIN. I am going to continue with some friendly questions. I won't pick up your statement about this Administration opposing privatization of Social Security, which I don't think is really its position, but let us go back to welfare for a moment, because I think your answer to Mr. Herger and to Mr. Crane, that answer is an important one, because no one wants to weaken the work requirement. What we want to do is to, as you say, help people who are working move up the economic ladder.

Mr. THOMPSON. That's true.

Mr. LEVIN. And we are glad that you are emphasizing that.

Mr. THOMPSON. Thank you.

Mr. LEVIN. The figures are pretty clear, though. I think the reporting requirements under the welfare bill were too weak, and I think you would agree. We don't really have a good enough idea of what is happening to people. But from the studies available, it is pretty clear that the majority of people who leave welfare to work remain in poverty are working at jobs that pay $6, $7, $8 an hour. That is the majority of people.

Mr. LEVIN. If we want work to lead to independence, the work has to be ruminative enough, and I think that is what you are emphasizing.

I might also point out, when we talk about level funding, if you take into account inflation, what is being requested here really isn't level if you compare it with the original amount; and as you know so well, because you have been a pioneer in this, I think now about maybe more than 50 percent of TANF is going for support services, not for cash income. So the question becomes how do we help people become productive enough in terms of their remuneration?

So let me ask you in that regard about transitional Medicaid because, as you know, a very substantial portion of people who leave welfare for work don't end up with health care; and, as you know, some of us, Mr. Castle and others and I, have proposed—and Mr. Cardin is very much into this—transitions into traditional Medicaid to make sure people who are working have health care. There is no provision in this budget, as I see it, for any improvements in transitional Medicaid. Why not?

Mr. THOMPSON. Congressman, we are putting in $350 million, which was going to be terminated in order for a continuation of 1 year of health care. We think that is a very positive step. I think we need to look at what you are saying, but, right now, the $350 million is a tremendous step forward.

The second thing you mentioned that I wanted to comment on is in regards to the cases, in regards to records. There are a lot of

States that have not kept individual case files on every case. I think it is very important for us. If we are going to move and allow for individuals to be able to continue, there has to be a case history, a case file and a case direction on every individual coming off of TANF. Right now, that is not the case.

Wisconsin is the only State that does that. I think it is very important if we are going to keep individual case files, we should be able to do them with our counselors, and States should have them. States will not particularly like it, but I think in this case when we are level funding, giving them the necessary dollars, that we should develop that case file. With that I think you can give the assistance necessary through the $25 million in counseling that we are asking in this budget bill, to be able to, in technical advice to the States, allow for a plan to be developed for each individual to be able to assist them in moving.

Mr. LEVIN. Okay. I want to ask you about the social services block grant quickly. I just urge—I think the transitional Medicaid improvement isn't in there because of a shortage of money. It is a grievous problem. People move out of TANF for—they may have some income support and they have no health insurance.

Let me ask you about social service block grant. Can you answer in just a couple of seconds? The funding request is $1.7 billion. Where is the money going to come from to improve it, to increase it? I understand the President agreed earlier today or yesterday to keep the promise made to the Governors to raise it. Where is the money going to come from?

Mr. THOMPSON. I am not sure, Congressman, of the answer. I will be back in touch with you.

Chairman THOMAS. The gentleman's time has expired.

It is the Chair's intention to continue this hearing until the bells ring. My understanding is that approximately 20 minutes to 12:00 p.m. the bells will ring. There will be two votes, and that will consume the remainder of the time. So if our Members are mindful of the time and especially of those who might have indicated that they would very much like to ask questions of the Secretary, the Chair would urge you to, among yourselves, try to prioritize the amount of time we have remaining. The Chair will call on each Member. The gentleman from Louisiana wish to inquire?

Mr. MCCRERY. Thank you, Mr. Chairman. I will be brief.

Quickly, on the question of privatization of Medicare, I think Chairwoman Johnson spoke to that well. However, I would note, Mr. Secretary, that the President's emerging proposals on Medicare do stem from the recommendations of the National Bipartisan Commission on Medicare Reform, and those in fact do envision a much larger role for the private sector in the delivery of health care through the Medicare system; isn't that correct?

Mr. THOMPSON. That is correct. It is about choices, Congressman. It is about allowing an individual to have the same choices under Medicare as a Federal employee does, with their own health insurance programs.

Mr. MCCRERY. Exactly.

Mr. THOMPSON. That is absolutely correct.

Mr. McCRERY. I just wanted to make that clear. On the issue of welfare reform, there is no one better situated than you, Governor Thompson.

Mr. THOMPSON. Thank you.

Mr. McCRERY. Mr. Secretary, to comment on the funding that was agreed to in 1995 and later enacted in 1996, I was on the Conference Committee on Welfare Reform, and you were ever present, as were a number of other Governors, Michigan's, for example, in pressing us to give the most liberal funding for the next 6 years; and we did that.

Mr. THOMPSON. That is correct.

Mr. McCRERY. In fact, Mr. Secretary, isn't it true that we gave the States, the Governors, a choice of base years on which to——

Mr. THOMPSON. You did.

Mr. McCRERY. Base the funding; isn't that correct?

Mr. THOMPSON. That is correct, and we negotiated——

Mr. McCRERY. And in each case the State chose the base year with the highest level of funding; isn't that correct?

Mr. THOMPSON. Not the highest. It could go back a couple of years.

Mr. McCRERY. The highest among the 3 years——

Mr. THOMPSON. Among the 3 years. They could pick a base year out of those 3 years. You are absolutely correct. They couldn't go back beyond that. But you are absolutely correct. It was negotiated between the Governors and the Conference Committee, and I thought we came out very well as Governors——

Mr. McCRERY. Yes. I thought the Governors came out extremely well. You did a——

Mr. THOMPSON. Well, I thought fairly well——

Mr. McCRERY. Great job of negotiating on their part.

I say all of that just to underscore the Administration's contention that the $16.5 billion level funding is sufficient for this program. In fact, I would certainly urge us to look at decreasing the funding. I know that may not be possible, but certainly no increase is warranted based on the discussion you and I just had and the experience we have had with the program over the last 6 years. With that, Mr. Chairman, I will yield back the balance of my time.

Mr. THOMPSON. Let me just say I do not think it would be in the best interest to cut it. I think we can get by on——

Mr. McCRERY. I am not sure that it would, but I think we ought to explore it.

Mr. THOMPSON. And the second thing is I did want to point out in my first answer to you, Congressman, that the President and I feel very strongly that a senior on Medicare should have the option to either go into the new program or stay in the existing one.

Mr. McCRERY. Absolutely.

Chairman THOMAS. The gentleman from Louisiana yields back his time. The gentleman from Maryland wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman.

Mr. Secretary, let me follow up on this fund level, because I think there are some misunderstandings here. We keep on saying there has been a caseload reduction, and I am not sure the figures we are using are accurate. There has certainly been a cash assistance reduction dramatically.

Mr. THOMPSON. That is right.

Mr. CARDIN. But the number of people being served with TANF funds is still a very large number.

Mr. THOMPSON. It is.

Mr. CARDIN. And that is good. That is a success story. When we help people move up the economic ladder, as you point out, that is what this should be about.

Mr. THOMPSON. That is true.

Mr. CARDIN. So States are using more and more of their TANF money for noncash assistance programs; and to the extent that we don't make Federal funds available, those programs are going to be the first hit, the ones we want to encourage the most, because cash assistance is going to have to be paid out. And if the economy remains soft and we know people are losing their jobs, we know some of them are not qualifying for unemployment insurance, they are going to end up—could end up back on cash assistance.

So I just caution my colleagues who are talking about the fact that they think that we have had dramatic reduction in the needs of the States, it is just not accurate; and, of course, the Governors and the legislators, State legislators, are here telling us that on a daily basis.

The last point on funding, if you level fund it by 2007, it is a 22 percent reduction in the basic funding level on what it could buy; and I hope we could do better. I agree with Mr. McCrery. I think we should consider the funding level. I take it from a different side. I think we need to at least adjust it for inflation, and I hope we will have a chance during the budget debate to talk about that.

I also want to also put in a plug, as I said earlier, about changing the goals. You mentioned child welfare, which I think is good. I would urge we broaden it to reduction of poverty, and I hope we will have a chance to sit around and talk about——

Mr. THOMPSON. I do.

Mr. CARDIN. The explicit goals within the welfare system. That is not a dollar issue. It is an issue of what is the next level. What do we expect the States to be able to accomplish during the next 5 years?

Then on the work requirement I want just to concur on your comments. I think giving a caseload reduction makes the work requirement meaningless. So I think we need to look for a better way to define it. We would suggest you take a look at making the credit based upon employment rather than on caseload reduction, because that is more relevant to what we are trying to accomplish.

Then, last, I want to thank you for, in the President's budget, having the child support pass-through provisions. This Committee has passed that on several occasions. We have not been able to get it through the other body. I am a little bit concerned on how you pay for it, but I do hope that we will be able to get that finally passed. That is extremely important to low-wage families and people who really need this additional assistance, and I want to thank you for including that in the President's budget.

Mr. THOMPSON. Thank you. If I could quickly comment on several things.

First off, in regards to the pass-through, as you know I pioneered that when I was Governor of the State of Wisconsin. We have 100

percent pass-through which we have paid through waiver savings. It has been very good, and there has been a recent study put out in the State of Wisconsin by I believe the Institute of Poverty. That shows that any welfare mother that has received any amount of money up to $100 per month once she leaves welfare is less likely to go back on if she is receiving the money from the father or the spouse that doesn't have custody of the child, a noncustodial parent.

The second thing is, in regards to work, I think it is important for us to modernize that, because the work requirement right now is nonexistent for most States and it is at such a low level we should be doing that. I appreciate that.

In regards to indexing the amount of money, that is a question we are going to have to discuss. You and I have discussed that in the past; we will in the future. I think I have a meeting with you coming up sometime in the middle of the month to sit down. I hope we can get together, Congressman Herger and Congressman Cardin, and sit down and develop a bipartisan—I think there are really some wonderful innovative things we can do to improve children and spouses in regards to going on to the next plateau.

In regards to child poverty, I think there are other things. I am willing to discuss that, but I think there is also child abuse and healthy standards for children, nutrition and so on and so forth all should be considered, all should be in the dialog, and I am willing to sit down and discuss that with you.

Mr. CARDIN. Thank you, Mr. Secretary.

Chairman THOMAS. Thank the gentleman for yielding back his time. The gentleman from Michigan, Mr. Camp, wish to inquire?

Mr. CAMP. Yes, thank you, Mr. Chairman.

Mr. Secretary, I appreciate your testimony today and particularly your comments that we ought to continue the success of the 1996 welfare reform law. Obviously, you laid out very well the successes in terms of caseloads declining by 50 percent, 2 million children having left poverty, work by welfare recipients having risen by 50 percent or more and record shares of single parents working now.

My question is, having just visited a Michigan work site which is really to help remove barriers to employment that people have and I was very struck by the efforts and successes they have had there, can you tell us what other States are working with people to help find good jobs and jobs of the future like the program we have in Michigan?

Mr. THOMPSON. Absolutely. The wonderful thing about the block granting of the TANF dollars is it allows States the flexibility to set up new and innovative programs. There are so many States that have set up different ways to do it, but there is one problem in the existing law. It did not require the States to develop a case record of every person.

What should be done, I believe very strongly in the new reauthorization of TANF, is that every State, every person that is still on TANF has to have a history and a plan of work and education and also development, and it should be based upon 40 hours every week. You should be able to do that, and I think you would be able to enhance, you know, the benefits for the recipient, but I think

you would also make great progress in moving more people into work and in better jobs.

If you follow that record and follow that history, you should be able to develop a better plan for individuals; and with the declining caseload it seems to me that is where we should be putting some emphasis in the next reauthorization bill.

Mr. CAMP. I appreciate that; and just quickly, because I want to give other people some time as well, I appreciate the principles you laid out on Medicare reform.

Mr. THOMPSON. Thank you.

Mr. CAMP. Also, that any recipient could stay with the current system if they chose to. I think that is an important point to make. No one would have to opt for changes if they didn't want to.

Mr. THOMPSON. That is correct.

Mr. CAMP. Thank you. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The gentleman from Wisconsin, Mr. Kleczka, wish to inquire?

Mr. KLECZKA. Thank you, Mr. Chairman.

Mr. Secretary, if I could start out by making an observation, it wasn't too long ago when you were Governor of the State of Wisconsin, and the State had a small surplus, and you sent checks out to all the taxpayers. Then last year, when you are part of this Administration, we thought we had a surplus, and we sent checks back to all the taxpayers. Well, now, as you well know, the State of Wisconsin has a rather large deficit, $1.2 billion, and now as you come here before the Committee and testify, this budget puts us back into a deficit. Now, I don't really think you are a jinx, Governor, but there is some real bad luck following you around, Okay?

Mr. THOMPSON. I have been congratulated over here, and I am being criticized now for the——

Mr. KLECZKA. I am just trying to make this observation, that there is some bad luck following you around. But, on a serious note, I have to believe that the Administration voiced——

Mr. THOMPSON. I just would like to point out that I vetoed the first bill that the legislature passed to send back the checks. Then they went back and passed another one instead of having it vetoed, so you know that.

Mr. KLECZKA. Right. But there is a deficit of $1.2 billion.

But I think I recall that the Administration did voice support for the Breaux-Frist Medicare reform bill which provides for a voucher or some of us say a premium support plan wherein the seniors are going to get a fixed dollar amount and have to go shopping in the private market for a health insurance plan. I just recall as I sit here the words of former Speaker Gingrich who indicated that his goal was to have Medicare wither on the vine, and I think if we ever go to that system you are going to see that Medicare is going to be slowly phased out. So for those of us who fear that once that system comes on board that we are going to privatize Medicare, I think those fears are genuine, and I think that criticism is right on the mark.

What the Committee Republicans tried to do was partially privatize Medicare with this thing they called Medicare Choice, and I think it is time that, instead of slugging another $4 billion into Medicare Choice, we admit it is a failed experiment.

I can only point out to the Milwaukee experience wherein the seniors there in their Choice plan, one of the remaining Choice plans, didn't pay a deductible, and this company came and indicated, well, now we are going to put into the policy a—was it $350 hospital deductible for the seniors? And they just blew a gasket and, you know, thanks to the hard work of Mr. Scully, they did come to their senses and drop it somewhat.

But, nevertheless, the GAO came before this Committee early last year, and they indicated point blank that the Medicare Choice program is costing Medicare more dollars than the fee-for-service. Now, the Chairman of the Health Subcommittee, Ms. Johnson, can try to remake history, but that is exactly what the GAO told us.

So my plea to you and to our Health Subcommittee, which will be meeting on this issue shortly, is to admit defeat. The Medicare choice program did not work. Over a half a million, 500 million I think——

Mr. THOMPSON. Five——

Mr. KLECZKA. Five-hundred million seniors have already exited the program knowing full well it is not to their benefit, and let us admit the mistake and move on.

Now as far as the drug benefit, everyone is talking today about the need for a drug benefit as part of Medicare. Well, the rhetoric doesn't match the facts. The program that this Committee passed out 2 years ago provided for a drug benefit run by the insurance companies. When we asked the insurance companies whether or not they wanted to participate in this, all of them said, no; and I think later on one said, maybe. So that was the Republican drug benefit.

As I look at this budget, what we are talking about is a welfare drug benefit. Now there are no other portions of the Medicare Program shared with the States. This is a Federal initiative. I think if we are going to be honest with our seniors, some 30, 35 million seniors, let us provide for a drug benefit as part of the Medicare Program just like we provide for physicians care, just like we provide for hospital care, and forget this stuff about just a welfare program. Because the Medicare Program was never meant to be a welfare program, and I don't think that we should change it at this juncture.

So those are the observations, Mr. Secretary, that I wanted to make to you. Hopefully, we can work together over the coming months to make the program better but to leave in place the guaranteed benefit of a Medicare Program. If we are going to start shifting these folks to the private market like we tried in the Medicare Choice, we are going to go back to where we were 35 years ago, where 50 percent of the seniors in this country didn't have any health care insurance because they couldn't afford it. If we tamper with that guaranteed Medicare benefit, that is exactly, Mr. Chairman, where we are going to be headed. Thank you very much.

Chairman THOMAS. The gentleman's time has expired.

Mr. THOMPSON. Congressman——

Chairman THOMAS. For accuracy in the record, the Chair would like to note that former Speaker Gingrich's statement about withering on the vine was in reference to HCFA or the Health Care Fi-

nancing Administration. And, lo and behold, rather than withering on the vine, there was a mercy killing under this Administration.

With that, the last Member that the Chair would recognize prior to the two votes carrying us to noon would be the gentleman from Minnesota, Mr. Ramstad.

Mr. RAMSTAD. Thank you very much, Mr. Chairman.

Like my colleague, Mr. Kleczka, I agree that you did a great job as Governor of Wisconsin and you are doing a great job as Secretary of Health and Human Services, especially for a guy from Wisconsin.

Mr. THOMPSON. Thank you, Congressman.

Mr. RAMSTAD. But as my neighbor and long-time friend, Mr. Secretary, you know that our States are penalized by the Medicare managed care reimbursement formula, a formula that defies logic by rewarding high-cost, inefficient health care States. I notice that the President's budget includes some reforms for Medicare+Choice that will improve conditions but unfortunately stop short of the comprehensive reform that is needed. Why doesn't the Administration support looking at more a comprehensive reform that includes reimbursement reform?

Mr. THOMPSON. Congressman, I wish I had a simpler answer for you. I don't. I think that the only way we are going to be able to do that is to get involved in restructuring Medicare and strengthening it and taking care of those discrepancies that you talked about for Minnesota and Wisconsin and Iowa and a lot of rural States in which their reimbursement formulas are under what other individuals get. It is going to require dollars, but with the limited dollars that we had we wanted to structure a Medicare benefit for pharmacy and for drugs, and we also felt that that was the best thing.

We also wanted to keep the Medicare+Choice plans as viable as we could within limited dollars we had, and that is the reason, sir.

Mr. RAMSTAD. I understand those limited dollars, but the current disparities are just an unconscionable outrage for Minnesota seniors, Wisconsin seniors, Iowa, North Dakota, and South Dakota. Those more rural States—Washington State. They are just so inequitable to those seniors and States that have been delivering health care in a cost-effective way. We are being penalized——

Mr. THOMPSON. Absolutely.

Mr. RAMSTAD. And that makes no sense. Just as I said earlier, it defies logic.

The other question I had, I was encouraged to see a strong commitment to addressing the problem of access to substance abuse treatment. The President's budget calls for an increase of $127 million as a first step to close the treatment gap to serve an additional 52,000 Americans suffering from addiction. I hope Administration, and I am sure you do, realizes that this is a small step, that last year 3½ million drug addicts, drug addicts according to the Office of Drug Control Policy, 3½ million drug addicts were denied treatment for lack of access in this country. So to give 52,000 Americans treatment is a step in the right direction, but the American Medical Association (AMA) tells us there are 26 million alcoholics and addicts in this country. Until we go to parity for chemical dependency treatment in the private sector as well as mental health treat-

ment, we are not going to solve this problem. Is there any consideration of supporting chemical dependency treatment parity?

Mr. THOMPSON. Yes, there is, Congressman, and we are looking at that. This Administration, the President feels very strongly about it, and that is why he put that $127 million in there. There are limited resources, but this is indicating that this is a priority of this Administration, and we want to make sure that we provide for improving chemical and drug treatment as well as mental health in this country. We also wanted to do this by putting in the $127 million and trying to get away from the disparity that now exists.

Mr. RAMSTAD. I am so heartened to hear you say that, Mr. Secretary. The AMA declared in 1956 addiction and alcoholism are a disease; and if you accept that, which I think most Americans do, you can't justify the discrimination against treatment of this disease vis-a-vis all other physical diseases. So thank you very much for that recognition and your efforts.

Chairman THOMAS. Thank the gentleman. The Chair would note we have less than 5 minutes on the vote.

Mr. Secretary, there are Members on both side of the aisle on this Committee that wish to ask you questions. We will make sure that they submit them in writing, and we would appreciate a relatively rapid response to those questions.

With that, the hearing is adjourned.

[Whereupon, at 11:40 a.m., the hearing was adjourned.]

[Questions submitted from Messrs. Houghton, McInnis, Foley, Doggett, and Mrs. Thurman to Secretary Thompson, and his responses follow:]

Questions Submitted by Representative Amo Houghton

Question:

The President has proposed $77.1 billion over 10 years for States to offer prescription drug coverage for low-income seniors. As you know, some States already have significant programs in existence; for instance, New York covers seniors with individual incomes up to $35,000 and families of two up to $50,000 (approximately 300 and 400% of the Federal poverty level, respectively). Would this new proposal allow States like New York to use the new Federal money in place of current expenditures (and free up money for other health initiatives) or would they only be allowed to use the new Federal assistance for further expansion of current programs?

Answer**:**

Yes. The new Federal money may be used in place of current expenditures. While the administration would encourage that it be used for further expansion of current programs, it is not a requirement. As I've stated at previous hearings, this administration is committed to ensuring that beneficiaries receive the high quality care they need and deserve, including prescription drugs, and we want to continue to work together to develop a comprehensive prescription drug benefit.

Question:

I applaud you and the administration for not proposing any further cuts to providers—my rural district in upstate New York is still struggling with BBA cuts. I look forward to working with the Administration to ensure quality care for these fragile areas. There's a part in the budget proposal that I believe states that any payment adjustment to providers should be budget neutral—could you clarify? Is that budget neutral among just the provider pool?

Answer**:**

The Administration shares your commitment to ensuring quality of care for all Medicare beneficiaries, including those in America's rural areas. You are correct, the

administration's budget proposal does state that any adjustment to providers be done in a budget neutral manner across all providers. So if increasing payment to one type of provider is on the table, then we think adjusting other provider payments should be as well. We believe that any such change should be undertaken carefully to ensure that we do not adversely impact beneficiaries' access to care.

Question:

I applaud you and the administration for your proposal to continue funding levels of the TANF block grant, despite the reduction in case load—I think that will allow states to take "the next step" in continuing the success of welfare reform. Can you expand on what general improvements the Administration would like to see made to welfare program?

Answer**:**

On February 26, President Bush announced the administration's proposal to build on the successes of the Temporary Assistance for Needy Families (TANF) program. The President's welfare reform agenda will strengthen families and help more welfare recipients work toward independence and self-reliance.

Key components of the President's welfare reform proposal include helping welfare recipients achieve independence through work by increasing the minimum work requirements. Under current law, at least 50% of welfare families are required to participate in work and other activities designed to help them achieve self-sufficiency. The President's plan phases out the caseload reduction credit (which significantly reduced current state work participation requirements) and increases the work requirement by five percentage points each year until reaching 70% in FY 2007.

The plan also requires welfare recipients to be engaged in work activities for 40 hours per week, either at a job or in programs designed to help them achieve independence. At the same time, the President wants to give states more flexibility to count education, job training or substance abuse treatment as work. Therefore, the proposal would require that only 24 hours be spent in the workplace. The additional 16 hours could include training, education and other activities related to a TANF purpose, as determined by the state. States have broad latitude to define these additional constructive activities. The plan makes special accommodations for parents with infants, teenage mothers attending school, and individuals who need substance abuse treatment, rehabilitation or special work-related training.

The Administration also proposes to strengthen child support enforcement by encouraging states to give child support payments to custodial parents and their children. Under current law, government keeps a substantial portion of the money collected to pay child support in cases of families that have ever received welfare. The President's proposal provides financial incentives for the states to give as much of this money as possible to families, especially to parents who have left welfare.

Our proposal embraces the needs of families by promoting child well-being and healthy marriages. To this end, we establish improving the well-being of children as the overarching purpose of TANF. This meaningful change recognizes that the four current goals of TANF (providing assistance to needy families so that children may be cared for in their or their relatives' homes, ending the dependence of needy parents on government benefits, preventing and reducing the incidence of out-of-wedlock pregnancies, and encouraging the formation and maintenance of two-parent families) are important strategies for achieving this purpose. Similarly, we clarify and underscore that the fourth goal of TANF is to encourage the formation and maintenance of healthy, two-parent, married families and responsible fatherhood. In a new initiative, the President's plan directs up to $300 million for programs that encourage healthy, stable marriages. These programs include pre-marital education and counseling, as well as research and technical assistance into promising approaches that work.

Finally, the proposal encourages innovation by states to help welfare recipients achieve independence. New waiver authority would be established to enable states to integrate a range of programs in order to improve their effectiveness. This new flexibility will help states design fully integrated assistance programs that could revolutionize service delivery. Under the President's proposal, states would be given the flexibility to streamline and coordinate support programs—such as food stamps, childcare, income supplements and transportation assistance—which now operate under different agencies, different rules, and different reporting requirements. Although the waivers will allow new flexibility, States will remain accountable for program performance and will be required to develop integrated performance goals, measures and evaluation criteria. The integrated programs must meet the underlying objectives of the involved programs.

Questions Submitted by Representative Scott McInnis

Question:

Mr. Secretary, your Medicare budget document notes that you recognize that "Medicare's extremely complex provider payment systems, based on regulated prices, do not always function smoothly and equitable over time." The document also states that you are willing to work with Congress to reform payment policy by making "budget neutral adjustments across provider payment updates." Does this mean that some providers will benefit and others will not? I represent a number of rural areas in Colorado with small community hospitals as well as some larger hospitals in more urban areas. Mr. Secretary, can you explain how changes in hospital payment updates for Fiscal Year 2003 are going to impact these different sectors in health care?

Answer:

As you may know, the hospital market basket update is set into law at market basket minus 0.55 for FY 2003. It should be noted that since the inception of inpatient PPS, hospitals have only once received a full market basket update (FY 2001). Given this, the hospital industry overall has faired well. In 1997, the inpatient PPS margin rose to a historical high of 16.0 percent. Although there was a decrease in 1999 to a 12.4 percent margin, the inpatient hospital margins still remain very high. Hospitals in large urban areas are fairing better than those in smaller urban areas and in rural areas. There are several proposals that address this issue including MedPAC's upcoming recommendation of an update of market basket minus 0.55 for large urban areas and a full market basket update for hospitals in all other areas. As we move forward, we need to explore such proposals and continue to ensure that hospitals are paid appropriately, regardless of their location.

Questions Submitted by Representative Mark Foley

Question:

Do you have any recommendations on how to get more Federal money to hospitals for the care they provide to illegal aliens?

Answer:

Historically, Medicaid, like other federally funded entitlement programs, has never been allowed to cover "illegal" or "undocumented" aliens. It is generally limited to legal immigrants who intend to remain in the United States permanently. The Personal Responsibility and Work Opportunity Reconciliation Act 1996, in addition to reforming the nation's welfare programs, tightened up longstanding immigration laws to ensure that legally admitted aliens can support themselves without turning to publicly supported programs. The law prohibited new entrants from receiving Medicaid benefits for 5 years after entry. The President has indicated that he does not intend to pursue a change in this 5-year prohibition as part of the reauthorization of the 1996 law.

There are very limited circumstances in which hospitals can be paid by Medicaid for services provided to illegal aliens. States are required to cover emergency services for all aliens who meet all other Medicaid eligibility requirements. This includes people in the country illegally, as well as non-citizens in the United States legally, but barred from Medicaid for some other reason. "Emergency services" are those needed immediately to treat conditions of sudden, unpredictable onset that have possible serious health outcomes.

Questions Submitted by Representative Lloyd Doggett

Question:

Since nicotine addiction is the leading cause of preventable death in America today, what new initiatives have you undertaken as Secretary to reduce this public health epidemic?

Answer:

In fiscal year 2002, the Department of Health and Human Services (HHS) increased its commitment to funding tobacco control programs by 7 percent, for a total of $975 million. The National Institutes of Health's (NIH) tobacco control research budget increased by 14 percent to $486 million. Listed below are additional initiatives I have been pleased to be part of:

- An initiative to increase awareness of tobacco use among women and girls. In August, Women and Smoking: A Report of the Surgeon General was released. HHS and our public and private partners have undertaken this initiative to engage women across the country in the fight against tobacco.
- I have taken a number of steps to increase the visibility and coordination of tobacco use cessation and treatment initiatives throughout HHS. The Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), NIH and the Substance Abuse and Mental Health Services Administration have all collaborated on the development of a national blueprint for disseminating and implementing evidence-based clinical and community strategies to promote tobacco use cessation.
- I have asked the Office of the Surgeon General and CDC to establish a cessation sub-committee to the Interagency Committee on Smoking and Health.

Question:

Tom Novotny, a 23-year employee of your Department was the leader of the US delegation to the International Framework Convention on Tobacco Control (FCTC). Since the August 2001 announcement of his departure, has the US delegation taken any position on any pending public health issue at variance with the position of the tobacco industry? Is so, please describe them.

Answer:

HHS is committed to a strong FCTC. Dr. Kenneth Bernard now serves as the head of the US delegation. Dr. Bernard brings to the delegation a wealth of public health, international, and diplomatic experience. Under Dr. Bernard's leadership, the process for developing the US position has remained unchanged. An experienced and active interagency workgroup, comprised of highly qualified professionals from across the Federal government, is the primary vehicle for discussion and debate. In addition, Dr. Bernard and other members of the interagency workgroup have met with a variety of private organizations interested in the FCTC. These organizations include tobacco product manufacturers as well as non-governmental health advocacy organizations. While it is essential that the delegation be informed regarding the issues and concerns of all interested parties, the position of the U.S. Government is developed through independent and objective analysis. This position is being developed to ensure an effective framework for reducing tobacco use globally. We continue to believe that the Member States of the World Health Organization must work together to achieve a convention the majority of members can sign. The FCTC will be a strong convention because of its breadth and the large number of members who sign it.

Question:

In your July 2001 response to my prior questions regarding the involvement of your Department in deliberations of an interagency working group related to tobacco trade matters, you stated that HHS played an advisory role in discussions between the United State Trade Representatives (USTR) and the Government of the Republic of Korea regarding the privatization of the Korean Government's tobacco monopoly and the imposition of import tariffs on cigarettes. Specifically, you stated, "In considering the potential public health impact, HHS has focused on whether the proposed policies would increase demand for or reduce the price for tobacco product."

Did your Department conclude that public health would not be adversely affected by any reduction or delay in the imposition of the 40% tobacco import tariff proposed by the Korean government?

Please also provide a full description of HHS analyses and conclusions on this matter, along with any and all documentation. Include in this a complete listing of all agencies and employees within your Department that were involved.

Answer:

HHS is actively involved in the implementation of Executive Order 13193—Federal Leadership on Global Tobacco Control and Prevention. HHS was involved in the interagency discussions of proposed changes to the Korean Tobacco Business Act and privatization of the Korean Government's tobacco monopoly. HHS' position in these discussions was based on scientific findings that demonstrate increasing the price is one of the most effective ways to decrease consumption of tobacco products. Based on this scientific evidence, HHS supports policy actions that increase the price of tobacco products. Therefore, the U.S. position in the discussions with Korea was consistent with public health goals because the tariff on tobacco products was increased.

Question:

Aside from the Korean trade proceedings, has the USTR invited your Department to offer advice on any other tobacco-related matters? If so, provide a complete listing of each instance along with a description of the circumstances and include any analyses and conclusions developed by your Department. Include in this material a complete listing of all agencies and employees within your Department that were involved in developing your advice.

Answer:

Since July 2001, USTR has consulted HHS on three matters.

- In September 2001, the USTR considered a request from the Government of Indonesia to designate 12 additional products for benefits under the Generalized System of Preferences (GSP). Tobacco was initially one of the 12 products. HHS recommended excluding tobacco from the list of products for which GSP was granted. After interagency deliberation, tobacco was excluded.
- In February 2002, USTR contacted HHS regarding a request for guidance from the Embassy in Warsaw, Poland regarding correspondence from Phillip Morris that expressed concern over a government of Poland proposal to raise the tariff on unprocessed tobacco from 30 percent to 105 percent. USTR indicated that their recommendation was that Embassy in Warsaw not make representations to the government of Poland. HHS concurred with this recommendation.
- USTR requested HHS participation in an interagency meeting as part of the ongoing negotiations on the U.S. Chile Free Trade Agreement. Dr. Stuart Nightingale represented HHS at this meeting, and presented positions developed by CDC in consultation with the U.S. Department of Agriculture. As an adviser to USTR in these matters, HHS requested that its position be noted in all public discussions of the U.S. position, including the summary of the discussions that will be made available to the public at the close of negotiations, as required by Executive Order 13193. Because negotiations are ongoing, this information is considered deliberative. For further information, please contact John Veroneau, Assistant U.S. Trade Representative for Congressional Affairs, who can set up a briefing for a member of your staff with the appropriate clearance.

Question:

I was also pleased to hear from you that your Department, in accordance with section 2(c) of Executive Order 13193 "Federal Leadership on Global Tobacco Control and Prevention," has made progress with international tobacco control needs assessments. In your July 2001 correspondence with my office, you stated that the CDC would produce the first report on the People's Republic of China by December 31, 2001.

Please provide me with a copy of this report. In addition, please update me on the status of the needs assessment on India, which in your July 2001 letter you stated would be ready for peer-review early this year.

Answer:

I am pleased to report that significant progress has been made on the international tobacco control needs assessment. Although the complexity of the tobacco control situation in China and the challenges of coordinating a global peer review process has resulted in some delay, the report currently is undergoing final review. As soon as the report has been finalized, we will provide you with a copy. With respect to the report on India, work has already begun and we project the report will be completed by the end of the year. CDC staff will be in India in April and will use this opportunity to continue discussions with Indian officials and researchers working on the report to advance its progress.

Question:

Regarding section 2(d) of Executive Order 13193, you stated that the National Institutes of Health (NIH) worked collaboratively with the World Health Organization to issue a Request for Application (RFA) that would solicit research projects on the global burden of tobacco use. Please provide me with a detailed description of any responses to that RFA. Also, please update me on the progress you have made since July 2001 in implementing this initiative.

Answer**:**

NIH's International Tobacco and Health Research and Capacity Building Program is a unique Fogarty International Center program developed in cooperation with several other NIH institutes, including the National Cancer Institute and the National Institute on Drug Abuse. The NIH received 62 applications in response to the RFA. These grant applications were reviewed on March 4 and 5 by an NIH Special Emphasis Panel, organized by the National Cancer Institute, that included scientists with special expertise in tobacco control issues globally. Once scores are available, the Fogarty International Center, and its collaborating partners, will prepare a funding plan based on the number of applications of high scientific merit and available funds.

Questions Submitted by Representative Karen Thurman

Question:

My question is simply this, given these circumstances, how do you expect states like Florida to pay for the President's Pharmacy Plus program?

Answer**:**

The President's budget includes two low-income drug proposals. Under the Transitional Medicare Low-Income Drug Assistance program, starting in FY 2003, the Administration proposes to expand drug coverage for low-income Medicare beneficiaries. States could expand drug only coverage to Medicare beneficiaries up to 100 percent of poverty at regular Medicaid FMAP. This should be considerably less expensive than providing the entire Medicaid benefit package. For individuals between 100 and 150 percent of poverty, Medicare would pay 90 percent of the costs of the drug only benefit and States would be responsible for the remaining 10 percent. Starting in FY 2006, the President's budget proposes a comprehensive Medicare modernization program that includes a prescription drug benefit for all Medicare beneficiaries. Federal support for comprehensive drug coverage for low-income beneficiaries would continue even after the Medicaid drug benefit is fully implemented, and would be integrated with it. There would be subsidies for premiums and cost sharing for the low-income.

While the Transitional Medicare Low-Income Drug Assistance program requires new legislation, States can implement the Administration's new Pharmacy Plus model waiver demonstration program right now. Pharmacy Plus is HHS' response to states' desires to initiate responsible solutions to a growing need for pharmaceutical access. Pharmacy Plus contains a check off application, model terms and conditions and a budget neutrality shell to guide states through the process of preparing and submitting a request for Medicaid Section 1115 demonstration authority to expand pharmacy only coverage. This initiative is intended to provide States with flexibility to design programs that meet the needs of state-specific populations, while guidance is provided up front on what HHS will require of states.

While states can provide drug benefits to the elderly with incomes below 100 percent of the poverty level, they must provide the entire Medicaid benefit package and cannot limit Medicaid coverage just to a drug benefit without a waiver. Without Pharmacy Plus, to provide drug benefits to this group, states would have to provide the full range of Medicaid-covered services as well. This would be very expensive, and many states don't have the funds available to provide that kind of coverage to a larger client population.

The Medicaid Pharmacy Plus waiver templates that CMS is providing as a companion to the President's Transitional Medicare Low-Income Drug Assistance budget proposal will help states get to the starting line of 100 percent of poverty if they are not already there.

Question:

I think many of my colleagues on both sides of the aisle have heard from their constituents that they simply cannot pay for their prescription drugs because they are just too expensive. Can you assure me that the President will be able to force manufacturers to provide a genuine discount to Medicare beneficiaries, and that the local pharmacist will not have to take a cut in their margin?

Answer**:**

The Administration highly values the important role pharmacists play in the lives of Medicare beneficiaries. It is extremely important to the President that this key role be preserved under the Medicare-endorsed drug assistance initiative. The initiative is designed to expand beneficiary access to the range of important services pharmacists provide beyond filling prescriptions, including counseling, information on the benefits of generic substitution, and identification of dangerous drug interactions.

The proposed design of the Medicare-endorsed Prescription Drug Card Assistance Initiative would deliberately move the discount pressure of the current discount card market away from pharmacies and toward manufacturer rebates and discounts. The Medicare-Endorsed Prescription Drug Card Assistance Initiative would pool market power to allow card sponsors to negotiate rebates or discounts with *manufacturers*. Medicare beneficiaries would belong to only one card program at a time, and would be allowed to switch card programs every 6 months. These two attributes of the proposed drug card initiative would give card sponsors the power to effectively negotiate with manufacturers for rebates.

Question:

Mr. Secretary, is there anything in the President's budget that keeps these plans from taking the money and running away with it in the following year?

Answer**:**

Let me assure you, I am committed to improving the Medicare+Choice program and seeing that it remains a viable option for Medicare beneficiaries. I, too, was troubled by the number of plan departures last year and this administration is committed to bringing stability to this program.

As you know, since 1998, payment increases for private plans have failed to stay anywhere close to medical cost increases in many parts of the country—the so-called "non-floor" counties that have accounted for the vast majority of Medicare+Choice enrollment. Between 1998 and 2002, private plan payments in these areas increased by just 11.5% while Medicare fee-for-service costs (government plan costs) went up by 22%—almost twice as much. It is no wonder the plans are having to cut benefits, raise copayments, and even pull out of the program—creating serious problems for the beneficiaries who depend on them.

Even with all the problems caused in recent years by the unfair payment system for private plans, there are still over 5 million Medicare beneficiaries enrolled in private plans—so for many seniors, private plans are the best option. Indicators of care quality and enrollee satisfaction in these plans are high. And even after the recent cutbacks in benefits, they can still be a better deal for seniors than enrolling in traditional Medicare and buying an expensive supplemental policy to cover the large benefit gaps.

We support a fairer payment system for private plans in Medicare because the current payment system is causing seniors to lose access to valuable benefits and is clearly hurting the quality of care they receive. I look forward to working with you on this important issue in the coming months.

Question:

Mr. Secretary, given the track record of Florida's high risk pool and the fact that premiums for risk pool enrollees are typically over 250% higher than for group insurance, do you think the President's tax credit proposal will provide enough coverage to enrollees? And, Mr. Secretary, how is Florida going to pay for reopening their already bankrupt high risk pool?

Answer**:**

The Administration's proposal creates a refundable income tax credit for the cost of health insurance purchased by individuals. The credit provides a subsidy of up to 90 percent of the health insurance premium, up to a maximum credit of $3,000 for a family of four. The credit is targeted toward lower income individuals and families who do not get coverage through their employer or a public program—since

they are more likely to be uninsured and do not benefit from the existing tax subsidy for employer-provided insurance.

To increase the purchasing power of this credit, qualifying health insurance could be purchased not only in the individual market, but also through private purchasing groups, state-sponsored insurance purchasing pools and state high-risk pools. High risk pools exist in 29 states and for people with serious illnesses they can provide an important vehicle to obtain quality insurance that provides comprehensive coverage. The credit would make premiums more affordable for those already getting coverage in a high-risk pool, but by their nature such pools do generally require state subsidies to cover their costs.

Recognizing that states with high-risk pools may not decide to expand their availability—and that many states do not have high risk pools—the President's proposal gives states additional options. In particular they will have the option of letting certain individuals use the credit to buy into privately contracted state-sponsored purchasing groups—such as Medicaid or SCHIP purchasing pools for private insurance, or state government employee programs (for states in which Medicaid or SCHIP does not contract with private plans). Overall this proposal will permit up to 6 million Americans who would otherwise be uninsured during a year get coverage, and will support many more lower income working families who must currently purchase health insurance with little or no government help.

Question:

The 15 percent cut. Are you or the President against eliminating this cut?

Answer**:**

The President's budget assumes no further delay in the implementation of the "15-percent reduction" in home health interim payment system (IPS) limits. As you may know, this reduction is somewhat of a misnomer. It does not translate into an across-the-board, direct cut in Medicare payment rates for home health services, as many have described it. Rather, the 15-percent reduction is a decrease in the payment caps under the old IPS. The actual percentage reduction in payments that will result from lowering the limits is much less. In fact, the CMS actuary estimates that the 15-percent reduction will only reduce payments to home health agencies by about 7 percent, not 15 percent. Further, after the PPS rates are reduced by 7 percent, we would apply the home health update (currently estimated to be 2.1 percent), leading to a net reduction of approximately 4.9 percent.

Home health spending is expected to rise by 42 percent for FY 2002. Even if the 15 percent adjustment occurs, we estimate that home health spending would increase 12 percent in FY 2003, 8.3 percent in FY 2004, and 7.8 percent in FY 2005. Therefore, we do not believe a repeal of the 15 percent adjustment in the caps is necessary.

Question:

Do you or the President support increasing the composite rate for dialysis facilities by 2.4 percent?

Answer**:**

I appreciate your special concern for the state of dialysis facilities. I share your concerns and am committed to providing the best possible care for all Medicare beneficiaries, including those with dialysis needs. To this end, we have been working to improve quality and to strengthen the conditions of coverage at dialysis facilities. For example, we are working to implement an electronic system to measure the appropriateness of care delivered at individual dialysis centers. We are also developing measures to improve the performance and accountability of ESRD Networks and State survey agencies. Furthermore, to increase options for ESRD beneficiaries, we have recently completed a demonstration project involving Medicare+Choice and we expect to have the results of an independent evaluation of the project by the end of the year. Although we are working to improve dialysis for Medicare beneficiaries administratively, changing the composite rate, as MedPAC recommends, would require legislation. There are a number of ideas on the table for addressing Medicare provider payment adjustments. The Administration is committed to working with Congress to make adjustments to provider payments that are budget neutral overall. We look forward to examining all of MedPAC's forthcoming recommendations and working with Congress on this issue.

Question:

Have you changed your mind, or will you seek to address medical errors this year?

Answer:

This is a high priority for this Administration and for me. A number of steps are being taken by this Administration to reduce medical errors and improve patient safety.

Last year, I created a Patient Safety Task Force, with the Centers for Medicare and Medicaid Services (CMS) as an active participant. Currently, CMS is working with its Federal agency partners—the Agency for Healthcare Research and Policy, the Centers for Disease Control and Prevention, and the Food and Drug Administration, as well as with the Veterans Health Administration's National Surgical Quality Improvement Project, to develop the Medicare Patient Safety Monitoring System. The task force recognizes and stresses the importance of partnerships—within HHS, across the Federal government and with the private sector and health care professionals.

The aim of the system is to produce state and national rates of patient harm and the risk factors that contribute to the harm among hospitalized Medicare beneficiaries. The system is scheduled to be in production in June 2002 with the initial reports ready by October 2002.

In addition, CMS is supporting special studies on patient safety by the New York and Ohio Quality Improvement Organizations (QIOs, formerly PROs). Also, several QIOs are carrying out local projects in patient safety. For example, the Wisconsin QIO is working with a statewide coalition to implement best practices to improve medication safety in Wisconsin hospitals. The Ohio QIO also has implemented a project in falls prevention in hospitals using safety culture surveys, root cause analysis tools as well as probabilistic risk assessment tools and the Alabama QIO is working to improve medication safety in dialysis centers.

[A submission for the record follows:]

Statement of AdvaMed

AdvaMed is the largest medical technology trade association in the world, representing more than 800 medical device, diagnostic products, and health information systems manufacturers of all sizes. AdvaMed member firms provide nearly 90 percent of the $68 billion of health care technology products purchased annually in the U.S. and nearly 50 percent of the $159 billion purchased annually around the world.

AdvaMed strongly supports the Presidents commitment to the protecting and preserving the Medicare program, increasing medial research through funding for the National Institutes of Health (NIH) and extension of the research and experimentation (R&E) tax credit, improving access to technologies for people with disabilities, and expanding access to health care coverage for the uninsured. We look forward to working with the Administration to ensure that the medical research developed by the government and in the private sector not only improves the quality of the care delivered to patients in all settings and programs, but also the productivity of the health care system itself.

With great interest, we noted that during President Bushs State of the Union address, the President mentioned the need to ensure Medicare beneficiaries access to the latest health care options. As the Committee knows, and has tried to address legislatively, Medicare is often too slow to incorporate technologies and methods of delivering care. These time delays frustrate the programs ability to provide the most cost-effective, high-quality care to Americas seniors and individuals with disabilities.

We believe it is in the best interest of patients and the Medicare program to have the Medicare system capitalize on advanced technologies, which have revolutionized the U.S. economy and driven productivity to new heights and new possibilities in many other sectors. Significant advances in health care technologies—from health information systems that monitor patient treatment data to innovative diagnostics tests that detect diseases early and lifesaving implantable devices—improve the productivity of the health care system itself and vastly improve the quality of the health care delivered. New technologies can reduce medical errors, make the system more efficient and effective by catching diseases earlier—when they are easier and less expensive to treat, allowing procedures to be done in less expensive settings, and reducing hospital lengths of stays and rehabilitation times.

Medicare Beneficiary Access to Technology

AdvaMed applauds Congress for the steps it took in the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act (BIPA)

of 2000 to begin to make the Medicare coverage, coding and payment systems more effective and efficient. In addition, the Centers for Medicare and Medicaid Services (CMS) has recently made some changes to modernize its coverage and payment systems.

Despite these efforts, however, current policies still fail to keep up with the pace of new medical technology. Serious delays continue to plague the amount of time it takes Medicare to make new medical technologies and procedures available to beneficiaries in all treatment settings.

As demonstrated by a Lewin Group report provided by AdvaMed to the Congress in 2000, Medicare delays can total from 15 months to five years or more because of the program's complex, bureaucratic procedures for adopting new technologies. Keep in mind that all this is after the two to six years it takes to develop a product and the year or more it takes to go through the Food and Drug Administration (FDA) review. In addition, these delays are even more pronounced when you consider that the average life span of a new technology can be 18 months.

The impact on patients has been dramatic. As physician witnesses testified in Congress last year, cancer patients have had to fight for years to get Medicare to cover positron emission tomography, a potentially lifesaving scanning technology that has been broadly available to people under private health insurance for a decade. In addition, tens of thousands of seniors and people with disabilities have not been able to receive advanced technologies like coronary stents (which reopen blocked arteries), cochlear implants (which restore hearing) and heart assist devices (which keep patients alive while waiting for a heart transplant).

These delays stem from the fact that for a new technology to become fully available to Medicare patients, it must go through three separate review processes to obtain coverage, and receive a billing code and payment level. Serious delays in all three of these areas create significant barriers to patient access.

That's why we strongly support provisions based on language from H.R. 2973, the Medicare Innovation Responsiveness Act introduced by Representatives Ramstad (R-MN) and Thurman (D-FL), and incorporated in HR 3391, the Medicare Regulatory and Contracting Reform Act developed with the leadership of this Committee, that would create a council for technology and innovation within CMS to oversee and coordinate Medicare coverage, coding and payment decisions on new technologies and require a GAO report on ways CMS can make better use of external sources of data to expedite hospital inpatient payment updates.

As the Senate continues work on this legislation, we look forward to Congressional receipt of the first annual BIPA-required report that was due December 1, 2001, on the time taken by the Secretary to make and implement necessary coverage, coding, and payment determinations for newly covered items, services, or medical devices.

Making Medicare's Coverage Process More Transparent and Timely

While CMS has improved the transparency for making national coverage decisions and attempted to instill timeframes within the process, timeliness is still a major problem. Under the current national coverage process framework, CMS has 90 days to determine whether it will make a coverage decision or refer the request to either the Medicare Coverage Advisory Committee (MCAC) or an outside health technology assessment (HTA) group—or sometimes even to both. These outside assessments take between 3 and 12 months each. CMS then has 60 days to review the recommendations of the MCAC or HTA, and should a positive coverage determination be made, it takes 180 days from the first day of the next calendar quarter to issue a code and set a payment level.

The coverage process should be streamlined and made more accountable, timely and transparent. Steps should be taken to reduce redundancies in the MCAC panel and HTA reviews. In addition, the focus of the MCAC panels should be directed toward gaining practical clinical advice from the medical experts on its panels.

Some of these issues were addressed in BIPA which requires CMS to act within 90 days of receiving a coverage decision request, to provide an avenue of appeals for affected parties, and to report annually to Congress, beginning December 1, 2001, on the coverage, coding, and payment timelines relating to the decisions made each year (noted above.) We have become increasingly distressed over the delay in implementing these provisions and request that the Committee urge CMS to implement BIPA without further delay.

These concerns at the national level highlight the importance of local coverage determinations in providing Medicare beneficiaries with access to new medical technology. Generally, about one dozen decisions are made a year at the national level;

compared to thousands made locally. We request that the Committee urge CMS to assure that it will continue to support local coverage decision-making authority.

Reforming the Coding Process

After coverage is approved, a coding process is used to determine how a device or procedure will be identified and to which payment bundle it will be assigned. There are three different coding systems, but each of them involves significant time lags in assigning and updating codes. Under the new hospital outpatient perspective payment system (PPS), CMS now assigns and updates codes on a quarterly basis. To reduce coding delays of 15-27 months, CMS should use the outpatient PPS system of quarterly updates as a model for applying similar systems to other settings, such as the inpatient hospital setting and doctors' offices.

Inpatient Prospective Payment System

Improving the timeliness and accuracy of Medicare payment adjustments to account for advances in medical technology and procedures used in the hospital inpatient setting remains an important priority for AdvaMed. An important provision in H.R. 2971, the Ramstad/Thurman bill, would address the concerns about inpatient reimbursement. Specifically, Section 5 of the bill would require the Secretary to assign items to an existing DRG if the national average base payment is at least equal to 90% of the cost of care involving the technology and within $2500 of the cost of such care. If no existing DRG satisfies these criteria, the Secretary would assign the technology to a New Technology DRG that does. We look forward to working with the Committee in 2002 to address concerns about timely inpatient technology access for Medicare beneficiaries.

Outpatient Prospective Payment System

The hospital outpatient prospective payment system (OPPS) has had a difficult time in these first two years of its implementation. One reason is that the type of data needed to construct the base Ambulatory Payment Classification (APC) groups is not easily obtained from historical claims submissions.

We believe that data inadequacies, as well as policies on incorporating resource costs associated with devices and medical technology will continue to be issues in the 2003 OPPS update, underway now. We request that the Committee urge CMS to:

- make this process open and transparent,
- share proposed data and methodology with interested stakeholders now during the development stages of the proposed rules
- define and accept additional sources of data, and
- work collaboratively to resolve issues before publishing the proposed rules.

Although the majority of new device categories under the pass-through payment system will sunset at the end of this year, this program, along with new technology APCs, provide important access for Medicare beneficiaries to innovation in the outpatient setting. CMS did not approve any new pass-through categories during the quarterly cycles since April 1, 2001. Some of the criteria established last fall for eligibility for a new pass-through category or new tech APC seem overly burdensome. We request that the Committee monitor this program, and urge CMS to be flexible.

Payment for New Clinical Laboratory Tests

Innovative diagnostic tests help saves live and reduce health care costs by detecting diseases earlier when they are more treatable. With today's advanced technology, testing can be performed in a variety of settings from large clinical reference laboratories to hospital outpatient labs, to physician offices, and even in patient's nursing homes.

Although BIPA substantially improved the processes for setting reimbursement rates for advanced diagnostic tests, serious flaws still exist, making it difficult for beneficiaries to gain access to many innovative technologies. That's why AdvaMed strongly supports provisions based on H.R. 1798, the Medicare Patient Access to Preventive and Diagnostic Tests Act introduced by Reps. Dunn (R-WA) and McDermott (D-WA) and incorporated in HR 3391 that would establish much needed procedures and criteria for determining reimbursement for new clinical laboratory tests. We are hopeful that similar provisions will be included in a companion bill in the Senate.

Conclusion

AdvaMed applauds Congress and the President for recognizing the value of medical research and innovation for improving the quality of care Americans receive. Innovative technologies can modernize and advance the efficiency of the Medicare program, and all other health care options, with early detection, better health care information technologies, less invasive procedures and devices. We look forward to working with Congress, the President and Secretary Thompson on ways to modernize Medicare, incorporating the benefits technology can bear, and furthering advances in medical research.