

**PRESIDENT'S FISCAL YEAR 2004 BUDGET FOR THE
U.S. DEPARTMENT OF HEALTH AND HUMAN
SERVICES**

HEARING

BEFORE THE

**COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES**

ONE HUNDRED EIGHTH CONGRESS

FIRST SESSION

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FEBRUARY 6, 2003
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**PRESIDENT'S FISCAL YEAR 2004 BUDGET FOR
THE U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES**

THURSDAY, FEBRUARY 6, 2003

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

The Committee met, pursuant to notice, at 9:42 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas (Chairman of the Committee) presiding.

[The advisory and revised advisory announcing the hearing follow:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE

CONTACT: (202) 225-1721

January 30, 2003

FC-3

Thomas Announces Hearing on the President's Fiscal Year 2004 Budget for the U.S. Department of Health and Human Services

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 2004 budget for the U.S. Department of Health and Human Services (HHS). **The hearing will take place on Thursday, February 6, 2003, 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 28, 2003, President George W. Bush delivered his State of the Union address, in which he outlined several legislative initiatives. The details of these proposals are expected to be released on February 3, 2003, when the President is scheduled to submit his fiscal year 2004 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, improving health care quality, 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."

FOCUS OF THE HEARING:

The focus of the hearing is to review the President's fiscal year 2004 budget proposals for HHS.

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, Thursday, February 20, 2003. Those filing written statements that 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 sealed-packaged deliveries to all House Office Buildings.

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. Any statements must include a list of all clients, persons, or organizations on whose behalf the witness appears. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers of each witness.

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.

NOTICE—CHANGE IN TIME

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE

CONTACT: (202) 225-1721

January 31, 2003

FC-3-Revised

Thomas Announces a Change in Time for the President's Fiscal Year 2004 Budget for the U.S. Department of Health and Human Services

Congressman Bill Thomas (R-CA), Chairman of the Committee on Ways and Means, today announced that the Committee hearing on the President's fiscal year 2004 budget for the U.S. Department of Health and Human Services, scheduled for Thursday, February 6, 2003, at 10:00 a.m., in the main Committee hearing room, 1100 Longworth House Office Building, **will now be held at 9:30 a.m.**

All other details for the hearing remain the same. (See full Committee Advisory No. FC-3, dated January 30, 2003.)

Chairman THOMAS. Good morning. First of all, I want to thank you, Mr. Secretary, and I want to thank the Members. I know there are a number of very important events that are going on, and Members manage their time and they prioritize, and Members have different needs and wants. This is an important Committee, and I am pleased that Members believe it so by their presence. You can talk a lot about what is or is not important, but when you spend your time, that is when you really know, and the Chair appreciates the Members' attendance.

Once again, we have the Secretary of Health and Human Services, former Governor Tommy Thompson. We look forward to his remarks. I do know that the Secretary has other obligations, and the Chair will attempt to conclude the hearing by 11:30 a.m., if at all possible.

One of the items that we will address early in this session is welfare, and I found it interesting that before the 1996 reforms, the average stay on welfare lasted what I consider to be an incredible 13 years, and as we now know, welfare rules actually discouraged work.

The changes that occurred turned the program around, increased work, boosted incomes, and significantly reduced child poverty and dramatically lowered dependency.

Our priority now, of course, is to help more people successfully transition to work. The House passed legislation to do that last year, but it did not get through all of the hurdles, including the Senate. Basically our Nation's major welfare program has effectively been on life support since September 2002. That is why there is some degree of urgency in acting.

In addition to that, as we heard during the State of the Union, the President has prioritized the improvement for seniors of Medi-

care and strengthening by adding a prescription drug benefit. Just as I indicated Members' presence tell their priorities, this administration more than doubled the amount in the budget for dealing with Medicare for \$100 billion in the President's budget. That is important. It is significant, and it is a number that allows us to make a number of decisions that we made on our own last year in our own budget, but it is very pleasing to see that the administration agrees that is a number around which you can begin to build a credible program.

One of the things that we have to remember, of course, is that the push to reform Medicare is not only to provide a better Medicare for our seniors, but because the program is going broke, we need to make adjustments that will bend the growth curves in the outer years.

We also, as the President addressed in the State of the Union, need to face the challenge of addressing uninsured Americans. It makes no sense whatsoever two people holding the same job, one gets 100 percent of their health insurance paid for by their employer, the other has to have a first dollar payment after taxes to provide themselves and/or their families with any insurance.

Reducing medical errors, tackling the increasing costs of health care in general, all of these are proposals that the administration has said that they want to address. It is a time and a need for change, and I believe with the administration and the Congress working together, we can finally make those very significant and meaningful changes.

With that, the Chair would recognize the gentleman from New York, the Ranking Member, for any comments he would make.

[The opening statement of Chairman Thomas follows:]

Opening Statement of the Honorable Bill Thomas, Chairman, and a Representative in Congress from the State of California

Good morning. We welcome Health and Human Services Secretary Tommy Thompson and look forward to his remarks on the Administration's welfare reform and health care priorities. We note that other obligations by the Secretary will require us to wrap up this hearing by 11:30 a.m.

Before the '96 reforms, the average stays on welfare lasted an incredible 13 years. And welfare rules actually discouraged work.

The 1996 welfare reforms turned the program around, and increased work, boosted incomes, significantly reduced child poverty and dramatically lowered dependency.

Our priority now is to help more people successfully transition to work—the only real and permanent path out of poverty. The legislation the House passed in May 2002 did just that. Unfortunately, the Democrat-led Senate failed to pass our legislation. So the Nation's major welfare programs have been effectively on life support since September 2002. We must act soon to put this successful program on firm footing.

The President has also prioritized modernizing and strengthening the Medicare program. It is important to note the Administration has put \$400 billion on the table over 10 years—more than double the amount he provided in last year's budget.

One principle we should apply to any Medicare proposal is whether it actually reduces costs over time. Absent any change in law, the program's actuaries predict that annual spending on Medicare will nearly double within 10 years. And then the sizeable baby boom generation retires, and the numbers of workers per beneficiary drops from 4:1 today to 2:1 in the year 2030. The Medicare program must be run more efficiently, because the alternatives of cutting benefits or raising taxes are unacceptable.

We also face the challenge of addressing uninsured Americans, reducing medical errors and tackling the increasing costs of health care in this country. I look forward to learning more about the Administration's proposals on these key issues.

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

Mr. RANGEL. Thank you, Mr. Chairman, and thank you, Mr. Secretary. We—the Nation is indeed fortunate to have a former Governor who understands the importance of Federal responsibility and that of local and State to be heading this program for us.

It is very, very difficult for us as legislators and being in a minority to deal with the process that is supposed to allow us to make intelligent decisions for our constituents. Let us just take the welfare bill. With all of the concern that we had in the last Congresses, it is my understanding that when a session ends, the Congress ends, and that we have new Members of Congress, new Members of this Committee. We haven't had hearings this year. We don't know why we are on such a fast track. If indeed the bill expires, the Senate has indicated that they don't intend to do anything until March. They won't extend the funding until September. The Majority have the votes, and so it is not a question who wins and who loses. It is just an effort just to keep us out of the process, and so without coming to the Committee as we thought we had some degree of assurances, we understand that our Committee is going to be bypassed. So, we won't get a chance to ask you questions, because we don't have a bill.

We get to Medicare. The President campaigned on providing prescription drugs. It is a national issue. We know Medicare, and there may be an effort by the administration to try to destroy Medicare as we know it, but if there is none, then as we look at what we hear a program is without detail is that prescription drugs would not be provided under the Medicare program, but under the health maintenance organization (HMO) program, which means that you have to leave Medicare and join HMOs. My friend Ben Cardin said he did not have any HMOs in Maryland, and then expert Pete Stark says if you don't have an HMO, the administration will make something up for you to get your prescription drugs. Then a staffer says, but I don't get it. I am under 55.

It would seem to me that if we had more hearings and more dialogues since health care has to be a bipartisan issue, that we shouldn't have to frighten our seniors with questions that we don't have answers, and that somehow it would be healthy for us to go back to our respective Governors, all who are complaining about the shortages of funds and deficits that they have and the unfunded mandates that they are getting from the welfare bill.

So, what I am saying to you is that you enjoy a luxury that some of my Republican friends can't enjoy. You don't have to be partisan. You haven't been partisan. You are here because you have been a great Governor and you understand the complexity of these matters. Help us not to be bipartisan, but share with us answers that we need to questions.

Some of the Members have said we should have our own hearings, we should bring in the Governors, we should have witnesses. Well, you and I know that if we do that, it is going to be political. If the Chair—strike the Chair. If the leadership—because he is merely a tool of the leadership who makes these important deci-

sions. If the Speaker refuses to allow us to talk with you and administrators of the welfare program and the Medicare program, I hope that you would consider coming and talking with us, whether it is a formal hearing that we are having or not, so that we can go home better informed as to the direction in which the administration would want to go.

If we disagree with you, that is what America is all about, but to bypass hearings for issues this important, or to have us to vote up and down on details that are not before us is grossly unfair. I don't think the American people want it that way, and I look forward, Mr. Secretary, notwithstanding what the Majority does, to let you know that we on the Minority side would welcome an opportunity to discuss these complex issues with you so that we don't have to make up what we think the administration perceives as to how we deliver health care and welfare care.

Thank you, Mr. Chairman.

Chairman THOMAS. I thank the gentleman very much.

The Chair would acknowledge that there are Members who do have activities that they must attend, notwithstanding their current attendance, and that written questions may very well be submitted. As this is something we have done in the past, I assume that the Secretary and the administration would be prompt in responding to those questions that may be submitted in writing by the Members. With that, Mr. Secretary, any written statement you have will be made a part of the record, and you may address us, as I say, in any way you see fit.

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

Mr. THOMPSON. Thank you very much, Mr. Chairman. Good morning to you, Congressman Rangel, Members of this Committee. Thank you so very much for inviting me to testify this morning.

Mr. Chairman, I am going to thank you for your continued leadership on so many issues that are vitally important to the American people. Over the past 2 years I have had the pleasure of working with you and Mr. Rangel, and I want you both to know that I appreciate your friendship, value your passion for public service, as I do each and every Member on this Committee.

It is very good to have this opportunity to discuss the President's fiscal year 2004 budget for the U.S. Department of Health and Human Services (HHS). In my first 2 years at the Department, we have made tremendous progress in our efforts to improve the health, the safety and the welfare of the American people. We continue to make extraordinary progress in providing health care to lower income Americans through waivers and State plan amendments that have been granted to States for their State Children's Health Insurance Program (SCHIP) and Medicaid programs.

We have expanded access to health coverage for more than 2.2 million people and have expanded the range of benefits offered to 6.7 million other Americans. Our progress is substantial, but far from being completed.

So, this year our work continues as we propose new and innovative programs to meet the health and the well-being and the wel-

fare needs of our fellow citizens. The President's budget proposal contains \$539 billion for HHS, an increase of \$36.9 billion, or 7.3 percent, which will enable the Department to continue to work to improve the health and safety of our Nation.

This proposal will fund programs to increase the Nation's readiness to respond to potential bioterrorist attacks, bolster disease prevention efforts, strengthen the Child Support Enforcement Program, enhance Temporary Assistance for Needy Families (TANF) and foster care, and strengthen and improve Medicare and Medicaid.

Mr. Chairman, I know that you share the President's and my commitment to strengthening and modernizing Medicare, and, I might add, every Member of this Committee, in order to meet the growing and changing health care needs of seniors and individuals with disabilities.

There has been much discussion and speculation in the media in recent weeks about the administration's plans to provide drug benefits to Medicare beneficiaries. One of the biggest fallacies is that we are going to force all seniors to go into HMOs, which is not the case. The Administration's proposal to strengthen and improve Medicare is still being developed, and further details will become available in the next few weeks, but I can assure you that the President and I are absolutely dedicated to adding a prescription drug benefit to Medicare and enacting meaningful changes to strengthen and improve the program. We have dedicated \$400 billion over the next decade to achieve this ambitious goal, and we look forward to working closely with this Committee to develop and pass a responsible and effective and far-reaching Medicare bill this year.

Another issue of key and personal interest to me—and I know one of Congresswoman Johnson—is the drastic toll that chronic diseases take on our society. Consider the following facts: More than 125 million Americans are living with a chronic disease; 7 of every 10 deaths, more than \$137 million every year, are caused by chronic disease. More than 108 million American adults were either obese or overweight in 2001, and roughly 300,000 Americans die each year due to weight-related illnesses.

We do things somewhat backward in America dealing with health care, because our health care system waits for people to get sick and then spends billions of dollars to make them well. We want to do things differently. That is why our budget proposes a coordinated Department-wide effort to promote a healthier lifestyle by emphasizing the prevention of obesity, diabetes, asthma and risky youth behavior. The HMO budget also includes an investment of \$125 million for targeted disease prevention, and, as I mentioned earlier, enhanced preventative benefits will also be an integral part of our Medicare recommendations.

Mr. Chairman, reforming welfare has also been a project that has been close to my heart for many years. As a Governor in the 1990s, I worked with Congressman Shaw and many Members on this Committee, and I appreciate this Committee's interest in what we achieved in Wisconsin, as well as the opportunity to work with Congress in 1996 on the national welfare reform law. I think I speak for most Americans in thanking all of you for tremendous

success, a success that has transformed people's lives for the better, by moving adults from the dependency of a welfare check to the independence of a paycheck. You have improved the prospect of countless children.

The President's budget proposes to build on that success in reauthorizing TANF this year and for the next 4 years after that. The proposal makes improving the well-being of children the major purpose of welfare. Despite that over 50 percent drop in TANF case-loads, we will continue to advance this cause by continuing to provide current program funding levels for the TANF block grant to States, tribes and territories. Billions of dollars that previously went toward cash assistance can now continue to be focused on improving the self-sufficiency of parents and strengthening families.

The President's proposal also maintains a high level of commitment to child care funding at \$4.8 billion. We must not turn our back on the opportunity to build upon the most successful social revolution in America in the last 60 years, as well as the millions of families who are beginning or continuing to climb the career ladder thanks to welfare reform.

Improving child well-being remains an elusive goal, if we do not respond to families who seek support in building strong foundations and healthy marriages. The President proposes to let States offer voluntary innovative programs and services to support parents in providing their children with strengthened foundations and healthy family relations.

This year we are also continuing the President's effort to improve the lives of children who are at risk of abuse and neglect. The budget proposed a child welfare program option that States can use to improve their child welfare systems. This option will allow States to develop innovative ways to integrate and coordinate their child welfare programs with their foster care programs. The expectation is that States will not only develop interventions that may prevent inappropriate removal of children from their families, but they will also improve services when foster care placement is the appropriate course for that child. All participating States would be required to maintain existing child protections to ensure that the safety and the permanency and the well-being of children continues to be the utmost and first priority.

Another key component to the administration's commitment to America's families is our Child Support Enforcement Program, which I am very pleased to tell you has had some very impressive results. In 2001, over 1.6 million paternities were established or officially acknowledged. In 2002, child support collections hit a record \$20 billion, up from \$17.9 billion in 2000 and \$19 billion in 2001. The President's budget will allow the Department to continue to build on this success.

We will soon offer a legislative proposal to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. When combined with the opportunities to increase child support contained in the President's budget proposal last year, these proposals offer an additional \$7½ billion in increased child support payments to families over 10 years.

Mr. Chairman, the budget the President has proposed for HHS funds a wide variety of programs with a combined single purpose, to improve the lives and the quality of those lives of the American people.

All of our proposals for building on the successes of welfare reform, to protecting the Nation against bio-terrorism, from increasing access to health care to strengthening and enhancing Medicare, all these proposals are put forward with the goal—in the goals of ensuring a safe and healthy America. I know the Members of this Committee share this goal, and with your support we are committed, Mr. Chairman, to achieving it.

[The prepared statement of Mr. Thompson follows:]

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

Good morning Mr. Chairman, Mr. Rangel, and members of the committee. I am honored to be here today to present to you the President's FY 2004 budget for the Department of Health and Human Services (HHS). I am certain you will find that, viewed in its entirety, our budget will help improve the health and safety of our Nation.

The President's FY 2004 budget request continues to support the needs of the American people by strengthening and improving Medicare, enhancing Temporary Assistance for Needy Families (TANF) and Foster Care; strengthening the Child Support Enforcement Program; and furthering the reach of the President's New Freedom Initiative.

The \$539 billion proposed by the President for HHS will enable the Department to continue its important work with our partners at the State and local levels and the newly created Department of Homeland Security. Working together, we will hold fast to our commitment to protecting our Nation and ensuring the health of all Americans. Many of our programs at HHS provide necessary services that contribute to the war on terrorism and provide us with a more secure future. In this area, I am particularly focused on preparedness at the local level, ensuring the safety of food products, and research on and development of vaccines and other therapies to counter potential bioterrorist attacks.

Our proposal includes a \$37 billion increase over the FY 2003 budget, or about 7.3 percent. The discretionary portion of the HHS budget totals \$65 billion in budget authority, which is an increase of \$1.6 billion, or about 2.6 percent. HHS' mandatory outlays total \$475.9 billion in this budget proposal, an increase of \$32.3 billion, or roughly 6.8 percent.

Your committee will obviously be vital to achieving many of the Administration's most important priorities. I am grateful for the close partnership we have enjoyed in the past, and I look forward to working with you on an aggressive legislative agenda to advance the health and well being of millions of Americans. Today, I would like to highlight for you the key issues in the President's budget that fall under the Ways and Means Committee's jurisdiction.

Supporting the President's Disease Prevention Initiative

One of the most important issues on which we can work together is disease prevention. We all have heard the disturbing news about the prevalence of diabetes, obesity and asthma that could be prevented through very simple lifestyle changes. The statistics, I am sure, are as alarming to you as they are to me. For example:

- Diabetes was the sixth leading cause of death listed on U.S. death certificates in 1999, representing approximately 19% (450,000) of all deaths in the U.S. in people aged 25 years and older.
- In 2000, 38.8 million Americans met the definition for obesity;
- Data indicate that 26 percent of all adult women, and 20.6 of all adult men are obese;

For this reason the HHS budget, consistent with the President's HealthierUS effort, proposes a coordinated, Department-wide effort to promote a healthier lifestyle emphasizing prevention of obesity, diabetes, and asthma. The FY2004 budget includes a new investment of \$100 million for targeted disease prevention, and enhanced preventive benefits are an integral part of our Medicare reform recommendations.

Strengthening and Improving Medicare

Through the leadership of Chairman Thomas, the Ways and Means Committee has been at the forefront of efforts to strengthen and improve the Medicare program. As we are all aware, our Nation's Medicare program needs to be strengthened and improved to fill the gaps in current coverage. This committee has dedicated countless hours to increasing public understanding of the challenges confronting the program, and your efforts have significantly advanced the debate over program modernization. While we remain steadfastly committed to ensuring that America's seniors and individuals with disabilities can keep their current, traditional Medicare, the President has proposed numerous principles for Medicare enhancements to ensure that we are providing our seniors with the best possible care. The budget builds on those principles by dedicating \$400 billion over ten years to strengthen and improve Medicare, including providing access to subsidized prescription drug coverage, better private options and better insurance protection through a modernized fee-for-service program.

Prescription Drug Coverage

Ensuring that Medicare beneficiaries have access to needed prescription drugs is a top priority for the President and me. This budget proposes a prescription drug benefit that would be available to all beneficiaries, protect them against high drug expenditures, and would provide additional assistance to low-income beneficiaries through generous subsidies for low-income beneficiaries to ensure ready access to needed drugs. The Administration's prescription drug plan would offer beneficiaries a choice of plans and would support the continuation of the coverage that many beneficiaries currently receive through employer-sponsored and other private health insurance.

Medicare Choices

Medicare+Choice was introduced to provide beneficiaries with options in their health coverage. Over the past year, the Department has made significant strides in expanding beneficiaries' Medicare+Choice options by approving 33 new preferred provider organization through a demonstration. However, due to a variety of factors, in many parts of the country, few new plans have entered the program. More needs to be done to encourage plan participation in this important program. This Administration believes that Medicare+Choice payments need to be linked to the actual cost of providing care. America's seniors should have access to the same kind of reliable health care options as other citizens. We believe that we should move away from administered pricing to set Medicare+Choice rates and that those choices should be provided through a market-based system in which private plans compete to provide coverage for beneficiaries. Those beneficiaries who select less costly options should be able to keep most of the savings. It is time we give our seniors the choice they have been promised in Medicare.

Modernized Fee-for-Service

One of the basic tenets of our reform proposal is that seniors deserve the same range of health care delivery choices as federal employees enjoy. These choices should reflect the benefit innovations incorporated into private sector plans. The Administration is very interested in updating Medicare to reflect the insurance protections offered in the private sector. This system would modify and rationalize cost-sharing for beneficiaries who need acute care. It would also eliminate cost sharing for preventive benefits and provide catastrophic coverage to protect beneficiaries against the high costs caused by serious illnesses.

Medicare Appeals Reform

Our budget also includes \$129 million for the implementation of Medicare appeals reform. The adjudicative function currently performed by the Administrative Law Judges at the Social Security Administration would be transferred to the Centers for Medicare and Medicaid Services (CMS). In addition, the Administration proposes several legislative changes to the Medicare appeals process that would give CMS flexibility to reform the appeals system. These changes will enable CMS to respond to beneficiaries and provider appeals in an efficient and effective manner.

New Freedom Initiative

Although Medicaid falls under the jurisdiction of the Energy and Commerce Committee, let me quickly mention several Medicaid initiatives that will also impact some vulnerable Medicare beneficiaries. Home care as an alternative to nursing homes for the elderly and disabled is a priority of this Administration. The New Freedom initiative represents part of the Administration's effort to make it easier

for Americans with disabilities to be more fully integrated into their communities. Under this initiative, we are committed to promoting the use of at-home care as an alternative to nursing homes.

It has been shown time and again that home care combines cost effective benefits with increased independence and quality of life for recipients. Because of this, we have proposed that the FY 2004 budget support a five-year demonstration called "Money Follows the Individual" Rebalancing Demonstration, in which the Federal Government will reimburse States for one year of Medicaid services for individuals who move from institutions into at-home care. After this initial year, States will be responsible for matching the Federal government at their usual share. The Administration will invest \$350 million in FY 2004, and \$1.75 billion over 5 years on this important initiative to help seniors and disabled Americans live in the setting that best supports their needs.

In the same spirit as the "Money Follows the Individual" Rebalancing Demonstration, the Administration proposes four demonstration projects to support for the President's New Freedom Initiative. Each promotes at-home care as an alternative to institutionalization. The demonstrations are to provide respite services to caregivers of disabled adults and severely disabled children; to offer home and community-based services for children currently residing in psychiatric facilities; and to address shortages of community direct care workers.

There are additional key proposals in our budget that will improve the lives of millions of Americans. For example, we are interested in working with Congress on a Medicaid Spousal Exemption and Medicare Part B Premiums for qualified individuals (QI's). The Medicaid Spousal Exemptions would give States the option to continue Medicaid eligibility for spouses of disabled individuals who return to work. Under current law, individuals with disabilities might be discouraged from returning to work because the income they earn could jeopardize their spouse's Medicaid eligibility. This proposal would extend to the spouse the same Medicaid coverage protection now offered to the disabled worker. Medicare Part B Premiums for QI's will continue 100% Federal Medicaid coverage of Medicare Part B Premiums for qualifying individuals, who are defined as Medicare beneficiaries with incomes of 120% to 135% of poverty and minimal assets. Premium assistance will continue for five years.

Empowering America's Families

Reauthorization of Temporary Assistance for Needy Families (TANF) and the Child Care Development Fund

Building on the considerable success of welfare reform in this great nation of ours, the President's FY2004 budget follows the framework proposed in the FY2003 request which includes the reauthorization of TANF. The proposal includes five years of funding for the TANF Block Grants to States, Tribes, and Territories; Matching Grants to Territories; and Tribal Work Programs at current levels. In addition, the FY2004 budget reinstates authority for supplemental population grants at \$319 million; Social Service Block Grant transfers to 10 percent; as well as funding of the \$2 billion Contingency Fund with modified maintenance of effort and reconciliation requirements to make it more accessible for States.

The central focus of the proposal strengthens work requirements while allowing States greater flexibility to define activities that will lead toward self-sufficiency. The Bonus to Reward High Performance States would be redesigned to provide \$100 million a year for bonuses on employment achievement. We are proposing to eliminate the bonus to reduce out-of-wedlock birth. Our proposal offers a two-pronged family formative initiative: \$100 million to fund research, demonstrations, and technical assistance efforts, and \$100 million for matching grants, focused on building strong families and promoting healthy marriages. In addition, the Budget proposes to reauthorize state-based abstinence education grants for five years at \$50 million annually to further assist with reducing the number of out-of-wedlock births, reducing the spread of STDs among teens, and helping teens make health life choices. These proposals demonstrate that this Administration is committed to strengthening foundations for our children and supporting programs that will empower persons who have not been able to work, for any number of reasons, to achieve self-sufficiency.

Hand in hand with these efforts, the President's FY2004 budget also follows the framework established in the FY2003 budget and requests reauthorization of the Child Care and Developmental Block Grant Act and the Child Care Entitlement to assist States in meeting the critical child care needs of families.

Increasing Support for Children in Foster Care

In a continuing effort to improve the lives of children who are at risk of abuse and neglect, this Administration is proposing a child welfare financing option that States can use to improve their child welfare service systems. This plan would allow States to choose a fixed allocation of funds over a five-year period rather than the current entitlement funding for the title IV-E Foster Care program. Participating States would receive their funds in the form of flexible grants which could be used for a wide array of child welfare-related purposes, such as child abuse and neglect prevention, maintenance and administrative payments for foster care, child welfare training, and family support. The flexible funding will allow States to develop innovative ways to ensure the safety, permanency and well-being of children, tailored to meet the needs of their child welfare populations. States which elect this option and experience emergencies affecting their foster care systems may access additional funding from the TANF contingency fund.

The Administration is proposing a nearly \$5 billion budget for Foster Care in FY 2004, an \$89 million increase over last year's request. Not only will these funds support the child welfare program option, but they also will be used to provide payments for maintenance and administrative costs for more than 240,000 children in foster care each month, as well as payments for training and child welfare data systems.

The Adoption Incentives Program has been successful in contributing to the substantial increase in the number of children who are adopted from the public foster care system in recent years. The President's FY4004 budget request includes reauthorization of this important funding. Additionally, we propose changes to the incentive system to target older children, who despite the overall gains in adoptions constitute an increasing proportion of the children waiting adoptive families. The President's budget request for the Adoption Incentives Program is \$43 million.

Another important issue we face with foster care is the transition for children out of these programs. Last year, nearly 20,000 children aged out of the foster care system. In order to assist these children, the President is committed to maintaining the Foster Care Independence Program, which provides a variety of services for youth who will likely remain in foster care until they turn 18 and former foster children between the ages of 18 and 21. The President's budget request for the Foster Care Independence Program is \$140 million. Our budget also includes \$60 million for an education and training voucher program for the approximately 20,000 youth who age out of foster care each year. Additionally, the Administration continues our commitment to the Promoting Safe and Stable Families Program, and this Budget increases substantially funding for the program to \$505 million to assist States' ability to strengthen families and to promote child safety, permanency, and well-being. This important program also helps promote adoption and provides post-adoption support to families.

Child Support Enforcement

Related to my commitment to strengthening America's families, I am proud to tell you that our Child Support Enforcement program has made some impressive gains. Child support collections hit a record \$20 billion in FY2002, and in FY2001, over 1.6 million paternities were established or acknowledged.

The President's FY2004 budget will build on this success. Legislation will be proposed to enhance and expand the existing automated enforcement infrastructure at the Federal and State level and increase support collected on behalf of children and families. For example, proceeds from insurance settlements and gaming winnings will be subject to intercept for past due support and the process for freezing and seizing assets in multi-state financial institutions will be simplified. When combined with the opportunities to increase child support outlined in the President's FY2003 budget (expanded passport denial, offset of certain Social Security benefits and mandatory review and adjustment of support orders), these proposals offer an impressive \$2.6 billion in increased child support payments to families over five years. The Budget also recognizes that healthy families need more than financial support alone and increases resources for the Access and Visitation Program to support and facilitate non-custodial parents' access to and visitation of their children.

Responsible Fatherhood and Healthy Marriages

The President's budget also proposes \$20 million for promotion and support of responsible fatherhood and healthy marriage. This funding will promote and support involved, committed, and responsible fatherhood and encourage the formation and stability of healthy marriages.

Fighting Bioterrorism

As Americans confront the realities of terrorism and hatred around us, it is imperative that the Federal Government be prepared to keep our citizens safe and healthy. HHS' \$3.6 billion bioterrorism budget substantially expands ongoing medical research, maintains State and local preparedness funding, and includes targeted investments to protect our food supply. The President's proposal significantly expands research funding needed to develop vaccines and medicines that will make biologic agents much less effective as weapons. HHS is committed to working closely with the new Department of Homeland Security to ensure that its pharmaceutical stockpiles include proper amounts of effective drugs and vaccines, and other biologics.

Faith-Based and Community Initiatives

In support of the President's Faith-Based and Community Initiative, the HHS FY2004 budget supports programs that promote positive relationships that link faith- and community-based organizations, State and local governments, and Federal partners to develop a shared picture for substance abuse treatment and positive youth development.

We are proposing to establish a new \$200 million drug treatment program. For some individuals, recovery is best assured when it is achieved in a program that recognizes the power of spiritual resources in transforming lives. Under this new program, individuals with a drug or alcohol problem who lack the private resources for treatment will be given a voucher that they can redeem for drug treatment services. The program will give them the ability to choose among a range of effective treatment options, including faith-based and community-based treatment facilities. Another important program that helps some of our most vulnerable children is the Mentoring Children of Prisoners program. We are asking for funds to be increased to \$50 million, which would in turn be made available to faith-based community-based, and public organizations for programs that provide supportive one-on-one relationships with caring adults to these children who are more likely to succumb to substance abuse, gang activity, early childbearing and delinquency. In addition, the budget request for the Compassionate Capital Fund is \$100 million, the same amount requested in FY2003, and an increase of \$70 million over the FY2002 appropriation. These funds would continue to be used to support the efforts of charitable organizations in expanding model social service programs. The Fund would also continue to provide technical assistance to faith- and community-based organizations to expand and enhance their services. These are just a few examples of the services that can be provided to those in need under this initiative.

President's Management Agenda

I am committed to improving the management of the Department of Health and Human Services, and I realize that as we work to improve the health and well-being of every American citizen, we also need to improve ourselves. The FY2004 budget supports the President's Management Agenda and includes cost savings from consolidating administrative functions; organizational delayering to speed decision making processes; competitive sourcing; implementation of effective workforce planning and human capital management strategies; and adoption of other economies and efficiencies in administrative operations. We have also included savings in information technology (IT) which will be realized from ongoing IT consolidation efforts and spending reductions made possible through the streamlining or elimination of lower priority projects. I am also very excited about the IT infrastructure consolidation which should be fully implemented by October, 2003, that will further reduce infrastructure expenditures for several HHS agencies.

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

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 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; all these proposals 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. Thank you very much, Mr. Secretary. I find it incredible that I need to ask you a series of questions, the an-

swer to which may be illuminating not only to some folks who may be in the room or watching these programs, but perhaps would be to Members as well. The questions would go something like this: If a senior goes to a doctor who is in private practice, who is not employed by the government but is in private practice, and is treated by that doctor, is that under Medicare?

Mr. THOMPSON. Yes.

Chairman THOMAS. If that doctor tells the senior that they need to go to a hospital, the hospital could be for-profit, not for profit, run in many different structures, but let us take the most extreme case, which would be a private for-profit hospital, is that under Medicare?

Mr. THOMPSON. Yes, sir.

Chairman THOMAS. If a senior purchases an insurance policy to assist them in what is normally called the Medicare benefits, and they exercise those insurance structures, is that under Medicare?

Mr. THOMPSON. Yes.

Chairman THOMAS. If they were to go to a particular health organization structure, call it an HMO, if you will, and receive medical treatment at an HMO, is that under Medicare?

Mr. THOMPSON. Yes.

Chairman THOMAS. Obviously the direction of my questions I hope at this point are clear. You can say the benefit is going to be private rather than under Medicare, but all that says is either you do not understand Medicare, or you are purposefully creating a distinction without a difference in terms of where the senior is to receive either the health care or, as we anticipate, prescription drugs in the new program.

For someone to say that what the President is attempting to do and what this Congress—this House especially has done in the last two Congresses, and hopefully will do in this Congress, is to modernize and improve Medicare, is to provide seniors a better service within and under Medicare and not create some bifurcated system which is Medicare and not Medicare. Based upon the Secretary's answers which will always be—in any way you characterize the way in which the seniors interact with the health care structure, it will be under Medicare, and if anyone attempts to create the idea that a program to serve those seniors, although different in the current program, we certainly hope, with far more benefits and with prescription drugs added, is not under Medicare is doing it knowingly to either scare seniors or to create an argument which has no merit.

This Committee looks forward to working with you in creating a better Medicare, delivering services in new and novel ways, especially continuing the emphasis that this Majority has placed on preventive and wellness as a structural part of Medicare, and finally providing prescription drugs for seniors. Whatever the delivery vehicle will be, it will be under Medicare, and I thank the Secretary for participating in what the Chair would have hoped would not have to be a series of illustrations for the Members of this Committee as to what we are engaged in. I appreciate that, and with that I would recognize the Ranking Member if he wishes to inquire.

Mr. RANGEL. Thank you, Mr. Chairman.

When I was a youngster in law school, they had an expression that if the law and the facts were not on your side, raise your voice. I never understood it before today, but—you didn't understand that, Amo? Having said that, I assume with your answers, Mr. Secretary—

Chairman THOMAS. Will you let me—

Mr. RANGEL. Of course. Take your time.

Chairman THOMAS. The problem is the gentleman assumed that I was raising my voice. Those who know me know that that was really pretty low.

Mr. RANGEL. That may be a part of the problem, Mr. Chairman. Having said that, you didn't want your answers to be misinterpreted that there is no difference between HMOs and Medicare, did you, Mr. Secretary?

Mr. THOMPSON. I am sorry, Mr. Congressman. I am sorry. I didn't hear that.

Mr. RANGEL. You did not want us to misunderstand your answers to the Chair in having us to believe that there is no difference between receiving services for Medicare and receiving services from an HMO, would you? There is a difference, isn't there?

Mr. THOMPSON. Well, Medicare includes all of the services, Congressman, as you well know.

Mr. RANGEL. Well, suppose we have a hypothetical here, and someone wanted prescription drugs, and we are allowed to believe that you can only get it from an HMO, and those that were—did not want to join an HMO, they would not get prescription drugs under that hypothetical. I don't know the details, because it hasn't been shared with the Committee.

Mr. THOMPSON. Under a hypothetical, the person was in Medicare and was not going to get drugs unless they were in an HMO; under a hypothetical, your question would be correct. My answer would be yes, but the hypothetical is not what the President is advocating, Congressman.

Mr. RANGEL. Well, that is good. That would mean that someone on Medicare now under the President's program would be able to receive prescription drugs without ever having to leave Medicare and to join an HMO, since an HMO, would not be—

Mr. THOMPSON. Since prescription drugs are not offered under Medicare yet, until Congress acts and the President signs it, right now the only way you get prescription drug coverage is either by another insurance policy or an employer or some other way that—

Mr. RANGEL. No. I am talking about the details of a proposal which I am asking you to share with us, and that is that if someone was enrolled in Medicare as we know it, and the Chair would have me to believe that HMO is just an extension of Medicare—I don't want to get involved in that. I want to know how to explain to my folks back home that they can stay where they are in this broken down but well-respected Medicare system and not have to go into these HMOs that we never know from one night to the next whether they are going to leave town and insult the old folks; that they can stay there, and that we are looking for a proposal that would allow them to enjoy the benefits of a prescription drug program.

Mr. THOMPSON. Congressman, we are still working on the Medicare proposal in the administration.

Mr. RANGEL. Mr. Secretary, we don't have hearings here. We have to take advantage of your presence here. They go in the back room. They come out with these things. Please share with us. You have had to think about this.

Mr. THOMPSON. I can assure you, Congressman, that the President is not going to force seniors into HMOs in order to get prescription drugs, but the final decisions dealing with prescription drugs have not been completed yet. We are still working on it, Congressman. I am sorry. We haven't finished it, but we are working on it. As soon as it is finished, I will be more than happy to come up, sit down with you and discuss it with you in full detail, sir.

Mr. RANGEL. Okay. Now, when it comes to the so-called welfare reform that you played such a leadership role in, you do note that we have received real concerns from the Governors, your former colleagues, in terms of the changes in the economies, the increase in unemployment, the lack of being able to get the same waivers that you were able to use effectively to improve the quality of delivery of service. We would like to hear from them as Members of Congress. We won't be able to do this. We won't be able to ask them what do they think about the administration's proposal. Members of Congress that just got here haven't the slightest clue as to how they can improve the quality of their questions so they can go back home. We have new Members on this Committee.

Would you not agree that the best way for us to understand and support your program would be for this Congress to have hearings on the President's proposal?

Mr. THOMPSON. Congressman, I do not want to get involved in the internal operations of the Committee or of the Congress. I can assure you that I will be more than happy to come up and discuss it with you and other Members at any time that you so desire. I can assure you that the President and I want to pass a TANF proposal as soon as possible, and we want to work with you and try and make sure we get the best bill possible.

Mr. RANGEL. Well, Mr. Chairman, I hope you don't consider it political, but I am taking advantage of the Secretary's offer, and I hope you allow us to have this room so that we can have a meeting with witnesses, and I hope you will cooperate so that—

Mr. SHAW [presiding]. I was going to say, Mr. Rangel, you have the soft-spoken Chairman now.

Mr. RANGEL. Well, I am glad to see that you are back and that you are fully recuperated. You look better than ever, and we welcome you back to the Congress.

Mr. SHAW. Thank you. I feel good.

Mr. RANGEL. Having said that, I was announcing that we intend to ask the Chair for the use of this room or any other room so that we could bring witnesses in, and hope we can receive the cooperation of the Chair in bringing in witnesses so that we can better understand what the administration proposal is, and also to receive some comment from the Governors as to how this could be effective, and for them to provide services to the poor.

Mr. SHAW. Well, I am sure Chairman Thomas will have hearings on the proposals, but I am sure you can—

Mr. RANGEL. No. The problem, Mr. Chairman, is that it is my understanding from the leadership that we will not have hearings on the welfare proposal.

Mr. SHAW. Oh, the welfare. I thought you were talking about Medicare. I beg your pardon. No. It is my thought that the bill that is going to go to the floor is the exact same bill that came out of this Committee last year. That is my—

Mr. RANGEL. I am saying that we do have—well, I don't know whether you were listening, but I am saying that this is a new Congress, we have new Members on this Committee and in the House, and I just thought that it would make a lot of legislative sense that we have hearings on that.

Since the Secretary has agreed to cooperate no matter what restraints we have, I want to thank you for providing to us at least some window of opportunity to better understand the legislation. Thank you, Mr. Chairman.

Mr. SHAW. Mr. Secretary, it is good to see you back up here on the Hill, and I might add that if it were not for your example in Wisconsin with welfare reform, which much of the Federal welfare reform is patterned after, I doubt that we would have been able to sell the successes that we have sold.

Just one other caveat I will throw in here is that the real heroes of welfare reform particularly are the single moms. We had faith in them, and they stepped up to the plate, and they have done—they are heroes in their own right and role models now for their kids.

I would like to—Mr. Secretary, I got real close and personal with a feared disease in this country, being cancer, and in doing it, I was looking at some statistics that Amo Houghton passed along to me. Lung cancer is the leading cause of death of all of the cancers, yet we are only spending—we as a nation, not just as a government, are spending less on cancer research—lung cancer research than the next four forms of cancer combined. That is something we need to take a close look at, and I would hope that the cutting edge—your wonderful people out at the National Institute of Health (NIH), I hope that we can try to balance that playing field somewhat. It is not just a disease for smokers. It is for former smokers as well as nonsmokers. So, it is necessary that we attack this problem.

I was fortunate, early diagnosis, but mine could have gone unnoticed if it weren't for a cold or persistent cold I was having that caused me to have a chest X-ray that I normally wouldn't have had, and whereas my prognosis is good, still you have got the frightening thought of lung cancer as being the most deadly of all forms of cancer.

Mr. THOMPSON. Mr. Chairman, Congressman Shaw, first off I am delighted to have you back. I am so happy that they caught your cancer very early and that the operation was a success. I know I called you immediately after it, and I am so happy that you are back.

Mr. SHAW. I appreciated that call, too.

Mr. THOMPSON. You are a friend, and you were—

Mr. SHAW. Charlie called me, too.

Mr. THOMPSON. Well, he is a good man, too.

I also want to thank you for your leadership on the welfare proposal, the TANF proposal, because I worked very closely with you, and it wouldn't have happened without you, and I thank you for your leadership. Your comment about the single mom is absolutely correct.

In regards to lung cancer and all the cancers, it is an insidious disease. It has been around since time immemorial, and we are making progress. We have a great cancer institute director, Dr. Andy Von Eschenbach, who is just doing a wonderful job, and we are looking at the budgets and finding ways in which we can get more money into cancer research all the time, because this is one thing that the President and I, you, and most all the Members on this Committee certainly are concerned about. I am certainly hopeful that we are going to find that breakthrough.

We are getting closer each time. New research is done. Gleeevec this past year was a wonderful breakthrough drug which targets certain cancer cells and allows the good cells to continue. We are making that kind of progress, and hopefully we will be able to find a cure for all the cancers, lung cancer specifically, but all the others as well. All of us on this Committee and all of us in this room have certain loved ones that have been very close to us that have suffered cancers. It is a terrible disease, and we are going to do everything we possibly can and everything at my Department to do everything we can to find a cure.

Mr. SHAW. We certainly appreciate those comments, and you certainly—NIH and Andy out there is doing a wonderful job.

Mr. THOMPSON. Doing a great job.

Mr. SHAW. I thank you for the choice to lead us in these efforts. Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. Thank you very much, Mr. Chairman. There are a couple things that I do want to have a chance to say, but first I want to go through a brief series of questions parallel to the Chairman's. Mr. Secretary, under the law, is Medicare allowed to cover preventive care?

Mr. THOMPSON. Some preventive care, not enough, Congresswoman.

Mrs. JOHNSON OF CONNECTICUT. Only those specific things where we have changed the law, like mammograms—

Mr. THOMPSON. Those are the only things that you have specifically done, and this Committee has taken a leadership role, and you specifically, and I thank you.

Mrs. JOHNSON OF CONNECTICUT. Annual physicals, can Medicare provide annual physicals?

Mr. THOMPSON. No. In very limited cases dealing with some cancers but very little. Not—

Mrs. JOHNSON OF CONNECTICUT. Under the law—

Mr. THOMPSON. The law should be changed. If I may add, any time somebody signs up for Medicare, there should be a physical examination. It should be mandatory, and it should be paid for, and we would be able to stop a lot of diseases.

Mrs. JOHNSON OF CONNECTICUT. Correct. Does Medicare cover chronic illness, any management of chronic illness? Does Medicare do anything to—

Mr. THOMPSON. Only the ones we set up demonstration plans for.

Mrs. JOHNSON OF CONNECTICUT. Exactly. So, Medicare as we know it is inadequate, and I do not want to be part of delivering to the seniors of America Medicare as we know it. Medicare as we know it doesn't cover prescription drugs. Medicare as we know it doesn't cover preventive care. Medicare as we know it doesn't do anything to help the millions of seniors suffering with chronic illnesses. So, just let the record note, I for one do not want to come out of the end of this long legislative process with \$400 billion in the budget with Medicare as we know it.

Now, let me say one other thing. We have never had come before this Committee, never under any President, Republican or Democrat, what you have brought to us. For the first time you have brought to us a budget that provides \$28 billion to encourage people to get long-term care insurance, plus \$4 billion to help people who are caring for elderly in their home with the costs of providing long-term care for family Members.

Mr. Pomeroy and I have been working on this for 8 years at least. We have talked about it. We have had bills. The Chairman helped us with getting there. Mr. Hayworth helped us with getting a small provision in recently.

We have got to think about long-term care costs, because the taxpayers can't support it through Medicaid when the baby boomers retire, and you are looking now at pushing forward an initiative that is going to have long-term budget implications that will be favorable to young people working, but also will provide far better care for our seniors as they age and need long-term care support, both in home and out of home.

For the first time you are bringing us a budget with \$87 billion to begin the problem—attacking the problem of covering the uninsured, that is extremely important; \$84 million for patient safety in your budget; \$10 million to deal with the issue of developing interoperable technology. This is the future, and your budget has it in a very specific sense. I just want to thank you for that, and I hope at some other time we will have a chance before my Subcommittee to give you a chance to go into detail about your demonstrations, because they are bigger of heart and mind than any demonstrations that any Administration has ever proposed.

They even want three States to take on the responsibility of providing universal care. We haven't read about them. We don't know about them. They were in the paper, but Congress is way behind the wheel of what is happening out there already between government and the private sector.

Last, let me say that there are two counts in which we have to really think carefully—far more carefully than we have in the past as we move forward in prescription drugs. One is we have to do a better job of integrating care for our seniors, and I see the yellow light, so I am going to go to the other. The other thing we have to do is think about the fragility of our health care delivery system now, and on this I disagree with many on the other side of the aisle.

There is a wonderful article in the New England Journal called "The Homeostasis of Our Current System." It has received so much

change, so many regulations, so many cuts and reimbursements, that it is far more fragile, and, frankly, for us not to pass a fix on the doctors' reimbursements this month is in my estimation a dereliction of duty. For us to not notice that our hospitals are being absolutely attacked by increases in costs, malpractice premiums, blood costs, nursing crisis costs, and that our data won't show any of that for 2 years is also a very serious problem.

So, I just want the record to know that we should be doing a payer package now for at least 6 months, and that part of the \$400 billion is going to have to go to hopefully a 3-year package of payments that will stabilize the system.

My time is out. You don't get to answer. Sorry about that. I did want the Medicare as we know it issue and the big money in the budget to be a part of this hearing. Thank you.

Mr. THOMPSON. Can I make a 30-second reply?

Mr. SHAW. You certainly can.

Mr. THOMPSON. Thank you.

Thank you for your passion. Thank you for your direction. We are absolutely committed with you to do things on disease management and prevention of health. If you just look at the figures, \$155 billion a year in tobacco-related illness, 400,000 Americans die; \$117 billion a year on obesity-related illness, 300,000 Americans die; \$100 billion a year on diabetes, 17 million Americans have it, 16 million are pre-diabetic, and 200,000 die each year, all three of those total much more than the total Medicare package. We are trying to do 5 to 10 demonstration programs throughout America on disease management. We will have more bang for the buck, do more for quality care for Americans and improve the quality of health for all Americans. I thank you so very much for your leadership. Let us do it together.

Mr. SHAW. Mr. Cardin.

Mr. CARDIN. Mr. Chairman, if I could just make a unanimous consent request to put my questions in the record for Secretary Thompson in the interest of time. If it could be responded to, and we will be able to move on with the hearing.

Mr. SHAW. Without objection. Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman. I would just like to remind the Committee that in 1995, every Republican on this Committee voted against adding preventive benefits to Medicare, and they have had now 7 years to correct the inadequacies, and we have had no suggestions from the Republican-controlled Committee to correct them. I certainly look forward to the day when they will do that.

Mr. Secretary, welcome back. I want to talk about the budget that you—and your message in your prepared statement. I am afraid that your prepared statement, in addition to being vetted by Mr. Daniels at the Office of Management and Budget, was prepared by Reverend Swaggart and Reverend Robertson. It is interesting that you devoted 89 words to a drug benefit and a full page, or almost four times as much, to a faith-based voucher for people to go to Alcoholics Anonymous (AA). Now, as I recall, the President didn't have to pay a nickel when he went to AA, and I think that most of it is still free. Why we should give people a voucher for that when we can't afford a drug benefit escapes me.

We have had a—you did a wonderful job in our home State, in Wisconsin, on welfare reform, and the administration kind of finished it up. In this last go-round they added the Kohlers and the Bumlers and the Bradleys with a trillion dollar tax cut. The last time I looked in Wisconsin, those families didn't need any welfare, but they did get it. By giving them that, you took out, or your Administration unfortunately took out, any money left for a drug care benefit for the average citizen. You cannot, we cannot, afford to provide a drug benefit with \$400 billion. The one that was previously leaked by the administration to the press would have paid less than 20 percent of the drug benefit of anybody who spent up to approximately \$7,000 in drugs, and less any premium that might be charged. So, it is inadequate.

You have offered a discount card twice. You ought to get new lawyers, by the way. We are going to whip you the third time, Mr. Secretary, why you keep bringing that dead cat back here to give people a discount card. They get a better one from Reader's Digest and AT&T. Go away with that. It is a loser. Admittedly it maybe will make the seniors think they are getting something, but the seniors know better.

The drug benefit that we need is an entitlement, and let me ask Mr. Rangel's question somewhat differently. I am in part A and part B as an entitlement in Medicare today. Can you guarantee us that any drug benefit will be available through the direct entitlement part A and part B as I have it today to all Members in part A and part B? That is 85 percent of the current beneficiaries.

Mr. THOMPSON. All I can tell you, Congressman, is that the proposal is still being worked on, and the details have not—

Mr. STARK. What we are scared about is that those of us in traditional Medicare, which the seniors understand—85 percent of the seniors are in it—will have to join a private plan to get a drug benefit. Is that your understanding?

Mr. THOMPSON. Congressman, I have to repeat myself. Those proposals have not been worked out. There are several proposals on the board right now.

Mr. STARK. So, far what we have heard, Mr. Secretary—and stuff like that is hard to keep—that is, the plan is to put seniors into a private proposal which would no longer be an entitlement and would end up as a voucher. That is where we were in 1964. The private plans have left us. That is the fear that is out there.

I am not—you guys read the polls, the same polls I do. I hope that you can come back with a drug benefit, even if it is only \$400 billion, and make sure—even if it is only \$400 billion, and you can't spend all that \$400 billion just on drugs, but let us say it is, that is an entitlement that would be available on the same terms to all the people in the current part A and part B. You will go a long way to getting support, and we look forward to working together on that kind of an entitlement. We could argue about how much money then, but let us do that. I look forward to hearing from you as soon as you have formulated this plan. Thank you.

Mr. THOMPSON. Congressman, I will be more than happy to sit down with you as soon as a plan is done and come up in your office and discuss it with you.

Mr. STARK. I will come to your office.

Mr. THOMPSON. Thank you. I appreciate that.

Mr. STARK. We will have wall-eyed pike.

Mr. THOMPSON. All right. Thank you, sir.

Mr. SHAW. Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Mr. Secretary, as always, it is good to have you here. Thank you for your presence.

I have just got a couple of comments. One, to pick up on Mr. Shaw's comment about cancer research, the issue is that there is a lot of money being spent for cancer research. I don't know whether it is enough or not, but the proportions, it seems to me, are way off because there is a tremendous amount going into prostate and breast and colon cancer, but the biggest cancer killer of all is lung cancer, and I just think it is—the redistribution of that research money is important. So, that is number one.

The other thing really—

Mr. THOMPSON. Congressman, the only rejoinder I have got to that is the institute directors pretty much direct—well, pretty much, they do direct how the research money is going to go out, and I never get involved in it whatsoever. I certainly will carry your message to Andy Von Eschenbach, yours and Congressman Shaw's, and discuss it with him, but he will have to make the final decision, Congressman.

Mr. HOUGHTON. I understand that, and I know you can't direct everybody's program under you, but I just have one final word, that for years and years and years there has been a disproportion here, and it just seems to me that you put your money where the big problem is. Maybe we will have a chance to talk about that a little later.

The other thing I wanted to ask about is the Medicaid reform. New York State has a model called the SCHIP program. Nearly 500,000 children are involved, and the cost is a billion dollars, but the allotment for the State is about a quarter of that, and the rest is covered by redistributed funds.

Could you help me a little bit on this, because obviously the States' budgets are under tremendous scrutiny and tremendous pressure. What is going to happen as far as the Medicaid program?

Mr. THOMPSON. The Medicaid program? First, cancer research, we are putting in an additional—in this budget \$204 million, a 4-percent increase in the overall cancer research, and there are other moneys going into it, Congressman.

In regards to Medicaid, the Medicaid proposal is going to still guarantee the mandatory populations. Nothing is going to happen. States are going to have the opportunity on a voluntary basis to be able to get, front-loaded, approximately \$3.25 billion the first year and \$12.7 billion over 7 years if they go into a plan in which they will voluntarily redesign the non-mandatory populations. That is about one-third of the populations and two-thirds of the options that consist of about two-thirds of the Medicaid budgets.

We are also putting in a provision, Congressman, that will reduce the amount of money that States have to pay in order to get the matching share from the Federal Government. It is called the State match versus the Federal match, and under the current laws in order to get the Federal match, there are three things that go

into the component. The first is increased population, the second one is utilization, and the third one is the inflationary costs of medical costs in a particular State.

We are recommending in the budget, in the Medicaid proposal, that two of those things do not go into the equation anymore, one, the population increases, and the utilization, only the inflationary index of the medical costs, which means there will be less money from the State going in to get the Federal match. We are also allowing complete flexibility for States, if they so desire, to go into the Medicaid proposal on the optional population as well as the optional add-ons, which make up about two-thirds of their budgets. So, it should be a very good deal for the particular States that want to do this.

Mr. HOUGHTON. Thank you very much.

Mr. SHAW. Mr. McCrery.

Mr. MCCRERY. Thank you, Mr. Chairman. Mr. Secretary, I want to get back to Mr. Stark's line of questioning, because you could have answered him more affirmatively on his question about whether the prescription drug benefit contemplated by the administration would be an entitlement just as he is entitled to part A Medicare, part B Medicare.

Part B Medicare is an entitlement, but does every senior have to take advantage of part B Medicare?

Mr. THOMPSON. Not every senior, no.

Mr. MCCRERY. That is correct. It is voluntary, isn't it? part B is a voluntary entitlement. You don't have to sign up for part B.

Mr. THOMPSON. That is true.

Mr. MCCRERY. If you do sign up for part B, you are entitled to do that, and you pay a premium approaching \$60 a month now.

Mr. THOMPSON. That is correct.

Mr. MCCRERY. Isn't it contemplated by the administration that the drug benefit will be voluntary, and if a senior chooses this entitlement, this voluntary program, he will have to pay some sort of premium? Isn't that contemplated by the administration's proposal?

Mr. THOMPSON. There will have to be a premium paid, but in regards to the compensation of the drug benefit, it has not been fully decided yet, Congressman.

Mr. MCCRERY. It will be an entitlement, will it not.

Mr. THOMPSON. That it will.

Mr. MCCRERY. It will be a voluntary entitlement, won't it.

Mr. THOMPSON. Yes.

Mr. MCCRERY. Just like the part B that Congressman Stark says he likes so much. So, I think Mr. Stark made an excellent demonstration of how the drug benefit contemplated by the administration will, in fact, be an entitlement under Medicare, just like part B.

Now, speaking of Medicare and the long-term costs of Medicare, we know—or at least we suspect—the analysts tell us that by 2016 or so, the payroll tax revenues for Medicare won't be adequate to pay Medicare part A expenses; is that correct?

Mr. THOMPSON. That is correct.

Mr. MCCRERY. We also know that long term we have a fairly substantial unfunded entitlement under Medicare; is that correct?

Mr. THOMPSON. That is correct, Congressman.

Mr. MCCRERY. Mr. Secretary—

Mr. THOMPSON. Everybody knows that.

Mr. MCCRERY. Mr. Secretary, how will your Medicare modernization proposal improve that long-term financial outlook?

Mr. THOMPSON. Well, since we are still working on the proposal, it is hard to quantify exactly what the impact will be on the long-term survivability and the fundability of the Medicare proposal.

Mr. THOMPSON. We are expecting that it will improve the overall survivability of Medicare and make sure that it is there and put it on a better footing.

Mr. MCCRERY. Well, I appreciate your dedication to doing that. I am anxious to see the details of how exactly your proposal will in fact improve that long-time financial outlook.

Mr. THOMPSON. You are going to be able to improve it, but you are still never going to be able to make it financially solvent, Congressman, by adding a benefit, whether it be prescription drugs, stopgap loss or anything else. You can make improvements, but you will not close the gap in the future. If that is what you are asking me, it is impossible at this particular point in time without making some real, further, dramatic decisions.

Mr. MCCRERY. Well, and those are the kinds of decisions that we need to start talking about. Mr. Stark yesterday provided me with some information, for example, on how much we would need to raise the payroll tax to close that gap. While I certainly don't want to do that, we have just got to start facing the fact that my generation is going to reach retirement age and we are going to be drawing down a huge sum of money from the Foreign Sales Corporation, of this country and Medicare and Medicaid and Social Security and these other programs; and, frankly, we are not so far talking in real blunt terms about what to do to fix it. So, I am hopeful that your proposal will go a long way toward fixing that and then we can add some other changes in the next few years to close the gap.

Mr. THOMPSON. We have got to start someplace, and that is what the President wants to do. He wants to make some improvements to strengthen Medicare and the prescription drugs and the stopgap loss.

Mr. MCCRERY. Well, I look forward to those proposals that will do that.

On welfare, just very quickly, last year we had 13 Subcommittee hearings on welfare reform. We had three full Committee hearings. One hearing had 47 witnesses, Mr. Secretary. We have had extensive hearings on welfare reform. We produced a bill last year. It is unfortunate the Senate couldn't follow suit and produce a bill. My question to you is, very quickly, has the administration changed its recommendations for welfare reform from last year to this year?

Mr. THOMPSON. No, it has not, Congressman.

Mr. MCCRERY. Thank you.

Mr. SHAW. Thank you. Mr. Matsui.

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

Thank you for being here, Mr. Secretary. I am trying to understand what I thought was some discrepancy between your answer to Mr. Rangel and then your answer to Mr. Stark, and maybe it

is my misunderstanding rather than your misunderstanding. I have read in the newspapers, and these were only newspaper reports, that whatever prescription drug benefit the administration intends to give will be based upon the beneficiary moving from the traditional Medicare part A and B system to a new system, Medicare+Choice, or under some kind of HMO structure. Now, you have given Mr. Rangel the answer that, no, that is not so or that we are still working on it.

Mr. THOMPSON. We are still working on it. The—but let me go on, Congressman. There is a lot of misinformation out there that the President and the administration proposal is going to force seniors into HMOs to get prescription drug coverage. I can assure you that is not the case.

Mr. MATSUI. Okay. Let me just follow up then and maybe, given what you just said, I may not be able to get an answer from you. In your response to Mr. Stark—let me put it this way. Would a person have to give up the traditional entitlement Medicare benefits guaranteed to 36 million senior citizens if that individual wanted to get the prescription drug benefit under the new approach that whatever the administration is taking—

Mr. THOMPSON. Congressman, I wish I could answer you, but the truth of the matter is the decision has not been made.

Mr. MATSUI. So, it is possible then—and help me. It is possible then the newspaper reports are, in fact, correct, that maybe a senior would have to leave Medicare and perhaps go into an HMO or at least a non-entitlement type coverage in order to get prescription benefits. I am just putting it a different way. You could say it is possible or you can say no.

Mr. THOMPSON. I have to say no, because the proposals are still being worked on, Congressman.

Mr. MATSUI. Well, I don't know what you mean. If the proposal is still being worked out, I guess you could say yes.

Mr. THOMPSON. No, I could say no; and that is what I am saying is no.

Mr. MATSUI. No, no. You could say yes or no, because you are basically telling me at this time you can't tell me.

Mr. THOMPSON. I can't tell you. I cannot tell you the final decisions at this point in time because they have not been made, Congressman.

Mr. MATSUI. Thank you. So, then the articles that were written by these journalists, New York Times and Washington Post, could be accurate, because you have said there is misinformation out there. With respect to the basic question of whether or not that individual would have to leave Medicare, the traditional Medicare that 36 million seniors at this moment are receiving—

Mr. THOMPSON. The article, Congressman, that said that all seniors would have to join an HMO to get prescription drug coverage is wrong.

Mr. MATSUI. I understand that you answered Mr. Rangel's question in that way. That is not the question I asked.

Mr. THOMPSON. Well, that is the question I have answered, sir.

Mr. MATSUI. Well, then you are being non-responsive to me.

Mr. THOMPSON. Well, I am trying to be responsive. I told you that we did not have an answer yet, and I will come back and talk to you as soon as we have a decision.

Mr. MATSUI. Mr. Secretary, I am not trying to—this isn't Perry Mason. All I want to do is try to get some of the facts out of you, if I possibly can. If you are basically saying it is possible, it may not be possible, well, then I have to suggest then that perhaps the New York Times and the Washington Post stories may be correct. If you are saying—but you gave me the impression in your response to Mr. Rangel that, no, that those stories were not correct with respect to that basic issue. All I want to know is what it is. If you don't know, you don't know.

Mr. THOMPSON. Congressman, the articles that were printed that said that all seniors would have to join an HMO to get prescription drug coverage is not correct. We have a proposal on Medicare. We are still working on it. We are working very hard on it; and, hopefully, we will have a proposal that we can give to you relatively soon.

Mr. MATSUI. If I could just say that—and you know this better than I do, Mr. Secretary, because you have been a Governor that has worked on a lot of these issues that people need. Nineteen-sixty-four, when Medicare was first established, the reason it was established is because seniors just couldn't get the kind of coverage that people in the work force could get through either their employer or through private insurance because, obviously, you had a situation of adverse selection. You had a situation where seniors were more chronically ill than people in their thirties and forties. Unless you have community rating—I don't suspect the administration plans to move to a community rating.

I would just hope—I would just hope that we go back and understand the fundamental reason why Medicare had to be put in place for senior citizens in the first place, because the worst thing in the world—and I know my time has just run out—would be to set up a private insurance program for senior citizens and find out that, through adverse selection and otherwise, that many would be really priced out of the market. That is a real danger, and I think that is the reason some of us are concerned about this.

It isn't to try to put you on the spot or ask you questions that are difficult. It is really to try to find an answer to make sure that all seniors are going to be adequately covered in the real tough years.

Mr. THOMPSON. Congressman, I appreciate that line of questioning. I appreciate your concern, and I wish that I could answer it directly. Until the decisions are made I cannot, and I am sorry about that.

Mr. SHAW. The time of the gentleman has expired.

Mr. Secretary, I would assume from the answers that you are able to give us as a little bit of a preview of what the President's plan might entitle, might involve, include, that it would be an entitlement under Medicare, is that correct?

Mr. THOMPSON. That is correct, Congressman.

Mr. SHAW. Thank you. Mr. English.

Mr. ENGLISH. Thank you, Mr. Chairman.

Mr. Secretary, I appreciate your testimony; and I know one of the issues that has engaged you in the past is the problem of the nursing shortage which is having a huge impact in a lot of places, not just like northwestern Pennsylvania but all over the country, particularly in rural areas. Do you see that this nursing shortage and its adverse effect on patient access to health care is a continuing trend? If you do, what do you see as some of the solutions to stop this future nursing shortage? If you would, I would like you to, in the process, comment on the need for funding education for advanced practice nursing.

Mr. THOMPSON. Well, there is no question that the Nation continues to face a nursing shortage. We are putting in and this budget includes a total of \$100 million for the Health Resources and Services Administration nurse education program in order to help support those individuals going to nursing.

The good point, the bright spot, Congressman, is that we are seeing an increase in the enrollment in nursing schools across America this year, and the applications for next year are increasing as well. That is a positive sign. We need to continue to support scholarship programs for nurses. We need to continue to put out information to the high schools and colleges that nursing is a profession that has a great potential and is a great profession. We are doing that, and we are encouraging more along those lines.

The last part of your question I did not hear.

Mr. ENGLISH. Specifically having to do with funding under specific programs for advanced practice nurses. I might add I notice—

Mr. THOMPSON. The Nurse Reinvestment Act that was passed on a bipartisan basis that was signed into law by the President last year definitely appropriated money for that, and we are doing that, Congressman.

Mr. ENGLISH. Very good. My hope is that there will be an opportunity through this process to provide greater funding than the administration had proposed under a couple of programs, including the title VIII Advanced Education Nursing Program.

On another point, I am delighted with the administration's continued effort to push for reauthorization of TANF. You may be familiar with the issue of full check sanction of welfare recipients who have refused to meet TANF work requirements. I think this is a critical reform, and my understanding is that full check sanction is going to be included in the bill that is likely to be considered in this Committee. Does the administration support the inclusion of full check sanction as one of the provisions of this bill?

Mr. THOMPSON. It has certainly not taken a position on it totally. We certainly support the concept.

Mr. ENGLISH. Well, I thank you.

Finally, I wonder if you would comment for a couple of minutes on your view of the importance of funding for child care. I know that the administration in the past has taken a strong position in support of funding child care programs as a component of welfare reform and as a Governor I realize that was certainly your position. As we move toward reauthorizing TANF, I wonder if you would comment on where child care funding figures into the priorities of this process.

Mr. THOMPSON. Well, the administration's proposal had a total of \$4.8 billion set aside for child care. This Committee and the Congress added an additional mandatory increase of \$1 billion over 5 years, which is \$200 million each year. The Congress also appropriated—Congress also authorized an additional \$1 billion on top of that discretionary over 5 years. So, actually, the \$4.8 billion in the proposal being introduced and being discussed in the Congress is actually \$6.8 billion, an increase of \$2 billion over what the President had requested.

Mr. ENGLISH. That is most reassuring; and, Mr. Secretary, I hope for the opportunity to work with you to make sure that those funds are squared away as we move forward and finalize TANF re-authorizations. I thank you for your efforts. We deeply appreciate your expertise, dating from your service as Governor; and I thank you.

Mr. THOMPSON. Thank you very much, Congressman. Appreciate that.

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

Mr. LEVIN. Thank you. Welcome, Mr. Secretary.

Mr. THOMPSON. Congressman, how are you?

Mr. LEVIN. Good. Thanks. Quickly, there are about 35 million people now who receive traditional Medicare coverage. Are you saying that you are assuring to those 35 million that they will receive the same prescription drug benefit as anyone else who is covered by Medicare but not through the traditional fee-for-service program? Are you saying that now to the 35 million people?

Mr. THOMPSON. No, I am not. I am saying that the proposal has not been fully decided and those decisions have not been fully made at this point in time.

Mr. LEVIN. Okay. Have you seen a document that was dated January 10, 2003, that came from the White House that had three different options? One, the current system—

Mr. THOMPSON. I have seen that, Congressman.

Mr. LEVIN. Isn't there a difference in prescription drug coverage depending on which option one is under?

Mr. THOMPSON. In that piece of literature that you have got, correct.

Mr. LEVIN. Okay. You are saying—

Mr. THOMPSON. I am telling you the final decision has not been made.

Mr. LEVIN. Okay. That remains one option?

Mr. THOMPSON. That remains one option, as there are many options on the table.

Mr. LEVIN. All right. That remains one option.

Mr. THOMPSON. That remains as one option.

Mr. LEVIN. I urge everybody to look at it, and the 35 million, understand that their prescription drug coverage, if any, would vary whether they maintain their present coverage or not. It is that simple, that clear. That is one option. Let me just say a word—

Mr. THOMPSON. There are several other options, Congressman.

Mr. LEVIN. I know. That is one option the White House has put forth.

Second, just a brief word on wellness because—I am sorry Mrs. Johnson isn't here. Welfare, as we know it, for years a number of us have been proposing on a bipartisan basis the Medicare Wellness Act. You talked about smoking. Included would be smoking cessation services, hypertension and cholesterol screening, vision and hearing screening, hormone replacement therapy for people with osteoporosis, nutrition therapy. Why don't you support it? It is the Medicare Wellness Act. It has been there for several years on a bipartisan basis. If prevention is such a major premise, why not put it into Medicare? Why say we don't like Medicare as we know it when we can have Medicare as we want it? What is the problem?

Mr. THOMPSON. Congressman, I don't know what your question is. I probably happen to be the strongest advocate—

Mr. LEVIN. I know you are, but why—

Mr. THOMPSON. On prevention, that is the future. If we want to control health care costs, prevention has got to be front and center.

Mr. LEVIN. I am with you completely. I know where you stand. Where is the administration?

Mr. THOMPSON. I think the administration is full and four-square behind prevention. The President, I can assure you, is passionate about it.

Mr. LEVIN. All right. Well, then let passion be embodied in proposals. Where is it? It is a hundred million. Where is the yes or no on the Medicare Wellness Act that we have proposed on a bipartisan basis and that would also eliminate the copayments and the deductibles for essential screening proposals? I urge you—

Let me ask you this. If you could in the next week or two, tell us the administration position on the Medicare Wellness Act. Quickly, on welfare reform. You and I have worked together. We did in 1995 and 1996.

Mr. THOMPSON. Yes, we have.

Mr. LEVIN. Now, you say there is more flexibility in this proposal. Will the States be able, under this proposal that went through the House on a very partisan basis, will they be able to maintain their present mix of programs in all cases?

Mr. THOMPSON. They are going to have to make some changes.

Mr. LEVIN. All right. So, their flexibility will be reduced in certain instances, right?

Mr. THOMPSON. It will be reduced in some areas but expanded in many others. Let me give you an example, Congressman. Right now, under the TANF law, at the end of the year if you have any extra benefits, any extra resources, you have to spend that only on the benefit side of it. You cannot put it into education. You cannot put it into training. You cannot put it into child care. This proposal would allow State Governors and State legislators to have the flexibility to use that money. In this past year, at the end of this past year was \$2 billion—

Mr. LEVIN. We are all in favor of that.

Mr. THOMPSON. The \$2 billion that the States could have used if we would have been able to change the law. The new TANF law gives the States that flexibility. That is huge flexibility, and that is real dollars.

Mr. LEVIN. We are in favor of that. In many cases there is going to be less flexibility. I will send you the list of cases and if you will respond.

Mr. THOMPSON. I certainly will, Congressman.
[The list and comments follow:]

Current state programs which states would have to discontinue to meet the new work participation requirements under the President's plan/H.R. 4

1. Go to school 10 hours a week, work 10 hours a week, and study 10 hours a week. Michigan's 10-10-10 program. Michigan has a program in which participants are required to spend 10 hours working, 10 hours in class, and 10 hours studying.

2. After working for 4 months, go to school for a year to develop skills for a specific job and work 32 hours a week during the summer. Wyoming's skills upgrading program. Wyoming has a program which allows welfare recipients who have demonstrated a commitment to work by working full-time for 4 months to pursue training which will lead to a specific job. They must take at least 12 credits per semester and 32 per year. If they are not in school, they have to work 32 hours a week during the summer. And they must maintain at least a "C" average.

3. Work half the day and go to training for the other half of the day. Oklahoma's work & training program. Oklahoma has a program which allows people to work half the day and attend training to help them get promoted for the other half of the day. At the end of the training program, participants receive higher-level full-time jobs at their employers.

4. Conduct an intensive 6 week job search and then get skills upgrading services if you don't find a good job. Portland's job search program. Portland's program encourages people to pursue longer, more targeted job searches to make sure they get the best available jobs. Longer job searches led to higher-paying jobs and more people getting benefits. If a 6-week job search did not result in employment, the site then provided targeted education and training or other services for up to 6 months.

5. Allow welfare recipients to participate in job-sharing programs in which they share a 40-hour a week job and attend school part time. New York's job sharing program. Participants share a job. Each of them attends school and studies half the time (20 hours) and works at the job the other half of the time (20 hours).

6. Allow people who work at least 15 hours a week to go to school full-time and still receive TANF services. Arkansas program—state law mandates that at least 700 welfare recipients be in this program (13% of current adult caseload).

7. Provide 6 months to a year of intensive substance abuse treatment before placing the participant in a job. Utah's barrier removal program. According to the Utah TANF Administrator, their experience is that at least 6 months of intensive substance abuse treatment is needed before an addicted recipient can sustain employment.

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Thank you for sharing the examples of current state programs which would need to be modified in order to meet the new work participation requirements under the President's plan.

Several of these programs would require only minor modifications in order to be countable under the President's plan for welfare reauthorization:

- *Arkansas, Michigan, New York and Oklahoma* combine work with other activities to meet the current work requirements. These programs would need to expand the hours of required work to 24; in the latter two states, only an additional 4 hours a week would be required. Time spent in work-study positions, internships and co-operative education would all be countable toward the 24 hour direct work requirement under the President's plan. Classes and structured study time could still be counted for the remaining 16 hours of participation required.
- *Utah's* barrier removal program could be countable under the President's plan, if work activities are incorporated into the treatment program after the first 3 months. Such activities, including on-site community service, are common elements of existing substance abuse treatment programs. This approach is supported by recent research, which indicates that even intensive substance abuse treatment is ineffective in moving welfare recipients with substance abuse habits into work if it is not closely linked with employment-related activities. At the same time, involving such clients in produc-

tive activities, particularly work, early on and as part of treatment is considered very important to reducing their substance abuse problems.

States would receive more credit for some programs under the President's proposal than they do under current law.

- Under current law, none of *Utah's* barrier removal program could be counted toward the work participation rate calculation. Under the President's proposal, full-time substance abuse treatment, mental health services, or educational activities could be counted toward the participation rate for up to 3 months. Such activities may also be counted thereafter, when combined with direct work activities.
- Under current law, job search is countable for only four consecutive weeks, and for no more than 6 weeks in a year. Under the President's plan, *Oregon* would receive more credit for Portland's job search model than it does now. Intensive job search and targeted education and training could be counted toward the participation rate for up to 3 months. The work-related education or training could also be counted for up to 16 hours per week thereafter, when combined with direct work activities.

States that meet the participation rate requirement will continue to have flexibility regarding activities for the remainder of their caseloads.

- In the latest year for which data is available, *Wyoming* achieved a 71.8 percent participation rate, very little of which was due to its skills upgrading program. If it is able to sustain this level of achievement, the state may continue to allow additional recipients to engage in non-countable activities.

Chairman THOMAS. [Presiding.] Thank the gentleman. The Chair would recognize the gentleman from Illinois and would request that the gentleman recognize the Chair briefly.

Mr. WELLER. I would be happy to recognize the Chairman.

Chairman THOMAS. I do want to do it on the clock in the time that we have. The Chair apologizes for visiting with some constituents briefly. The direction of the statements that have been made need to be clarified and underscored.

The gentleman from Michigan is right. There has been some proposal introduced. My understanding is the first year it was introduced was the year 2000. They are to be commended for finally beginning to look at preventive and wellness programs in Medicare. His party was the majority party for more than 30 years when Medicare was on the books, and it wasn't until the new majority took over in the 104th Congress that we added quality preventive programs to Medicare. We did colorectal screening. We added diabetes testing and education. We added osteoporosis testing. In the last bill that passed the House of Representatives, that the gentleman chose to vote against, we covered cholesterol testing and we provided a physical for every senior in Medicare. Preventive and wellness was not added to Medicare until the Republicans became the majority.

I do want to underscore that I am pleased that the gentleman has tried to move in a bipartisan way to finally, in the year 2000, talk about adding some preventive. We set up a system in 1997 which allows the Institute of Health and others to examine what it is that we should add to preventive that clearly makes sense. Since then, we have added nutrition therapy to diabetes and high blood pressure. We have a process in place that continues to evaluate preventive and wellness and when cleared by the appropriate agency will be placed on the Medicare agenda.

For the gentleman to leave the impression that this administration or anyone else has not been aggressive and active in adding

preventive and wellness is to simply ignore the facts and the record for 40 years. For 30 years they were in control. Nothing added. Since we have been in the majority, all of the items that I just listed and a process to add more is in place.

The gentleman thanks the gentleman from Illinois for allowing for the time.

Mr. RANGEL. Mr. Chairman, in all fairness, you mentioned the gentleman from Michigan—

Mr. WELLER. Thank you, Mr. Chairman. Reclaiming my time.

Mr. RANGEL. I would ask whether the—

Chairman THOMAS. The gentleman from Michigan had his 5 minutes and made his points.

Mr. RANGEL. You really illustrate the need for prescription drugs.

Mr. WELLER. Reclaiming my time.

Chairman THOMAS. Well, the gentleman's frequent trips to Mexico in which he acquires drugs—the Chair may go along and actually get some prescription drugs. The gentleman from Illinois.

Mr. WELLER. Reclaiming my time. Thank you, Mr. Chairman. Mr. Secretary, good morning and thank you for joining us. We appreciate how well you represent the administration and the good work you do, and we enjoy working with you.

Mr. THOMPSON. Thank you.

Mr. WELLER. Focusing again on preventive measures, let's talk about community health centers.

Mr. THOMPSON. Yes.

Mr. WELLER. I have been—as one who has taken an active interest in community health centers, I have been very pleased with the priority the President is giving—has given both with respect—

Mr. THOMPSON. It is a huge priority to the President.

Mr. WELLER. The personal commitment to community health centers and particularly with his proposal to expand care to uninsured Americans, and of course that is a goal I support.

Over the last year or so, I have been working with some of my colleagues' legislation to improve the Medicare Program for health centers' elderly patients, for seniors who qualify for Medicare. Of course, as you have outlined today, the administration budget reinforces the importance of preventive benefits for the Medicare population. However, health centers are limited in what they can offer under Medicare and what they can provide and of course be reimbursed for; and many of us would like to see community health centers be able to offer and be reimbursed for those same services that other Medicare providers are able to offer. I was wondering, do you believe it makes sense to limit if you are a senior in a rural area or an area that is only served by community health centers not to be able to obtain those same type of preventive services you would be from another health care provider? Or would you support expanding it so community health centers could offer the same?

Mr. THOMPSON. Congressman, I am so passionate and such a strong advocate of preventative health measures for all Americans, especially for seniors. If we are ever going to control health care costs in America, we have got to put prevention front and center, as I mentioned in answer to a question by Congressman—Con-

gresswoman Johnson and Congressman Houghton. I would support it. I believe it is the right thing. It is the right direction, and anything we can do in this area I will support.

Mr. WELLER. I look forward to working with you. Thank you, Mr. Secretary.

Mr. THOMPSON. Thank you.

Chairman THOMAS. Thank the gentleman. The gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman. Let me yield 30 seconds to the gentleman from Michigan for a brief response.

Mr. LEVIN. Mr. Thompson, we are talking about the future, but you have raised the past. In the 1995–1996 session, we proposed an amendment to add colon cancer, mammography, diabetes and prostate cancer screening to Medicare; and you voted against it, as did every other Republican who was then there and who is now on this Committee.

Mr. KLECZKA. Mr. Chairman, thank you for the recognition. Mr. Secretary, I have a couple of quick questions. Number one, there is a physician fee freeze in the current budget reconciliation bill that we are addressing here in the Congress. I am getting letters and I am assuming my colleagues are that doctors aren't going to accept any more Medicare patients. They are not going to accept the assignments that many of the physicians have done because of the payment rates. Are you supportive of the freeze contained in the budget bill which would, I believe, lock in the—or prevent the decrease until October of this year?

Mr. THOMPSON. There has been much discussion about it, as the Congressman knows. The Administration is in support of doing something for the physicians. Congressman Thomas has made a proposal as well as the Senate and the administration is hoping that Congress can reconcile it.

Mr. KLECZKA. Okay. What position or what proposal does the administration support?

Mr. THOMPSON. The Administration is hopeful that the Congress will be able to resolve that. The Administration has not taken a position on either one of the proposals.

Mr. KLECZKA. So, you are saying the administration does not support the Senate proposal since that is the only one that is before us.

Mr. THOMPSON. It is my understanding that Congressman Thomas has made a proposal.

Mr. KLECZKA. Well, we haven't, okay? We haven't seen that here.

Mr. THOMPSON. Oh, that is my understanding.

Mr. KLECZKA. Well, could you share with this Member what that proposal is?

Mr. THOMPSON. It is my understanding that there is a proposal that Congressman Thomas has, and there is a proposal that the Senate has, and the administration has not taken a position on either one. They support the concept.

Mr. KLECZKA. Thanks.

Chairman THOMAS. Would the gentleman yield on my time to explain it?

Mr. KLECZKA. Sure. Go ahead.

Chairman THOMAS. Last year, the House sent to the Senate a provision which would allow the administration to make a correction in the formula for reimbursement to physicians since there is what we call a plug number there now and we now have accurate data. If the accurate data were put into the formula, those significant negative updates would, in fact, reverse themselves.

That legislation was moved out of the House and presented to the Senate. What the Senate has done in this Congress on the omnibus appropriation is to provide a \$600 million short-term funding to stop the administration from going forward with the regulation which has been characterized by those individuals in charge of it. Used to be the Centers for Medicare and Medicaid Services (CMS). I can't remember what the name of it is now. They said that they would prefer not to implement that regulation.

The Senate provision is a short-term funding. It also includes several other provisions which assist some providers and not all providers. The goal is to fix the flawed formula for physicians and then address in a broad and complete way reimbursement for all providers, just not certain hospitals or certain home health. So, the Secretary's characterization of our position and their position is that the House is for fixing the flawed physician formula and then moving forward addressing Medicare and assisting providers. The Senate has legislation on an appropriations bill in an attempt to help only some. The goal would be to try to stop the flawed formula from going forward and then address in a broad way all the other decisions that need to be made.

Mr. KLECZKA. I thank you, Mr. Chairman. I am aware of the fact that we did pass legislation out of this Committee and out of the Congress last year—

Chairman THOMAS. Right.

Mr. KLECZKA. Addressing the problem in a more permanent way through a phasing process. However, the fact is that constituents around the country, or Medicare constituents, are faced with the prospect of the doctors denying them service because of the dilemma they are in. To hear that the administration today has no position and it is up to the Congress to do it, I think that is a cop-out; and I would have hoped that the Secretary would have come before the Committee and said, okay, we urge the Congress to do this so we can help those seniors who are going to be denied service by the physicians. Mr. Secretary—

Mr. THOMPSON. Congressman, I would like to respond to that.

Mr. KLECZKA. You already said you want Congress to fix it. I only have 5 minutes.

Chairman THOMAS. Let me briefly say to the gentleman from Wisconsin—

Mr. THOMPSON. You said the administration is not doing anything. The Administration delayed the rule until March 1, 2003 to get Congress to do it. We can only implement the laws that you pass, Congressman. We cannot change them. We cannot change the fix on the physicians fee until Congress makes a change. We are complying with the law, and we delayed it till March first so Congress would have ample opportunity to fix it, Congressman. The Department did that.

Mr. KLECZKA. Okay. We just were presented with a massive budget for fiscal year 2004 where the administration is taking a position on almost every part of this Federal government, okay? They weren't bashful in doing that, which I think is their job and their responsibility. On this one you seem to be taking a duck.

Mr. Chairman—or Mr. Secretary, we are told by the OPM director that for the foreseeable future all dollars in the Medicare trust fund are going to be used for Federal operating expenses. Now you recall the talk when you were first appointed to the job of the lockbox and not touching these funds and all that other stuff. What is your view of drawing down and using every dollar in the Medicare Trust Fund for annual operating expenses of the Federal government?

Mr. THOMPSON. Congressman, that is out of my Department's prerogative. That is up to Congress. If Congress passes the laws and they determine how it is to be funded—

Mr. KLECZKA. Do you think that is wise policy on the part of Congress?

Mr. THOMPSON. Well, it would be nice if we didn't have a recession, if we didn't have a war on terror. It would be nice if we had a stronger economy and we wouldn't have to do it.

Mr. KLECZKA. It would be nice if we didn't have \$2.4 billion in tax cuts that are not only adding to the deficits but forcing us to draw down those trust fund dollars. The President's budget states that the legislation passed to modernize medicine last session did not meet his principles. What were the deficiencies in the Medicare modernization prescription drug bill of last year that doesn't meet the President's principles?

Mr. THOMPSON. Congressman, I didn't hear you. I am sorry.

Mr. KLECZKA. Okay. In the President's budget he states that no bill, and I am quoting, no bill met the President's principles for strengthening and improving Medicare. Last session, the bill that we passed out of the House was the Medicare Modernization and Prescription Drug Act. What was deficient about that bill that didn't meet the President's principles?

Mr. THOMPSON. Well, that bill was a start. We just don't think it went far enough to make sure that the Medicare proposal for the future was going to be one which was going to be financially stable, and we certainly are concerned about that. We are also concerned about the fact that it doesn't have the stopgap loss in it. We also do not believe it had enough preventative health measures in it, and those are the things that we are concerned about. We think that there needs to be more choices. We think that seniors should have the opportunity to have the same choices in their health plans as you do and as I do.

Mr. KLECZKA. Under the Medicare Program.

Mr. THOMPSON. Yes, sir.

Mr. KLECZKA. Okay. Mr. Chair, thank you for your generosity.

Chairman THOMAS. Thank the gentleman for allowing for the exchange. Our purpose here is to, as much as we are able, enlighten rather than to inflame. The gentlewoman from Washington wish to inquire?

Ms. DUNN. I do, Mr. Chairman. Thank you very much and welcome, Secretary Thompson.

Mr. THOMPSON. Thank you, Congresswoman.

Ms. DUNN. It is great to have you here, and I want to give you kudos for your proposal to allow States to retain their SCHIP funds for longer periods of time. It is really important to us in Washington State.

Mr. THOMPSON. I know it is.

Ms. DUNN. Yes. As you are also aware, I am sure, there are several States, including my State, New Mexico, New Hampshire, Vermont and Minnesota, that expanded their coverage for young people under the age of 18 before the SCHIP program came into being. So, to qualify for SCHIP funds they had to expand their program again.

So, while I give you kudos for allowing us to retain the dollars longer, I also believe that we need to insure that those States that were innovative, that really showed an interest in covering children aren't penalized for that degree of progressivity that they showed when they did that. Washington State, for example, cannot actually utilize its SCHIP funds for children below 200 percent, even though we took the initiative to expand our Medicare Program.

So, I am hopeful, Mr. Secretary, that as we consider improvements to that program, which you are doing in the administration, I hope that you will find it in your heart to be supportive of our efforts that we have done in our States and to allow that handful of States that were not grandfathered that expanded their child coverage programs that they would be able to use these SCHIP funds for children already on Medicaid.

Mr. THOMPSON. Congresswoman, you will be happy to know the Medicaid proposal that we designed in the Department and which I unveiled last Friday does exactly that.

Ms. DUNN. Thanks. That is all I needed to hear. Thank you very much.

I am also worried about the payment formulas in Medicare. We have had this conversation before, talked about it a number of times. In most cases, certain States like Washington, Minnesota, Iowa continue to receive a lower payment for providing the same services to Medicare patients—

Mr. THOMPSON. That is correct.

Ms. DUNN. These geographic differences in payments can hinder access to services or quality of care. Let me just give you a couple of examples.

The Medicare+Choice program that Washington State health plans have receives a lower payment compared to health plans everywhere else. Second, geographic adjusters and the physician payment system also result in different reimbursements in different regions.

We certainly expect some variations but not the types of variations that we have been seeing and that we are penalized for in Washington State. I hold a concern that seniors be treated equally everywhere, that there is equity among seniors, regardless of where they live and where they receive their coverage.

I would like to hear from you some comments on the administration's efforts to help stabilize the Medicare+Choice program, especially for these low-payment States.

Second, I would like to hear your comments on how to fix the flaws in these formulas.

Mr. THOMPSON. Congresswoman, I agree with you completely. I think that there needs to be some changes in the discrepancy of payments and the fluctuation of payments on Medicare reimbursement. The truth of the matter is that 71 percent of the reimbursement goes into wages, and that is the biggest driving force, and that is statutory. In the compilation of how we make the reimbursements that is statutory, and this Congress and the Department need to work together to review that.

Regarding the Medicare+Choice, we are still working on that. The details are to be forthcoming as soon as we have completed action. I will be more than happy to sit down with you as soon as the decisions are made on the Medicare+Choice as well as on the Medicare strengthening proposal that we are going to advance.

Ms. DUNN. I appreciate that, Mr. Secretary. I would like to call your attention to a piece of legislation that I am going to be offering this year that we do a number of things, including increasing the 2 percent update that is offered every year to 6.5 percent for the next 2 years. I would like to have a chance to talk with you, get your input on that piece of legislation. Since I still have a—

Mr. THOMPSON. Thank you. I would be more than happy to.

Ms. DUNN. Thanks. The other problem that I am concerned about is our access to medical innovations, drugs, devices but also tests. Currently, there are barriers to access to all of these. Last year I had proposed a bill that had to do with access to testing, and parts of this bill were included in the House Medicare package, which, as you well know, did not pass; and the thrust of it was to create a transparent system so that—and a predictability system at CMS so that we could allow these tests to be applied for and then eventually covered by Medicare. I am hopeful, Mr. Secretary, that you will work with me and our Subcommittee on Health and the full Committee to develop this kind of transparent process that we are all looking for in CMS so that seniors will have the access to technology that they need.

Mr. THOMPSON. Thank you. Thank you very much, Congresswoman. I am more than happy to work with you and the Subcommittee.

Chairman THOMAS. Thank the gentlewoman. Gentleman from Washington wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman. Pleasure to see you here. You are a great cheerleader for the administration, and I would like to understand how you view a couple of things here. I understand that you have told us that people will not have to change anything in their coverage to get the pharmaceutical benefit. They won't have to go into any kind of other organization. People in Milwaukee, where there is one place, they will be able to stay just as they are and get this new benefit, is that correct?

Mr. THOMPSON. Congressman, I did not say that. I said that they will not be forced into an HMO in order to get the new pharmaceutical. The decisions have not been made yet, and as soon as they are I will be more than happy to sit down with you and discuss them.

Mr. MCDERMOTT. I hope it is out here in public. Let me go to another issue. The President says he wants to take care of people who aren't covered, and we come up with a tax deferral or a rebate for people to buy their own insurance. Now, I would like to ask—well, first of all, I think it is inadequate, because I think it is going to make people leave employment insurance to go out and buy their own or that is what is going to happen. Some employers are going to say, look, I am going to stop offering coverage. You can buy your own. Use the tax credits, and you are on your way.

I want to know why you didn't think about expanding either Medicaid or Medicare? What is it? The studies that I have seen show that that is a much more efficient way to spend the money that the government's putting into it. Rather than giving a tax break which is an expenditure, why not put it into Medicare and Medicaid and let people join those programs?

Mr. THOMPSON. You mean for the uninsured.

Mr. MCDERMOTT. Yes. The President's put forward a package that reduces the number of people on Medicaid and is making it more difficult at the same time he says he wants to cover more people, and I don't—I really don't understand that. Why not put more money out to the States to cover Medicaid?

Mr. THOMPSON. Congressman, we are going to allow \$3.25 billion for the States that want to voluntarily go into this new Medicaid proposal and allow for the States to design a program so that the uninsured, if they so desire, could go into the Medicaid program, if in fact the Governors and the legislators of that State so desire. We are going to allow them to have control over the optional side of Medicaid as well as the optional benefits so that they can make the determination in their own State.

Mr. MCDERMOTT. Mr. Secretary, you were a Governor—

Mr. THOMPSON. Yes, I was, 14 years.

Mr. MCDERMOTT. When the Federal government gives with one hand and takes back with the other—

Mr. THOMPSON. I don't understand where we are taking back. We are giving in this case.

Mr. MCDERMOTT. You are giving them revenue neutral over 10 years.

Mr. THOMPSON. For the first 7 years, Congressman, it is going to be an additional \$12.7 billion.

Mr. MCDERMOTT. Oh, I see. So, get it through these next two Administrations or two terms of office and then we will leave the problem on the doorstep of somebody.

Mr. THOMPSON. It will be beyond that, Congressman.

Mr. MCDERMOTT. I see. Okay. Well, I am glad to hear that. Now, this was—

Mr. THOMPSON. I would like to point out for you, Congressman, that States right now can do this. States can change the optional programs. The States can change the optional population, and they are doing it. We are giving them the opportunity to continue the Medicaid coverage for those populations. That is the beauty of the Medicaid proposal and advancing the money right now so that the States can do it, Congressman.

Mr. MCDERMOTT. You can have all the flexibility in the world, but if you don't have the money—I don't know what the deficit in

Wisconsin is. It is something like \$3 billion this year. Now to say to the Governor of Wisconsin and the legislature, hey, you guys, you have got all the flexibility in the world but no money. The same thing is true in the State of Washington. They are using the flexibility, and they are cutting the program. So, I don't see, if you don't put more money into it—

Mr. THOMPSON. Congressman, that is what they are doing now. If we pass the Medicaid proposal, they will have an additional \$3.25 billion this year, plus it will reduce their expenditure from the State of Washington and the State of Wisconsin to the Federal government. Under the Medicaid law, in order to get the Federal matching share, States have to make a computation annually on three factors: the population increases, the utilization and the indexing and inflation of medical costs. What we are saying in the Medicaid proposal is reducing it so they will not have to pay for the population increases or the utilization. So, there would be less money from the State of Washington coming to Washington, DC, in order to get money back to Washington State. So, it is really a good deal for the State of Washington, and I am fairly confident that your Governor will be very enthusiastic and supportive of that.

Mr. MCDERMOTT. What is our share of the \$3.2 billion?

Mr. THOMPSON. I haven't figured it out. I will get that figure to you before the end of the day if you want it.

Mr. MCDERMOTT. I would like to have that.

Mr. THOMPSON. Okay.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The gentleman from New York indicates that at the program that Members chose not to attend, but rather to come here, they have concluded the program by playing Taps; and the gentleman from New York, I think rightly, suggests that those of us that are here conducting the people's business pause briefly and recognize through a moment of silence not just the ceremonies honoring those individuals but those individuals themselves. Thank you. The gentleman from Georgia wish to inquire?

Mr. COLLINS. Thank you, Mr. Chairman. Thank you, Mr. Secretary. It is always a pleasure to listen to your wisdom; and, once again, I want to reissue the invitation to you to visit Columbus, Georgia, and visit our community health center, one that has done remarkably well in delivering services to a very needed area of Columbus, Muskogee County. That is an area where there is a very substantial amount of poverty and low income. I hope that you will be able to make that visit.

It is now—the health center is actually now located in the district of Congressman Sanford Bishop, but I know that he, too, would be glad to welcome and have you visit that area.

Mr. THOMPSON. Thank you, Congressman.

Mr. COLLINS. I am pleased to see that you all are proposing more funds to help the community health centers. This particular need at this center is not so much in the area of additional funding for the care but the resources for the capital outlay to have additional area to be able to provide the service in. They started out in a small facility several years ago, attending to just a handful of

patients. Now they are up to over 4,000 patients and over 10,000 visits annually, and their facility is not much larger than the office suite that I occupy across the hall. So, you can know that they are in very much need. They have taken quite a load off of the local hospital, so I hope you will consider and come down as early as possible.

Mr. THOMPSON. Thank you very much, Congressman. I would be more than happy to do that.

Mr. COLLINS. In the area of the prescription drugs, my concern is this, and it is a concern of those who I have in the district and discussed this with on a number of occasions, that anything we do here or whatever we do here could possibly jeopardize the coverage that many already have. Even last year's bill that passed in the House had a tendency to—the numbers given to us, that would cause a third of those who were insured through a previous type of employment or such to lose that coverage. That about 95 percent of seniors would opt into that program under the Medicare insurance.

Those numbers don't quite rhyme together with me, but is it the administration's position that those who have coverage will not lose that coverage because of something that is offered here by the Congress?

Mr. THOMPSON. That is certainly going to be up to the individual, and we are certainly not going to force anybody to give up their coverage in any way, shape or manner.

Mr. COLLINS. Well, the concern is not that they would—they would have the option of doing so, but the option might be someone else's to discontinue the coverage that they had under their previous employment or through their retirement. That is of concern to me.

Mr. THOMPSON. You are talking about the supplantation of—

Mr. COLLINS. Yes. I hope that we will take that and you all will take that into consideration with Administration, too, because that is—it could cause someone to go into a program that is much different than they have today or with less benefits than they have today. So, I hope we will keep that in mind.

Much has been said about entitlement. This should be an entitlement. I know when we were dealing with the welfare reform bill back in 1996 and you were so helpful with us on that, at that time the welfare was a Federal entitlement. The way we structured it and with the help back to the States it became a State entitlement. The States control and look after the welfare. That is the approach I like about what you said a minute ago about the Medicaid program. The Medicaid program is a way to really get to and help those who are very low income, who are having to actually make a decision as to whether or not they are going to be able to get assistance and pay for their actual needs for existence at their home or buy drugs. There is very little help for them. It depends on the State and how they set the poverty rate.

So, I would hope that we would be able to take a real serious look at that. I know there is some reluctance in the Congress to address it in the fashion you have brought forth. I hope that the Congress will take a look at that because I think it is a very work-

able solution to those who really need access and yet not jeopardize what others already have.

So, I appreciate your work. I appreciate what you are doing. For those who want to use the word HMO when it comes to Medicare in maybe a negative way, I view it, Medicare, as a giant government-run HMO with 535 Members of the board of directors who can't decide on anything, who don't trust one another, who are behind when it comes to wellness, devices, procedures, and services and payment. Thank you for your time.

Mr. THOMPSON. Thank you for your observations, Congressman.

Chairman THOMAS. Thank the gentleman. The gentleman from Missouri wish to inquire?

Mr. HULSHOF. Thank you, Mr. Chairman.

Mr. Secretary, welcome. I want to begin by also providing some kudos to you and specifically to the gentleman seated behind you, Mr. Scully, the Director of the Centers for Medicaid and Medicare Services. In the State of Missouri we have had, for a period of time, a dispute regarding our provider tax; and that situation has been resolved. Mr. Scully and his staff, I think, helped fashion a solution that has really been a constructive solution and maybe a model for other disputes regarding that difficult situation, so I wanted to publicly give Mr. Scully a plug for all of his efforts in our State.

I want to focus my remaining time on the situation regarding the average wholesale price. Your own Inspector General, the General Accounting Office, your predecessor, others have highlighted the over payments for Medicare part B covered drugs and biologics. This is because, as most folks here probably know, that part B—that Medicare reimburses part B drugs at 95 percent of the average wholesale price, and these prices are generally viewed as being higher than the price that manufacturers charge providers.

As you consider changes—and we certainly welcome changes. Nobody here on either side wants to see overpayments for these drugs. I would also caution you—in fact, maybe a little stronger, I would implore you that as you consider these changes you also consider them in tandem with making sure that physicians are actually reimbursed for other costs that are ignored by Medicare. Let me just give you a specific example.

There are some oncologists in my district, indeed, across the country, that are performing miracles every day with cancer survivors. Sometimes these are clinical trials, sometimes cutting-edge, innovative technologies. Mr. Shaw, who we welcome back here today, is thankfully a cancer survivor. Yet many of these oncologists, as they provide this treatment, they have specialized training for oncological nurses and have to deal with side effects with these patients. Yet none of that is reimbursed at all.

So, my fear is we have got a very cost-effective way in an outpatient setting to really help more Americans be cancer survivors, not cancer victims. My fear is that if we just focus entirely on moving to a competitive bidding structure, which I—again, I think a lot of us would support, that we are going to force a lot of these cancer patients into a perhaps less effective, more expensive inpatient setting.

So, my only caution to you would be, again, as we look at market-based models, you are going to find a lot of support there, but let's really look at all of the costs, some of which are not being reimbursed, so that we can continue to have more success stories like Mr. Shaw.

That is my comment, and if you wish to comment further—

Mr. THOMPSON. Congressman, I would just like to say thank you for recognizing Tom Scully and the job that CMS is doing and the whole Department. We have attracted some real stars over there, and I appreciate that people recognize that.

I also would like to tell you that we are trying to continue to streamline and revise Medicare reimbursement formulas, and it is a difficult and a very complicated procedure. I can assure you that we will continue that effort.

I thank you for your comments and your suggestions. We will take them to heart, and we will continue to work with you toward the goal of making better coverage decisions. That is something that I have asked Tom Scully and Members of CMS to do, because we can save more money doing the kinds of things you said and the kinds of things that Congresswoman Johnson and Chairman Thomas have said in the areas of prevention. We can provide better care, more quality care and save dollars. It is a passion of mine to do that, and I thank you for your comments.

Chairman THOMAS. Thank the gentleman. The gentleman from Texas, Mr. Doggett, wish to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman; and thank you, Mr. Secretary. I do respect what you say and the service you are providing our country.

I have to tell you that it is really troubling that every time this morning that we ask for a specific on this prescription drug plan you basically offer your regrets because you don't have any specifics. We have rushed forward with this hearing this morning at a difficult time when you were saying basically you would like to answer our questions, but you just don't have your orders from the administration yet. This Administration is in, now, year three of its life; and I believe that during that entire time it has yet to come forward with a specific prescription drug legislative plan; and I think just the failure over that time period to come forward with any specific legislative proposal is an indication of a rather low priority that it places on addressing what many seniors really view as a crisis.

One, you have addressed this this morning that one health care reporter this year—now that we are finally focused on the possibility that you might come forward with a plan, one reporter after another has been reporting that the core of that plan is that if a senior wants to be able to get access to these desperately needed prescription drugs they have got to give up their choice of a doctor. You have said that that is not true. I don't think they pulled that notion down out of thin air.

I understand that the administration—and I—if there is one thing this administration is incredibly good at, is just truly miraculous, more miraculous than any of these prescription drugs and their cure, at spinning these proposals. You may have some kind of eyewash that comes out to cover the proposal or another near

worthless discount drug card or something, but the question that I want to ask you about this, I understand y'all want to disclaim any limitation on people's choice of their doctor with the political cost associated with it. Can you guarantee us that you personally will not support any prescription drug plan that does not give a statutory guarantee to those that are in traditional Medicare, 36 million people, that they will not be disadvantaged in any way if they choose to get their prescription drugs through the traditional Medicare rather than choosing to go into an HMO or some kind of private health care scheme?

Mr. THOMPSON. Congressman, let me assure you that Medicare strengthening, revitalization, prescription drug coverage, is of the highest priority of the President, of myself, and the total Administration.

Second, let me also reiterate that we are working extremely hard and have spent many hours, many days spent on this Medicare proposal. We continue to meet on it. We continue to work on it, and the final decisions have not been made. I do not want to give you any erroneous information. I do not want—

Mr. DOGGETT. I understand. I just want to know about the guarantee. Can you do that or not?

Mr. THOMPSON. I am not going to say anything about the details of the proposal until they are done. It would be foolish on my part to comment on a proposal that a decision may be made that will—

Mr. DOGGETT. I respect your position. I understand you have to work within this administration, and you are telling us you cannot guarantee that what some in this Committee call an incentive to go into a private insurance plan and I would call a penalty of a discrimination, that if you want your prescription drugs, you are going to have to pay a high penalty for doing it, you are not going to be treated the same way as those who go into—as I gather from some of the questions that you answered this morning, we have a Medicare entitlement, but it would be an entitlement to whatever limited coverage the HMO wanted to provide, and the administration in its plan has been unwilling to announce that there would be those statutory guarantees against discrimination.

You all can have all the compassion, and I am sure it is great and extensive, and that you care about it as much as I do, but you can have all the compassion you want and you could have all the speeches you want, but if you do not put in statutory guarantees to prevent discrimination against the people that have relied on this Medicare system since Lyndon Johnson signed it into law, then you are going to harm them and you are going to be limiting them in their choice.

Now, as relates to this supposed imminent collapse of Medicare, the truth of the matter is Medicare is not becoming officially insolvent for 28 years, is it? The longest time in its history that it has projected solvency. Isn't that correct?

Mr. THOMPSON. It is not supposed to be financially insolvent until 2030.

Mr. DOGGETT. Twenty-eight years. Better than it has been in the past. Those who want to buildup some kind of phony crisis in order to apply radical solutions, shouldn't they consider that our

ability to solve any problems with Medicare which needs to be addressed is going to be significantly worsened if we add more than \$1 trillion of debt to the national debt by the various proposals this administration is advancing?

Mr. THOMPSON. Congressman, if in fact the administration policy is able to rejuvenate the economy, create more jobs, create more tax revenues, we will have enough money, but it is——

Mr. DOGGETT. It is 10 years the deficit is in—and a trillion even under your estimate.

Mr. THOMPSON. All I can assure you is that is not my bailiwick. I am working on Medicare and Medicaid and uninsured and liability insurance and welfare, and those are my issues. You want to ask me questions about them, I would be more than happy to answer them to the best of my ability.

Mr. DOGGETT. Thank you, Mr. Chairman.

Chairman THOMAS. Prior to recognizing the gentleman from North Dakota, the Chair recognizes the gentleman from New York.

Mr. RANGEL. I have to leave, and I thank you for extending me this privilege, and thank the Secretary and——

Mr. THOMPSON. Thank you, Congressman.

Mr. RANGEL. Also, we look forward that we hope that the leadership would see its way clear to have hearings on these issues, but we accept your kind invitation to join with you for more clarification.

I also would like to join in and thank Tom Scully for the great sensitivity he has displayed during the emergencies that we are having in our hospitals. He has been a good trooper. Thank you.

Chairman THOMAS. Thank the gentleman. The gentleman from North Dakota wish to inquire?

Mr. POMEROY. Thank you, Mr. Chairman. Mr. Secretary, you are from Elroy, Wisconsin.

Mr. THOMPSON. That is correct.

Mr. POMEROY. I am from Valley City, South Dakota, small towns in rural America.

Mr. THOMPSON. How big is your city?

Mr. POMEROY. Several times the city of Elroy.

Mr. THOMPSON. It is a big city.

Mr. POMEROY. The disadvantage of rural America in keeping health care services available are very, very troubling. I have had meetings all across the State on the reimbursement disadvantage of our Medicare, yet in light of the aging nature of these small towns on the prairie, it means that disproportionate sums of their money come from Medicare. So, you will have small hospitals that are getting 70 percent of their money from Medicare, but Medicaid disadvantages among the reimbursement rate, especially if they are not community access hospitals. This has really created an extraordinary problem with keeping care available in rural America. These facilities, you can tell they think they are absolutely at the breaking point.

I am interested in your thoughts in terms of how we continue to address issues relative to rural reimbursement and making certain that the disparity between rural and urban reimbursement becomes addressed. As you mentioned, 70 percent of the Medicare reimbursement is wage related, and there is a wage discount relative

to rural America. On the other hand, as they fight for doctors and fight for nurses and these medical professionals, they find that they are not in a rural labor pool. They are competing head to head with these city areas.

So, what are your thoughts on that, Mr. Secretary?

Mr. THOMPSON. Congressman, let me tell you that when I was the Governor of Wisconsin, I sued Medicare on that question and lost. It is statutory, and I welcome your comments. In fact, I support your comments. Coming from a rural area and a city that is seven times smaller than yours, I certainly understand full well. Approximately 71 percent—well, not approximately, it is 71 percent. The reimbursement formula is based upon wage, and rural areas do not measure up under that formula. Congress has got to change that formula. We cannot do it administratively, Congressman.

Second thing is there is less of an adjustment for rural hospitals versus urban hospitals, and that is also statutory.

Mr. POMEROY. I note that in the proposal to enhance funding for rural health centers, in a way the disparity continues. North Dakota, for example, has one rural health center, as opposed to the rural health clinics which we have several serving vast areas.

Mr. THOMPSON. I understand that.

Mr. POMEROY. Is that an administrative call and could you reevaluate that question?

Mr. THOMPSON. I would be more than happy to reevaluate that. We were putting in an additional \$169 million this year to build more community health centers, and hopefully we can get some into North Dakota.

Mr. POMEROY. I have enjoyed and North Dakota providers have enjoyed having access to Tom Scully. He has been kind enough to—

Mr. THOMPSON. What is this, a Tom Scully cheering squad?

Mr. POMEROY. There is always a—

Mr. THOMPSON. Don't encourage him.

Mr. POMEROY. There is something behind a compliment usually in a Congressional hearing. I would ask that Tom Scully come to North Dakota to hear firsthand from some—

Mr. THOMPSON. I would be happy to send him to North Dakota—

Mr. POMEROY. Maybe in February, Mr. Secretary.

Mr. THOMPSON. February would be a good time for Scully. He usually goes to California and Florida in February, but I think North Dakota is better.

Mr. POMEROY. I thank you for that. I would just close, Mr. Secretary, by adding that we don't have an HMO in North Dakota anymore delivering the services. I used to be the insurance commissioner in our State, so I am very familiar with basically the failure of HMO model delivery systems in rural America. I think a lot of the concern you have heard on our side of the aisle this morning about linking a prescription drug benefit to forced enrollment in HMOs is—we don't have HMOs. You do something like that, our people don't get prescription drug—

Mr. THOMPSON. Congressman, I can assure you we are not going to force seniors into HMOs.

Mr. POMEROY. Thank you, Mr. Secretary.

Chairman THOMAS. Thank the gentleman. The gentleman from Kentucky, Mr. Lewis, wish to inquire?

Mr. LEWIS OF KENTUCKY. Yes, thank you. Back last year when we were working on the welfare reform bill, I had a lot of educators in my district that were concerned about forcing people into low-wage jobs that were dead end, and they were very concerned about that. My question is, is that the case, and how does it compare to the Aid to Families with Dependent Children (AFDC) results on good employment for individuals?

Mr. THOMPSON. Congressman, every person who was on AFDC was locked into poverty. They were approximately 22 percent below poverty level on AFDC. If you were just on minimum wage, you are above the poverty line, and if you get the earned income tax credit added onto that and if the State has an earned income tax credit, you can be anywhere, at a minimum wage job, anywhere from 15 to 30 percent above the poverty line. So, by working, you definitely are better off than by being on the old AFDC. Most of the AFDC recipients who have left and have gone into the workplace are much higher than minimum wage. So, it has worked out extremely well.

Another good statistic is even though during this downturn, during the economy downturn, the cases on welfare are continuing to go down nationwide by 3.9 percent; and so now over 54 percent of the recipients have left the old AFDC since 1996 and over 59 percent of the individuals—54 percent of the families and 59 percent of the individuals. So, it is working, and it is continuing to work. The failures are going to be coming out at the end of next week that will show that during this downturn, the caseload—even though the unemployment increases have been going up, the welfare levels have still continued to go down by the rate of 3.9 percent.

Mr. LEWIS OF KENTUCKY. Isn't there an even greater incentive for States to put in the revised welfare reform bill, I think a bonus—\$100 million bonus for States that create the kind of jobs or provide the kind of jobs that are going to be helpful to—

Mr. THOMPSON. We want to make sure we go to the next plateau in welfare reform in America. We want to assist those individuals. We want to make sure that we help individuals continue to leave the welfare rolls and get the kind of assistance they need, get the opportunities to live and to work like every other American, and get the opportunity for themselves to have a job and raise their family and hopefully purchase a house.

Mr. LEWIS OF KENTUCKY. Wonderful.

Mr. THOMPSON. Thank you so very much for your comments.

Chairman THOMAS. Thank the gentleman. The gentleman from Texas wish to inquire?

Mr. SANDLIN. Yes, sir. Thank you, Mr. Chairman.

Mr. Secretary, thank you for coming today, and I will try to be as brief as I can. You have been asked a lot of specifics about basic coverage provision. Let me ask you something a little bit different. I notice the budget contains \$400 billion for Medicare. Specifically, how much of that \$400 billion in dollars is applicable to prescription drug coverage?

Mr. THOMPSON. That has not been determined yet. You cannot determine that—our actuaries cannot make that ascertainment until after we make the final details of the package. As soon as that is done, we will be able to quantify that for you.

Mr. SANDLIN. Okay. Now, you said that the President's position is and the administration's position is that seniors will not be forced out of Medicare in the HMOs. Is that correct?

Mr. THOMPSON. That is correct.

Mr. SANDLIN. We have not heard or not seen any statutory language or budget notation or anything that establishes or identifies a specific prescription drug plan within Medicare itself, as has been discussed today as a part A or part B-type plan. Is that correct?

Mr. THOMPSON. There are several proposals out there, Congressman, and the final determination has not been made. That is why I cannot answer your question directly. I am sorry about that. I apologize to you, but until the final decisions are made—once they are made, I will be more than happy to come up and talk to you.

Mr. SANDLIN. No apology necessary. Since no decisions have been made, it is possible that the government—

Mr. THOMPSON. A lot of decisions have been made, but not the total decision.

Mr. SANDLIN. On that, I understand what you are saying. Since no decision has been made on that, then it is quite possible that the plan will be just to give money to HMOs and let them operate a plan independent or outside of Medicare. Isn't that correct?

Mr. THOMPSON. That—

Mr. SANDLIN. That is possible?

Mr. THOMPSON. It is—no. It is not possible.

Mr. SANDLIN. It is not possible. Then you are saying for sure the administration—

Mr. THOMPSON. It is not possible for all the \$400 billion into HMOs and be the only one—

Mr. SANDLIN. I didn't ask you about all the \$400 billion. You are telling me now that if it is not possible, that they will be required to go into an HMO; then, conversely, you are telling me the administration's plan is to specifically put a part A or part B-type plan into Medicare so that there will be prescription drug coverage for seniors under Medicare.

Mr. THOMPSON. I didn't say that, Congressman. That—

Mr. SANDLIN. I know you said both ways, so I am just trying to see which way we are going to hop.

Mr. THOMPSON. Those decisions have not been made.

Mr. SANDLIN. You understand we are probably going to vote on this next week.

Mr. THOMPSON. I don't think so. That is not my understanding.

Mr. SANDLIN. Okay. Well, that was what I was told.

Mr. THOMPSON. If you are going in this next week, God help you.

Mr. SANDLIN. That is exactly what I was thinking. That is the help I need. In looking at the budget, in the event that it does go the HMO route, there is no specific notation within the budget or requirement that certain benefits be provided by an HMO, is there?

Mr. THOMPSON. Once again, Congressman, those decisions have not been made.

Mr. SANDLIN. Well, I know the decisions haven't been made, but I assume you are discussing them. We are not going to just pull them out of a hat.

Mr. THOMPSON. We are discussing it every single day, Congressman.

Mr. SANDLIN. So, that is one of the possibilities?

Mr. THOMPSON. Anything is possible.

Mr. SANDLIN. Anything is possible.

Mr. THOMPSON. The probability of that is so unlikely, that it is—

Mr. SANDLIN. Okay. Let me ask you this—and I have not heard this. Does the administration ever look at the cost of overhead, for example, of Medicare versus a private HMO plan in determining which sort of benefit to provide?

Mr. THOMPSON. Yes, we do, sir.

Mr. Sandlin. I don't know if this is accurate or not. I have seen it—

Mr. THOMPSON. We plug this in, and our actuaries take into consideration the total costs.

Mr. SANDLIN. Let me ask you, because I am just asking for an education. Some of the newspaper reports have said Medicare has been able to—or they anticipate Medicare overhead to be 3 to 5 percent and the private plan is to be 25 to 30 percent. Would that be accurate with what you have heard or not?

Mr. THOMPSON. That is not—I don't think that is an accurate statement.

Mr. SANDLIN. Anyway, you consider that as a factor in making that decision?

Mr. THOMPSON. We consider that as a factor, absolutely.

Mr. SANDLIN. Of the \$400 million that you mentioned a while ago, some of that is set aside—

Mr. THOMPSON. Billion.

Mr. SANDLIN. Billion. It is set aside—I am a country boy, too, so that is a lot of money.

Mr. THOMPSON. It is a lot of money for us, yes.

Mr. SANDLIN. Is set aside for increases in provider payments. Is that correct?

Mr. THOMPSON. Sorry?

Mr. SANDLIN. Some of the \$400 billion goes to increases in provider payments, is that correct, such as to physicians?

Mr. THOMPSON. Oh, yes.

Mr. SANDLIN. Do we know what amount of money we—

Mr. THOMPSON. No.

Mr. SANDLIN. You would attribute there? So, we are talking about fitting Medicare and increase in provider payments to physicians. Is there anything in there—or does the administration support increasing the payments to hospitals, rural hospitals in particular?

Mr. THOMPSON. That is not part of the Medicare proposal.

Mr. SANDLIN. So, we don't have any proposal to increase payments to hospitals?

Mr. THOMPSON. Not in that proposal, no.

Mr. SANDLIN. I believe my time is up. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. The Chair feels compelled to announce that no markup is scheduled next week on Medicare legislation, and you probably could substitute the month of February at this time for that same announcement. The gentleman from Ohio wish to inquire?

Ms. TUBBS JONES. Thank you, Mr. Chairman. Mr. Secretary, thank you very much. It is my first time on this Committee, and I am glad to be—

Mr. THOMPSON. Congratulations, Congressman.

Ms. TUBBS JONES. Thank you. On behalf of all the residents of the State of Ohio, even though I don't represent all of them, I have some questions I would like to ask of you.

Of particular concern in the State of Ohio in the past has been the fact that with Medicaid, the HMOs have come and gone. We have had people with an HMO 1 day, 30 days later they are gone, and we are scuffling without notice to have them provide some other type of service.

I am interested in knowing, sir, are you familiar with this statistical information that in 1999, 99 HMOs withdrew or reduced service, leaving 407 seniors in a lurch?

Mr. THOMPSON. You are talking about Medicare+Choice, I believe?

Ms. TUBBS JONES. Excuse me. With regard to HMO, yes. I switched my statement a little bit. I started out saying that HMOs with Medicaid have run away from my constituents in Ohio. My question now is, are you familiar with the fact that under the Medicare+Choice program which began with 2.4 million beneficiaries, many have been forced out of Medicare, and that in fact in 1999, 99 HMOs withdrew or reduced their service, leaving 407 seniors without coverage?

Mr. THOMPSON. I don't know the exact statistics that you are referring to, but I am fully cognizant, Congresswoman, of the fact that Medicare+Choice has had a reduction in companies, reduction in HMOs and of course invariably a reduction in subscribers. I do not know the exact number in Ohio.

Ms. TUBBS JONES. So, clearly since you are familiar with that information, many of us on the Democratic side have been accused of trying to scare seniors about HMOs, when in reality there is sufficient data to support the fact that HMOs have run out on Medicare recipients and that we need to be concerned about their conduct. Is that a fair statement, sir?

Mr. THOMPSON. It is partially fair. The other part of it is that the Congress and the administration have not put enough money into Medicare+Choice for the companies that do offer the HMOs to make a return on their investment. As a result of that, they were going broke; and instead of going broke, they withdrew. So, there is enough blame to go around.

In regards to the reduction in size, yes, they have, from a little over 15 percent down to a little over 11 percent of the population. Those seniors that have chosen Medicare+Choice programs still in business and the Medicare beneficiaries who have them still argue

very strongly, very forcefully, that they like their Medicare+Choice and they like the choice, part of it.

Ms. TUBBS JONES. I don't have but a little bit of time, and so if you could just make your answers a little bit shorter, I would be appreciative. Let me say this to you, sir. The important part of all of this is that we as a government have not allocated sufficient dollars to health care, so that we have 41 million people in this country without any kind of health care. That is a fair statement, is it not, sir?

Mr. THOMPSON. There is no question we have 41 million—40 million Americans currently that are uninsured, and we have put forth a plan in this administration of \$89 million to address that.

Ms. TUBBS JONES. So, are you saying with the \$89 million we will cover all of the 41 million who don't have any health care?

Mr. THOMPSON. I am not. I am also saying that we are addressing that issue—

Chairman THOMAS. On the Chair's time to make sure that the record is accurate, we are not talking about 41 million people who don't have health care. It is 41 million who are without health insurance.

Mr. THOMPSON. That is correct.

Chairman THOMAS. Or whatever the number is. Now, the problem with that—and I will agree with the gentlewoman from Ohio that they oftentimes have to get their health care in the most expensive way, in emergency rooms and other places. It isn't timely, and it is a problem. That number is a number who are uninsured, or something close to it, not those who don't have health care. Thank you.

Ms. TUBBS JONES. Well, some would argue, Mr. Secretary, that the health care they provide is like having no health care at all, would they not?

Mr. THOMPSON. That is up to the individual, Congresswoman. I would point out that the tax credit proposal that is advanced by the President would take 6 million of those 40 million and give them health insurance, if the Congress would adopt it.

Ms. TUBBS JONES. The other 35 who don't have any money to pay health care up front wouldn't have any. I don't want to get lost in a discussion that I did not create.

Mr. THOMPSON. It is a step. I don't see anything else out there right now, and I am saying that we are advancing proposals to solve the problems, and that is what my Department is trying to do.

Ms. TUBBS JONES. Mr. Chairman, do I have some more time? I believe you said it was on your time.

Chairman THOMAS. Sure.

Ms. TUBBS JONES. Thank you very much. Let me ask you, Mr. Secretary, it says the—in your statement on page 5, the administration is very interested in updating Medicare to reflect the insurance protections offered in the private sector. This system would modify and rationalize cost sharing for beneficiaries who need acute care. It would also eliminate cost sharing for preventive benefits and on and on and on.

What insurance protections do you believe are provided in the private sector that ought to flow into people who have Medicare?

Mr. THOMPSON. We think seniors should have the same opportunity and the same health plan as you do, as the President does, as I do, and every one of the Congressmen. We believe every senior should have the capability and the option to have the same benefits as Congress and the administration.

Ms. TUBBS JONES. So, for example, Members of Congress's monthly premium is \$98.93. The seniors ought to be paying \$98.93. There is a monthly premium deductible, none for Congresspersons, but under the plan you propose there is \$275 for seniors, or would it be none? Last question.

Mr. THOMPSON. Well, there is no question that there are going to be some payments made as there are currently, and there is no question that the administration has put in \$400 billion to subsidize those drugs. There is no question that you have a selection, I believe, of 12 to 15 different health insurance programs, as I believe seniors should have.

Ms. TUBBS JONES. If they can afford to pay for it.

Mr. THOMPSON. Well—

Ms. TUBBS JONES. Thank you very much, Mr. Chairman.

Chairman THOMAS. Thank the gentlewoman. To underscore the point the Secretary made, the Federal Employees Health Benefit Program offers a smorgasbord of various programs, preferred provider organizations (PPOs), HMOs, a number of others, and obviously the services are different and each individual is able to pick and choose that health program that fits their needs.

One of the difficulties with Medicare is a "one size fits all," when in fact you have a very diverse lot who happen to be seniors today. The gentleman from Florida wish to inquire?

Mr. FOLEY. Thank you, Mr. Chairman, I do. I welcome the Secretary here, particularly in light of the fact that he has been so articulate on preventative health care. We have had a lot of discussions on this issue. I think some of my colleagues on both sides have minimized your commitment to that, and I want to thank you, because you recognized the importance, as my colleague John Lewis and I have fought for osteoporosis screenings and glaucoma screenings, to add that into Medicare.

Let me also underscore—and I think what is important as we discussed, the last speaker and the Chairman so adequately presented, Members of Congress do have an insurance plan and a prescription drug coverage, and I have never heard one of them refer to it as being forced into a plan. I have never heard one of them reject it. I know there are a lot of wealthy people who service in Congress, but none I think has passed on the opportunity to be an insurance model.

Mr. Scully was mentioned, and I hope he is clearly aware, faint praise is sometimes deadly in this building. "We have zero desire to push people into HMOs" was his statement to the Senate. I believe that stands, and I know you are of the same mindset.

All seniors will have access to prescription drugs, whether through Medicare, managed care, HMOs, PPOs. I know we are all on the same wavelength on that. Is that correct?

Mr. THOMPSON. That is absolutely correct, and thank you for saying that, Congressman.

Mr. FOLEY. We have a lot of people in Florida that are anxious to hear those words, and I know you are a man of your word. Senator Hagel and I had prepared, a couple years ago, a prescription drug discount card.

Mr. THOMPSON. Yes, you did.

Mr. FOLEY. We introduced it to Congress. The White House adopted it as a proposal. A recent court ruling indicated that it was out of order because Congress has not authorized it. I have reintroduced the plan. I am encouraged by the opportunity, and hopefully we will have quick hearings so we can put on the table a chance to have seniors have access to prescription drugs now at a discount.

Now, other groups have come out strongly opposed to it. They say it is a sham, it is an attempt not to provide prescription drug coverage. Well, I ask the American Association of Retired Persons—who offers discounts to their Members if they join their plan, discounts on food and lodging and travel benefits—if it is so good in their arena, why isn't it good for prescription drug coverage? I ask the millions of Americans who are at Costco and Sam's Wholesale Club, who buy a Membership card and then enjoy discounts on a wide variety of whole products, why it is such a terrible idea when we have it now offered to seniors in a discount setting.

So, you said last time that with an authorization, you could probably have a drug discount card up and running within 30 to 60 days. If this Congress passes that plan, can you still live with that guideline?

Mr. THOMPSON. Yes, we can.

Mr. FOLEY. That will provide real relief today?

Mr. THOMPSON. Yes, it would, Congressman.

Mr. FOLEY. I know why the other side doesn't like it, because it takes away the sting of their argument. It is interesting in this building that they call deficits—when it is a tax cut to the very seniors in my community who have actually thanked me for the conversation on relieving them of the taxation on dividends; because they say, if I am given more in my own wallet, I can go to whatever pharmacy I want, buy the drugs I need, pay my rent and food and other things, thanks to the fact that you are taking away a tax on the income that I hopefully will be able to use in the future. All of a sudden, tax cuts for the rich is the nomenclature around here, yet I always heard of dividend stocks as for widows and orphans, people who needed the income to help them in their golden years.

So, they want to spend \$900 billion on prescription drugs, but they don't call that a deficit spending proposal. They call that enhancements. So, I love the way this place works.

All I can say to you, Mr. Secretary, we are going to have a good time, because we are going to in fact bring prescription drugs to seniors through a discount card. Then we are going to ramp up our proposal to provide—which the President articulated—with the \$400 billion of new spending.

So, if people would rather play policy than politics, I think we can get something done. I know they have all left, mostly. Pete, I am glad you are still here, but I know at the end of the day, if people are serious about helping seniors, we can get it done.

Finally on the comment about no health care for people, 41 million people, there is emergency room service always provided to anyone regardless of ability to pay, race, creed, color, national origin. We also have health organizations within our own community, Palm Beach County Taxing District. We also have Medicaid. We also have Medicare. We have veterans' health care. So, anybody that suggests 41 million people are out there without any coverage is absolutely not understanding the facts on the table.

So, with that, if you have a minute to respond, unless the Chairman would like to interrupt and give me some more time, I would love to hear your thoughts on some of those proposals.

Mr. THOMPSON. Congressman, first off, thank you for your passion in the area of preventative health. This is something we have to do. I am so committed to it, because I think we can save so many dollars but improve the quality of health of all citizens in America by watching what they eat, reducing their smoking, or not smoking, and increasing their exercise, we can really improve the quality of health.

I love your passion on the drug card, and I have yet to find anybody, whether it be 10, 15, 20 or 25 percent that would not take the discount, and I thank you for it and I hope you pass it.

I am committed to coming in with an uninsured proposal. We have got a very modern Medicaid proposal, and the Medicare thing is—Medicare proposal will be coming. I want to work with you, and I want to work with all Members on this Committee, and I am confident with those individuals that really want to get something done, we can get something done this year and we can improve the quality of health for all citizens, especially the seniors in America.

Chairman THOMAS. Thank the gentleman. The Chair would recognize for the next and the last word the gentleman from California.

Mr. STARK. Thank you, Mr. Chair. Just a couple of things very quickly, Mr. Secretary. I was quite disappointed to learn that you had told your intermediaries to stop providing the information service to the seniors when they call in on the 800 numbers, providing an information service and publishing booklets that will explain the very complicated options that are available. I think that is penny-wise and pound-foolish, and I hope that you would consider—

Mr. THOMPSON. I don't think we did, Congressman—we have not, Congressman. The New York Times article was just plain wrong.

Mr. STARK. Was incorrect. I am happy to hear that.

Mr. THOMPSON. In fact, we are doing more of it, Congressman.

Chairman THOMAS. Incorrect means wrong. Right?

Mr. STARK. I think it is a service that should be provided.

Mr. THOMPSON. Absolutely. In fact, we are doing much more. In fact, we are putting it in many languages Congressman Stark.

Mr. STARK. Thank you.

Mr. THOMPSON. We are expanding it rather than reducing it, sir.

Chairman THOMAS. Do you have another one?

Mr. STARK. You are doing the Lord's work.

Second, I would hope that in the—in your urgency to inform people, that you and Chairman Thomas would say that within, say, 2 weeks after you all decide what this drug benefit will be, that you would return with Mr. Scully and we would have another hearing. I know we are crowded on the schedule, but if we could have a couple hours of hearing once that—just on the drug benefit once it is determined. I think you saw the interest on both sides today, and I hope you will find time to get together with Chairman Thomas, Mr. Scully, and come back so we can then get all the details on the drug benefit when it is finalized. Will you agree with that?

Mr. THOMPSON. I cannot agree with what the Committee is going to do, that is completely up to the Committee Chair; but if you want me to come back to see you, Congressman, I will be more than happy to do that. In fact, you are from Wisconsin. I would love to come and see you, Congressman.

Chairman THOMAS. I would tell the gentleman that it is my understanding and certainly the understanding of the majority that what we want to do is to improve Medicare in a number of ways, including prescription drugs.

The way in which you asked the question, which said we would only have a hearing on the prescription drug portion, would I believe shortchange the American people, when all of the other changes that we want to make would be included in that bill. I will tell the gentleman from California that we certainly will have hearings. We will make the request, depending upon time and circumstances. We always enjoy having the Secretary with us. I am sure that if he is not able to physically, we will have a written statement, but my goal would be to arrange the time so that the Secretary could be with us when we look at the legislation which would help in making Medicare a better product for seniors in a number of ways, including making available prescription drugs in a far broader way than they are currently available under Medicare.

The assumption that there are no drugs available under Medicare is, of course, an inaccurate one. Excuse me, it is wrong.

Mr. STARK. The sooner the better, Mr. Chairman, and we will be glad to—

Chairman THOMAS. Appreciate that.

Mr. STARK. Thank you.

Chairman THOMAS. Thank you. With that, the—no further questions, the hearing is adjourned. Thank you very much, Mr. Secretary.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

[Questions submitted from Messrs. Crane, Cardin, and Doggett to Mr. Thompson, and his responses follow:]

Question Submitted by Representative Crane

Secretary Thompson, as you may know, some Members of this Committee have expressed their concerns about physician-owned hospitals that specialize in specific health care services. In particular, some have suggested that such hospitals are a threat to existing full-service, community hospitals. As someone who believes that innovation and competition drive quality results in the health care marketplace, I hope Congress and the Bush administration will think carefully about advocating legislative or regulatory changes that will protect the status quo and stifle innovation rather than ensure a vibrant health care marketplace both now and for the future.

I believe it is worth noting that not all so-called specialty hospitals are the same. For instance, I am aware of some specialty hospitals that are licensed as general acute care hospitals with around-the-clock emergency rooms that simply focus on a particular area of health care. This type of innovation has been proven to result in better care, leading many non-profit hospitals to form similar joint ventures with physician partners.

The Lewin Group recently finished a study demonstrating how cardiac care services provided by a certain group of heart hospitals compare on measures of patient safety, quality, and community impact to cardiac services provided in peer hospitals, including major teaching hospitals, across the country. Attached for the record is a copy of this study.

Secretary Thompson, is this specific example in the Lewin study consistent with the Department of Health and Human Services' recent initiative to encourage hospitals and other health care providers to release quality of care data and patient satisfaction information?

Attachment

A Comparative Study of Patient Severity, Quality of Care and Community Impact at MedCath Heart Hospitals Executive Summary—September 2002

For informational purposes, each of MedCath's hospitals is licensed as a general acute care hospital, while the company focuses on serving the unique needs of patients suffering from cardiovascular disease.

Purpose

The Lewin Group prepared this report for MedCath to determine how cardiac care services provided in MedCath heart hospitals compare on measures of patient severity, quality and community impact to cardiac services provided in peer hospitals across the country that perform open-heart surgery.

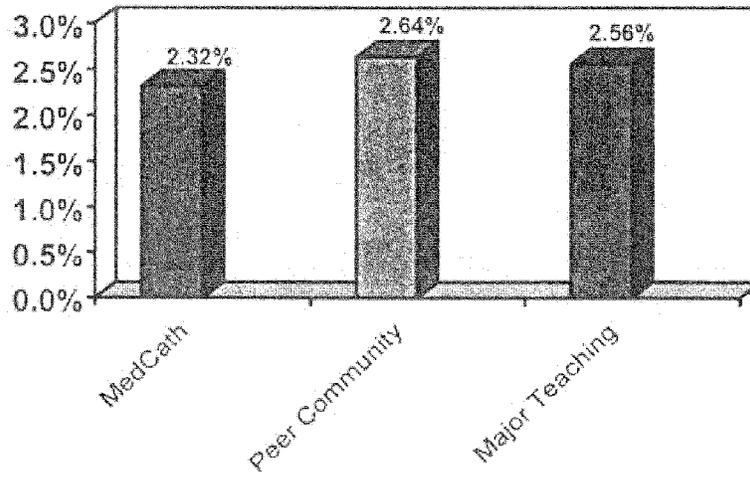
Methods

- Eight MedCath heart hospitals were compared to 1,139 peer hospitals that perform open-heart surgery in the United States. Peer hospitals are defined as short-term general hospitals, including major teaching hospitals. Peer hospitals consist of (1) Peer Community Hospitals—946 non-major teaching hospitals and (2) Major Teaching Hospitals—193 major teaching hospitals that have an interns and residents to bed ratio of 0.25 and above.
- To allow for statistical analysis, the patient data for the peer group of hospitals has been severity adjusted to be comparable to the MedCath data. Using publicly available information, the Lewin Group analyzed fiscal year 2000 MedPAR data using an APR-DRG cardiac case mix index (CMI). Cardiac case mix index calculations were based on Medicare discharges and were calculated using the general approach used by the Centers for Medicare and Medicaid Services (CMS).
- Quality of care was measured through an analysis of length of stay, mortality, discharge destination and patient complications.

Findings

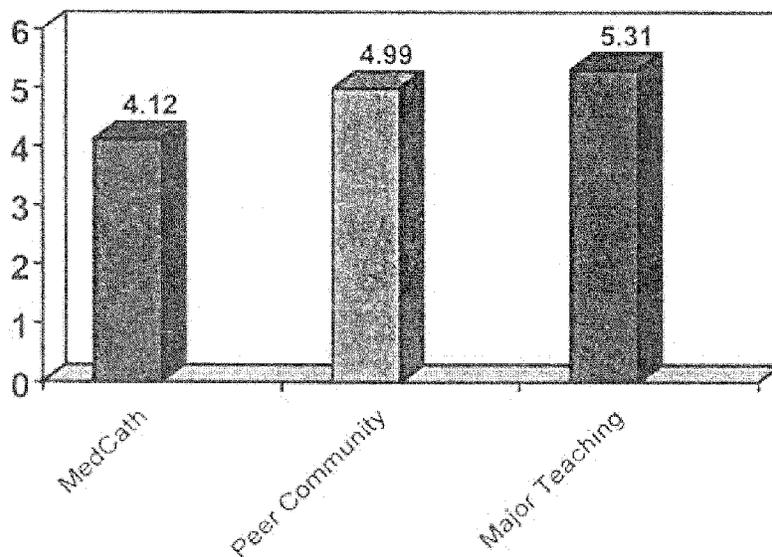
- As a group, MedCath heart hospitals have a higher case mix severity than the peer community hospitals.
- After adjusting for risk of mortality, MedCath heart hospitals on average exhibited a 12.1 percent lower in-hospital mortality rate for Medicare cardiac cases compared to the peer community hospitals.

After Adjusting for Risk of Mortality, MedCath Heart Hospitals (on Average) Exhibit 12.1% Lower Mortality Rates Than the Peer Community Hospitals



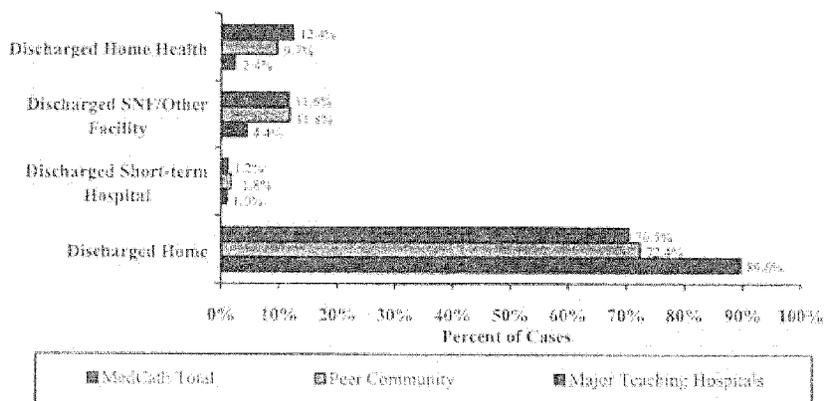
MedCath heart hospitals also have shorter lengths of stay for cardiac cases (4.12 days) than the peer community hospitals (4.99 days) after adjusting for severity.

MedCath heart hospitals, on average, have 17.4% shorter severity-adjusted length of stay for cardiac cases than the peer community hospitals



- MedCath heart hospitals discharge a higher proportion of patients to their homes as compared to the peer community hospitals (89.6% vs. 72.4%) and transfer a lower proportion of patients to other facilities or home health agencies (7.8% vs. 23.3%). ***This resulted in approximately \$12.2 to \$15.2 Million in reduced aggregate Medicare expenditures in FY2000 for patients treated in MedCath facilities as compared to the peer group. This is based on an actual savings of \$922—\$1,145 per discharge.***

MedCath heart hospitals discharge 23.8% more patients to their homes than the peer community hospitals and transfer fewer patients to other facilities



- In addition, an analysis of secondary diagnostic codes shows that patients treated at MedCath heart hospitals typically show lower rates of medical complications versus patients treated at the peer group community hospitals.
- MedCath heart hospitals ranked near the middle of their respective markets for the total volume of inpatient cardiac care provided to Medicaid and uninsured patients.

Conclusion

Our analysis found that in comparison to the peer group of community hospitals, MedCath heart hospitals had relatively higher cardiac case mix severity, lower mortality rates and lower average length of stay. We further found that MedCath heart hospitals discharged a higher proportion of their Medicare cardiac patients to their homes and transferred fewer discharged patients to other facilities. This results in reduced aggregate Medicare expenditures for patients treated in MedCath heart hospitals as compared to patients treated in the peer group community hospitals.

Answer:

The example you cite is consistent with our Department's initiative to encourage hospitals and other health care providers to provide consumers with quality of care data. Consumers and purchasers want to be able to make more informed decisions, and providers need to know how to improve the quality of their care. Through several initiatives at the Centers for Medicare and Medicaid Services, the Agency for Healthcare Research and Quality, and elsewhere, the Department is working in collaboration with others to help bring this about.

Questions Submitted by Representative Cardin

The Impact of the administration's TANF reauthorization proposal on States

Since you testified here last year on the administration's welfare proposal, State budgets have deteriorated significantly—to the extent States are now facing budget shortfalls approaching \$85 billion. In addition, unemployment has gotten worse—with a total of 2.3 million jobs lost over the last 21 months.

Question

Given these changes, how can you be confident that States will be able to implement the administration's welfare proposal, which imposes many new requirements with no new resources?

Answer

As a former Governor, I know how effective strong work programs and the States running them can be, even with fiscal constraints. With a renewed focus on work and the inherent flexibility of the TANF program, I am confident that States will meet the new requirements and move families to independence within the resources proposed in the budget. In light of current budgetary constraints and the nation's focus on homeland security, the administration's TANF request represents a significant commitment and maintains historically high levels of funding.

We believe that States should be able to meet the incremental cost of the increased work requirements associated with the administration's reauthorization proposal. As I demonstrated in Wisconsin, when States implement effective work requirements, and provide needed experience, training and supports to clients, the assistance caseload will continue to go down making more resources available to support low-income working families. Given that TANF funding is based on expenditures at a time when welfare caseloads were at their highest levels, and that States have significant flexibility in the use of their TANF and Child Care and Development Fund (CCDF) dollars, and in the design of their programs, meeting this challenge is within the capacity of States. Finally, it is important to note that even in the current economy, our latest numbers show that caseloads continue to decline.

As you will recall, both you and the President have said that States have enough resources because the "welfare caseload" has dropped by half while the welfare block grant has remained at the same level. However, this ignores the fact that while the number of people receiving cash assistance has dropped, the number of people receiving employment-related services has grown considerably, which is a stated goal of TANF. The TANF program serves both populations. Thus, simply talking about those receiving cash assistance does not make any sense, especially since the General Accounting Office (GAO) has told us that the number of families served by TANF might be twice as large as the cash caseload.

Question

Would you agree that just referring to those receiving cash assistance does not fairly represent the number of families that benefit from TANF funding?

Answer

States certainly provide a wide range of services and benefits to low-income working families that are not included in the caseload as receiving TANF cash assistance. GAO's report to you, "Welfare Reform: States Provide TANF-Funded Services to Many Low-Income Families Who Do Not Receive Cash Assistance," estimated that: "at least 46 percent more families than are counted in the reported TANF caseload (or 830,000) are receiving services funded, at least in part, with TANF/MOE funds." The report also explains that: "The number of families receiving monthly cash benefit payments declined by over 50 percent, which made more funds available for non-cash services." This highlights the critical dynamic of the President's reauthorization proposal—effective work programs lead to "assistance" caseload reductions and enhance a State's ability to fund other services and supports.

The GAO report also noted that the data States collect and report on families receiving services does not lend itself to a full count of all families served. In PRWORA, Congress defined the data to be collected and reported by States to those receiving assistance, and limited the Department's authority to collect additional information. As a result, we have little information on the number of clients or the nature of services and benefits offered by States outside of those on the cash caseload.

Last year, the Congressional Budget Office (CBO) informed us that the administration's welfare proposal would cost \$8 to \$11 billion to implement. However, your plan does not include any new resources for either TANF or child care.

Question

How do you expect States to meet this unfunded mandate? Aren't you concerned that they might be forced to cut services for the working poor to pay for the new requirements on welfare recipients?

Answer

We do not agree that the administration's proposal creates an unfunded mandate. As States implement stronger work requirements and move adults into employment, cash assistance caseloads can continue to decline, freeing up funding States can use for support services. This year's CBO analysis of the budgetary impact of H.R. 4 dated February 13, 2003, has clarified that the possible additional costs of work re-

quirements were based on the assumption that “states took no action to reduce or avoid such costs.” CBO goes on to clarify that it expects States to avoid most or all of those costs and therefore the work requirements are not unfunded mandates. In other words, States will use the tremendous flexibility that Congress provided in enacting PRWORA to meet the new requirements and provide services to the working poor, as the administration intended.

The TANF program has been highly successful in helping low-income families move to work, reducing dependency and child poverty, and transforming the welfare system to a program of temporary support. Thus, we proposed to maintain the basic funding structure and flexibility of the TANF program. Our plan builds on State success in promoting work by making sure that work expectations are meaningful and that States help all families make progress in moving from welfare to work. To strengthen families, our plan continues to provide support to low-income working families. Our plan even expands these supports by ensuring that families receive more of the child support paid by absent parents. We also are committing up to \$300 million per year in Federal and State funding for marriage and family formation activities that will give States incentives and program models that they can use to develop more effective efforts in these areas. And our plan authorizes new waivers that would help States improve the effectiveness and efficiency of their cash, housing, nutrition and work force programs.

The Increased Work Requirements in the administration’s Proposal

Last year, 41 of the 47 States surveyed by the National Governors’ Association said the administration’s plan would require “fundamental” changes to their welfare programs. Some specifically complained that the proposal would force them to focus on “make-work” rather than real jobs.

Question

Did the administration consider the States’ concerns when it resubmitted the same welfare plan this year?

Answer

Yes, we did. The Administration’s plan was developed after my department conducted extensive listening sessions that, I believe, allowed for an unprecedented degree of input from the States. The listening sessions were designed in concert with the National Governors’ Association (NGA), the American Public Human Services Association (APHSA), and the National Conference of State Legislators (NCSL) and involved both oral interaction and written input from nearly every State. What we heard as a universal theme was to keep the focus on work and to maintain flexibility. The Administration’s plan includes nearly all of the recommendations made by States and retains the basic Federal-State partnership that was a landmark feature of the 1996 legislation. In that legislation, States were given tremendous flexibility to operate their programs, but work requirements were established as the core of the TANF program.

We do not agree that our proposal will lead States to focus on “make-work” rather than real jobs. Our proposal strengthens current work requirements and useful work experiences in a wide array of programs that help clients build skills. Actual work experience and skills enhancement have been demonstrated as critical to work success in experiment after experiment. The Administration’s plan gives States broad flexibility to decide what activities to incorporate into their programs. States decide how best to assist recipients in moving from welfare to work and toward self-sufficiency. And the proposal continues to give States broad flexibility to spend their TANF funds on any activity that meets one of the four broad goals of the program.

Last year the House passed a welfare bill that would require States to increase the percentage of welfare recipients in work activities; eliminate vocational education and job search from the list of direct work activities; *not* serve legal immigrants with Federal grants; and cut an entire family’s welfare check for a parent’s non-compliance with certain requirements.

Question

As a former Governor, how do you justify all of these infringements on State flexibility?

Answer

I do not agree that our proposal infringes on State flexibility. Because work requirements had essentially been eliminated by the caseload reduction credit under current law, our proposal does strengthen requirements to enable all families to achieve independence through work. If we expect parents to leave welfare, we need

to help them find the best employment that they can in a job that is stable, that can lead to job progression, and that will help to move the family out of poverty. Our goal is to help parents figure out how to do that.

States have considerable flexibility in developing self-sufficiency plans for families. As a matter of clarification, the administration's proposal does not require 40 hours of "work" per week. It requires 24 hours of work and an additional 16 hours in work or other activities that achieve a TANF purpose. The difference is not that certain activities cannot be counted toward the 40 hours requirement. Rather we simply split them up, with work as the central focus. Job search and vocational education can then be blended with work activities. In addition, we have proposed allowing States to count, as participating for up to 3 months, cases in which parents are not working at all but are participating in other activities States deem as needed, such as job search, training or substance abuse treatment. Such flexibility does not exist in the current program.

In addition, both our proposal and the House-passed bill allow States to count on a pro-rata basis those working 24 hours or more. This increased flexibility is not allowed under current law.

With respect to legal immigrants, our proposal continues the 5-year bar for most qualified legal immigrants entering the U.S. on or after August 22, 1996. The bar applies to Federal means-tested public benefits, which include TANF and Medicaid program benefits. However, under current law, some qualified aliens are exempted from this 5-year bar. They include: refugees, asylees, aliens whose deportation is being withheld, Americans, Cuban/Haitian entrants, as well as veterans, Members of the military on active duty, and their spouses and unmarried dependent children. Additionally, States may choose to use their own funds to provide cash assistance to many legal immigrants. If States choose to provide immigrants with cash benefits, they can count those expenditures toward their State Maintenance of Effort (MOE) requirements. And according to the MOE report for FY 2000, State funds have been used to help legal non-citizens with food, medical assistance, and cash assistance in 12 States.

With respect to the full-check family sanctions in H.R. 4, this provision was not contained in the administration's reauthorization proposal.

Extension of TANF Waivers to States

When you were Governor of Wisconsin, you received a welfare waiver under the former AFDC program. You said the waiver was beneficial because it provided more flexibility for your State to experiment.

Question

Do you support allowing States to extend their existing waivers under TANF?

Answer

Because PRWORA has transformed welfare, we don't believe it is any longer necessary for States to continue waivers that were initiated over 6 years ago. Under the former, prescriptive AFDC program, waivers were needed for States to make work requirements a fundamental feature of the program and to implement other innovative solutions to enable families to achieve independence. That is why as Governor of Wisconsin I actively sought and implemented work-focused waivers that encouraged families to work and led to historic caseload declines. Under TANF, the context for such waivers has fundamentally changed and they are not needed. The TANF program provides States with extraordinary flexibility to fund and operate a wide variety of work and training activities, and to provide supportive services and benefits so clients can get and keep a job, and improve their economic circumstances.

Even when a State's waiver ends, the flexibility of TANF will enable the State to meet current requirements with little change in the design or operation of its program. Clients receiving assistance through Maintenance of Effort (MOE) funds expended in separate State programs are not subject to the work requirements. Through a judicious use of Federal, segregated MOE funds, and separate State funds, a State can fundamentally decide whether and how work requirements apply to families in different circumstances. For States with time-limit waivers, few or no changes in requirements or exemptions that apply to families will be required. For many families, the Federal clock only starts when the waiver expires, thus these families may receive assistance for 5 years after the end of the waiver. Federal assistance can be provided beyond 5 years for up to 20% of the entire caseload (including child only cases for whom time limits do not apply). A State may use segregated MOE or separate State funds to provide assistance without Federal time limit re-

quirements, or remove the needs of the parent(s) and continue to use Federal funds for these “child only” cases.

The waivers we needed under AFDC were due to restrictive policies that limited State flexibility. While TANF has been transformed, our concern now must turn to how well States can make TANF work with other assistance programs they operate. Other programs have their own and sometimes very prescriptive rules that inhibit a State’s ability to innovate and enable the wide array of these aid programs to work better together for the families they serve. As an alternative to extending old waivers, the administration proposes new waiver authority that will allow States to build stronger, more integrated and effective service systems across a broad range of public assistance and training programs. States would have broad flexibility to design new strategies and approaches for achieving stated program goals.

Proposal of an Optional Child Welfare Grant

The Administration’s FY 2004 budget includes an optional child welfare block grant. Similar proposals have been controversial in the past because of concerns about undercutting Federal protections for abused children and eliminating the relationship between need and funding.

Question

The Administration’s plan seems to suggest that if the proposed child welfare block grant funding is insufficient, then a State can use the contingency fund in the TANF program. Do you think it is a good idea to use this funding source considering the TANF contingency fund is capped, it is needed for the TANF program, and most importantly, it does not currently work as intended?

Answer

It is reasonable for these two closely related programs with similar populations to tap into a single safety net. Our projections indicate that—even in an economic downturn and in light of our proposal to make the Contingency Fund more accessible to States that encounter an additional need for TANF funds—the fund also can easily sustain the emergency needs of those States electing the child welfare financing option.

Our design for this proposal reflects our intent that access of the child welfare system to the fund be available in only those rare circumstances where the State itself is suffering severe economic crises and needs assistance to serve abused and neglected children. The triggers and other requirements we propose specifically for the child welfare financing option would offer safeguards that limit access to the fund to truly needy States and only when the crisis is not of their own making. For example, poor planning or policy decisions should not be rewarded.

Just as the TANF block grants have provided States the flexibility to meet the requirements of a similar population, the child welfare financing option is designed to allow States to invest in effective and innovative services that prevent child abuse and neglect, prevent foster care placement, and when necessary, place children in permanent homes. We believe that these investments, over time, will reduce the need for more foster care funds.

In summary, we regard both the child welfare financing option and the increased accessibility to the Contingency Fund for TANF programs embodied in the House-passed welfare reform bill to offer significant steps in program design that effectively provide for unanticipated program needs.

Medicare Provider Reimbursements

Question

On January 24, Rep. Dave Camp and I were joined by 291 other Members of Congress in urging immediate, bipartisan action early in the 108th Congress on Medicare provider payments. Twenty-eight of 41 Members of the Ways and Means Committee signed our letter, which is enclosed. Last June, the House passed legislation that would provide this much needed relief as part of a more comprehensive bill (HR 4954), and the Senate introduced similar legislation, but no action was taken before the 107th Congress adjourned. I would prefer that Congress enact a Medicare outpatient prescription drug benefit. Unfortunately, Congress has been unable to reach consensus on this issue. As a result, a number of reimbursement reductions have already taken effect, and access to hospitals, home health agencies, nursing homes, and physician care has suffered. I would urge you to support immediate action by Congress and CMS on the adequacy of payments in light of the financial condition of these providers, the implications for access for Medicare beneficiaries, and the overwhelming bipartisan support in Congress for reimbursement restorations.

Answer

Fairly reimbursing physicians who participate in Medicare is of great concern to the Department. To avoid a negative update in the Medicare physician fee schedule we had hoped for the possibility of a regulatory correction. CMS Administrator Tom Scully and I thoroughly explored CMS' options and concluded that the agency had no discretion in setting the physician fee update. However, in response to recent Congressional action that amended the statutory Medicare reimbursement formula, CMS on February 26 issued a regulation that recalculates the calendar year 2003 physician fee schedule rates based on a 1.6-percent increase to the fee schedule conversion factor—the dollar amount used to translate the resources used in providing a service into a payment rate. CMS is also sending revised payment files to Medicare carriers to allow physicians to be paid at the higher rates for services provided to beneficiaries on or after March 1. Because of the change in payment rates under this rule, CMS is extending until April 14 the deadline for physicians to decide whether or not they want to participate in Medicare. Nearly 90 percent of physicians enrolled to treat Medicare beneficiaries chose participating status in 2002.

Medicaid Emergency Care Access**Question**

As the author of the prudent layperson standard for emergency care that was enacted for Medicare and Medicaid beneficiaries in the Balanced Budget Act 1997, I was disturbed by the administration's efforts earlier this year to dismantle this protection for Medicaid managed care enrollees. This rollback of protections threatened to severely curtail access to necessary emergency treatment for the poor and disabled. In addition, those hospitals that serve this population would find that states' coverage limits could place an even greater burden on an already frail financial foundation. On January 17, I wrote to you to express my deep concern over this decision. To date, I have not received a written response. I am pleased that the administration rescinded this decision on January 23. However, CMS Administrator Tom Scully was recently quoted as saying, The December 20 policy letter was very defensible. There's a lot of justification for giving states more flexibility. Please advise me as to what action if any your Department intends to take in regard to this important standard.

Answer

In an effort to provide states with increased flexibility to manage their Medicaid programs and to facilitate more appropriate use of preventive and primary care, CMS notified state Medicaid directors in December 2002 that the administration was removing the "prudent layperson" standard for Medicaid beneficiaries enrolled in managed care organizations. However, on January 22, the administration rescinded its decision. CMS is enforcing the provisions you authored in the 1997 Balanced Budget Act requiring MCOs to provide coverage of emergency care services for Medicaid beneficiaries that a "prudent layperson" would consider necessary.

Beneficiary Education Cutbacks**Question**

I am greatly concerned by a December 24 bulletin signed by two senior officials at CMS instructing Medicare fiscal intermediaries that to save money all tasks associated with customer service plan functions are to be stopped, effective with the receipt of this memorandum. Thomas Grissom, director of the Center for Medicare Management, was quoted as saying that the directive was needed to stay within our budget restrictions. My office has since received a fact sheet clarifying the previous directive and assuring us that responses to beneficiary inquiries and local support through State Health Insurance Programs (SHIPs) will not be affected by budget constraints. However, the fact sheet does indicate that Medicare contractors will no longer participate in local seminars, and it does not challenge the reduction in call monitoring activities, which are used to ensure that correct information is given to beneficiaries and providers. I remain concerned by an emerging pattern in which mid level managers issue directives to rollback beneficiary protections and services, and that these directives are neither acknowledged, publicized, nor reversed until they are brought to light by the press. Please assess the extent to which funding constraints will affect beneficiary education and outreach activities for the remainder of FY03 and FY04.

Answer

Beneficiary education continues to be a high priority for CMS. Medicare beneficiaries are increasingly being asked to make complex decisions about their health care. Research indicates that many beneficiaries do not know where to go to answer

their Medicare questions. The National *Medicare & You* Education Program (NMEP) educates beneficiaries about their health plan options through print materials, a toll-free line, Internet site, and community outreach. The program also funds a national ad campaign to raise awareness of what resources are available to beneficiaries. In FY 2004, \$149.5 million will be allocated to NMEP, almost the same funding level as FY 2003. This reflects our desire to maintain our beneficiary education efforts while funding other priority activities. The majority of funding in the program covers the cost of providing telephone services and print materials.

Preventive Benefits/Colorectal Cancer Screening

Question

You have demonstrated an admirable commitment to strengthening and improving access to preventive benefits, in particular, colorectal cancer screening. I remain concerned that since the enactment of a Medicare benefit for screening, participation has only increased by 1 percent, according to a March 2000 GAO report. Because this benefit has been greatly underutilized relative to the 1997 CBO score, I maintain that removing barriers to utilization, such as waiving the deductible and co-insurance and providing an office consultation visit, which is currently covered for diagnostic colonoscopy, would be relatively inexpensive. I am hopeful that you will support bipartisan, bicameral legislation to effect these improvements that I will reintroduce shortly.

Answer

As you know, preventive medicine is one of my top priorities. I believe that disease prevention is one of the most important issues on which we can work together. For example, the HHS budget proposes efforts to promote healthier lifestyles to help people prevent obesity, diabetes and asthma. The FY2004 budget includes a new investment of \$100 million for targeted disease prevention, and enhanced preventative benefits are a focus of our Medicare reform recommendations. Along those lines, and to increase utilization of existing services, the President's "Framework for Modernizing and Improving Medicare" would waive all cost-sharing (co-insurance and application of the part B deductible) for all covered preventive benefits. Medicare covers several colorectal cancer screening procedures, including flexible sigmoidoscopies, colonoscopies, and barium enemas, which are currently subject to both co-insurance and deductibles. Also, CMS has announced its intention to use its national coverage determination process, which includes a public comment period, to evaluate the merits of covering a new type of fecal-occult blood test for colorectal cancer screening.

Physician Boutique Practices

Question

Last year, the growing problem of Medicare-participating physicians requiring seniors to pay substantial access fees to receive care, came to national attention. Your response to my March 2002 letter inquiring whether these "premium" practices violated balance billing protections in current law and urging you to clarify and enforce the law included a directive to Regional Administrators that they should remain neutral on these agreements if asked by physicians. Since that time, these practices have proliferated and are now threatening access to care for many of my constituents in Maryland. Physicians who participate in Medicare receive taxpayer-subsidized payments; at a time when the administration is expressing concern about Medicare's ability to meet its current and future obligations, support for these "exclusive" practices should not continue. I would hope that the administration would join me in taking action to end Medicare's participation in these "boutique practices."

Answer

I appreciate and share your concern about so-called "premium" practices, and I remain strongly committed to ensuring all Medicare beneficiaries have access to the high quality care they need and deserve. Physicians have some discretion in their ability to select patients under current law, particularly when providing care for non-covered services. However, we are continuing to monitor these "boutique practices." Should we uncover any evidence of coercive activity, we will consider what responses would be appropriate to address the situation.

January 24, 2003

Hon. Dennis Hastert
Speaker
U.S. House of Representatives
Washington, DC 20515

Hon. Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Speaker Hastert and Minority Leader Pelosi:

We are writing to emphasize our strong support for legislative action—as soon as possible—to stabilize the Medicare Program for the millions of seniors who rely on it for their health care needs.

We are seriously concerned that many Medicare beneficiaries in our districts are losing access to vitally important health care services due to the inadequacy of current Medicare payment rates. As a result of payment reductions and inadequate reimbursements, many beneficiaries have lost—or are at risk of losing—access to their physicians, hospitals, Medicare+Choice plans, nursing homes, home health services and other providers on whom they rely for care. To ensure that our elderly and disabled constituents do not experience further disruptions, Congress must take immediate action to address this urgent crisis now that the 108th Congress has convened.

This issue demands bipartisan action and a comprehensive solution. We urge you to assign a high priority to stabilizing the Medicare Program for both beneficiaries and providers. Thank you for considering our views on this important issue for our Nation's seniors.

Sincerely,

<u>Jane Camp</u>	<u>Ben Cal.</u>
<u>Maya</u>	<u>Frank Pallone, Jr.</u>
<u>Ed Somers</u>	<u>Jr. Gh</u> <small>IL-15</small>
<u>John Kline</u>	<u>Rend Lucas</u>
<u>Oak E. Childer</u>	<u>Edward G. Mackay</u>
<u>Joe Barton</u>	<u>Richard L. Quinn</u>
<u>J. L.</u>	<u>Doug Bunker</u>
<u>Gail Price</u>	<u>Mona Lee Lottinen</u>
<u>Ali C. Palmer</u>	<u>Richard L. Quinn</u>
<u>Wendell</u>	<u>Donald W. Payne</u>
<u>Ed Royce</u>	<u>Wally Heger</u>
<u>Edith E. Emery</u>	<u>Wayne T. Gibbatt</u>

<u>Gay S. Ackerson</u>	<u>Irish Anz-Town</u>
<u>Archie Crossley</u>	<u>San Luis</u>
<u>John Sallis</u>	<u>T. Hall</u>
<u>Ed Hayes</u>	<u>Bobby Pugh</u>
<u>Joe P. M.</u>	<u>Clay Shaw</u>
<u>James Hamman</u>	<u>Louis H. Moughton</u>
<u>Norm Nichols</u>	<u>Carl Weldon</u>
<u>Roy Wicker</u>	<u>May 7. Catlett</u>
<u>George R. Kittercutt, Jr.</u>	<u>Jack Quinn</u>
<u>Zach Wamp</u>	<u>Jenna Emerson</u>
<u>Alfred A.</u>	<u>James Greenwood</u>

Tim Ryan

Frank A. L. Binder

Zoe Fajen

Mark Foley

Allen Boyd

James Longwin

John F. King

Ann G. Goo

Artem Davis

Tim Summons
OT/2

Pat 100Mey

James Gibbons

Jim Pauter

Cardigan M. Canting

Pat Flynn

Mark Odell

Robin Hays

Pat A. Spady

Robert Weyler

Jim Materson

<u>Ally King</u>	<u>James J. Walsh</u>
<u>Al N. Cotton</u>	<u>Ralph M. Hall</u>
<u>Al Rogers</u>	<u>Wm. H. M. M. M.</u>
<u>Pete Holberton</u>	<u>Ernie</u>
<u>Marty Mabe</u>	<u>Melvin L. Watt</u>
<u>Benny Frank</u>	<u>Mike Fina</u>
<u>Gold Dumas</u>	<u>Paul J. Lee</u>
<u>Lynne Woolley</u>	<u>Al Rogers</u>
<u>Al Jefferson</u>	<u>Jim Marshall</u>
<u>Elie E. Curdson</u>	<u>Brotherhood</u>

<u>Sam A</u>	<u>Melvin C. Hart</u>
<u>Chris Rodriguez</u>	<u>Yung-Den</u>
<u>Oliver DeBelle</u>	<u>Yaron McCarthy</u>
<u>Raul M. Yijalun</u>	<u>Robert Adonis</u>
<u>Steve King</u>	<u>Shelley More Capito</u>
<u>Ray Q</u>	<u>David L. Bonney</u>
<u>Eric A</u>	<u>Chris Van Hollen</u>
<u>Mark Kennedy</u>	<u>Tom Udall</u>
<u>Phyllis</u>	<u>Kirk Card</u>
<u>De Htro</u>	<u>Pete Sessions</u>
<u>Sue Myrick</u>	<u>Vernon J. Ehlers</u>
<u>Sam B</u>	<u>Stewart A. Rosten</u>

<u>Alana Kiehl</u>	<u>Jim Gule</u>
<u>Virgil Woods</u>	<u>Doug Wilde</u>
<u>John Spruiell</u>	<u>Kenly</u>
<u>Vicki Jorgensen</u>	<u>Timothy V. Jorgensen</u>
<u>Sue Kelly</u>	<u>Olivia Davis</u>
<u>Olivia</u>	<u>Phil Pirgony</u>
<u>Eric J. Jorgensen</u>	<u>Jan P. Hill</u>
<u>Hilda L. Solis</u>	<u>Kenneth B. Mack</u>
<u>Ellen Tauscher</u>	<u>David Scott</u>
<u>Wally Lee</u>	<u>Steve Lee</u>
<u>Ken Cabret</u>	<u>John P. ...</u>
<u>Charles L. Gangel</u>	<u>_____</u>

Questions Submitted by Representative Doggett

February 10, 2003

Mr. Tommy Thompson
*U.S. Department of Health and Human Services
 200 Independence Avenue, S.W.
 Washington, D.C. 20201-0004*

Re: Written Questions Following the February 6, 2003 Ways & Means Hearing
 Dear Secretary Thompson:

Below please find the questions I submit following your February 6, 2003 appearance at the Committee on Ways & Means Hearing on the President's Fiscal Year 2004 Budget. I look forward to your prompt response.

Inclusion of Tobacco in the U.S.-Chile Free Trade Agreement

As you know, in December 2002 the U.S. Trade Representative concluded negotiations on the U.S.-Chile Free Trade Agreement. This agreement includes the phase out of import tariffs on leaf tobacco and manufactured tobacco products. You previously told this Committee that HHS was involved in deliberations of an inter-agency working group concerning the U.S.-Chile Free Trade Agreement.

1. Did HHS conclude that public health would not be adversely affected by the reduction or elimination of import tariffs on tobacco?
2. Has HHS been involved in similar deliberations regarding other bilateral agreements and the "Free Trade Area of the Americas" agreement?
3. Provide a copy of the memoranda and documents that contain HHS's analyses and conclusions concerning Questions 1 and 2.
4. Provide a complete listing of all agencies and employees within HHS that were involved in reaching the conclusions in Questions 1 and 2.

Other Advice Regarding Tobacco-Related Trade Matters

5. Identify by date and issue each time since January 2001 that the U.S. Trade Representative (USTR) has invited HHS to offer advice on any tobacco-related matter.
6. For each instance listed in response to Question 5, include a full description of the circumstances and include a copy of the memoranda and documents that contain HHS's analyses and conclusions.
7. For each instance listed in response to Question 5, include all agencies and employees within HHS that were involved in developing your advice.

Korean Tobacco Business Act

Your response to my February 2002 questions acknowledged the involvement of HHS in discussions regarding changes to the Korean Tobacco Business Act, which included a proposal by the Korean government for a 40% tobacco import tariff. However, my question also asked that you: "provide a full description of HHS analyses and conclusion 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."

8. As requested in February 2002, please provide the items that were not included in your answers, namely:
 - a. a full description of HHS analyses and conclusion on this matter,
 - b. any and all documentation, and
 - c. a complete listing of all agencies and employees within HHS that were involved.

Framework Convention on Tobacco Control

Since the negotiations on the Framework Convention on Tobacco Control (FCTC) began in October 1999, over 13 million people have died from tobacco-related illnesses. In 2002 you told this Committee that "HHS is committed to a strong FCTC."

9. What position has the HHS taken with regard to banning misleading terms like "light," "low tar," "mild" and similar terms on the packaging of tobacco products?
 Illicit trade in tobacco products results in billions of dollars in lost taxes while increasing the number of young smokers worldwide.
10. Does HHS support the inclusion in the FCTC of specific labeling and reporting requirements to allow enforcement officials to track tobacco products? If so, what requirements does HHS support?

International Tobacco Control

In your response to my February 2002 questions, you indicated that the international tobacco control "needs assessment report" on China was undergoing final

review and that you would provide me with a copy. You also indicated that the report on India would be completed by the end of 2002.

11. Please provide me with a copy of the China and India reports.

In your response to my February 2002 questions, you indicated that the Fogarty International Center and its collaborating partners would prepare a funding plan for the research and training projects on the global burden of tobacco use, pursuant to the requirements of section 2(d) of Executive Order 13193.

12. Please update me on the progress HHS has made since March 2002 on this initiative.

13. Please provide me with a copy of documents showing progress since March 2002.

Tobacco and U.S. Public Health

Nicotine addiction is the leading cause of preventable death in America today.

14. What initiatives has HHS undertaken since March 2002 to reduce this public health epidemic?

Medicare Prescription Drug Coverage

When you appeared before the Ways and Means Committee on April 17, 2002, you cautioned against the greater use of government bargaining power to lower prescription drug prices for Medicare recipients, as we have for veterans and military retirees, because of "the possibility of distorting the market."

15. Are you still reluctant to endorse getting the Medicare Program on the side of seniors in negotiating prices with the pharmaceutical industry?

Sincerely,

Lloyd Doggett

Answers

Thank you for your February 10, 2003, letter regarding global tobacco control activities at the Department of Health and Human Services (HHS). I appreciate the time you took to write and am pleased to respond to your questions.

Trade in Tobacco and Tobacco Products

At the invitation of the Office of the U.S. Trade Representative (USTR), HHS has participated in deliberations of the inter-agency Trade Policy Staff Committee (TPSC) and Trade Policy Review Group (TPRG) related to trade in tobacco and finished tobacco products. Our role in the TPSC and TPRG is to advise USTR and other Federal agencies regarding the potential public health impact of any tobacco-related trade action. Since January 2001, the USTR has consulted HHS on seven matters:

In the spring of 2001, HHS was involved in the interagency deliberations around discussions with the government of the Republic of Korea regarding the Korean Tobacco Business Act.

In September 2001, USTR considered a request from the government of Indonesia to designate 12 additional products, initially including tobacco, for benefits under the Generalized System of Preferences (GSP).

In February 2002, USTR contacted HHS on a request for guidance from the U.S. 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.

During the course of the second half of 2002, HHS participated in deliberations on the U.S.-Chile Free Trade Agreement having to do with reduction in tariffs on manufactured tobacco products.

In January and February 2003, HHS participated in deliberations regarding negotiations on the Free Trade Agreement of the Americas.

HHS has also provided initial consultation to USTR regarding negotiations on the Central American Free Trade Agreement and the U.S.-Australia Free Trade Agreement, both of which are at very early stages.

For our participation in the work of the TPSC and TPRG related to trade in tobacco and tobacco products, HHS has not produced any formal briefing materials or guidance documents. Below please find a list of agencies and employees who represent HHS in these matters:

Office of Global Health Affairs, Office of the Secretary

William Steiger, Ph.D., Director
Melinda Moore, M.D., M.P.H., Deputy Director
Stuart Nightingale, M.D., Chief Medical Officer

Office on Smoking and Health. Centers for Disease Control and Prevention

Rosemarie Henson, M.S.S.W., M.P.H., Director
 Terry Pechacek, Ph.D., Associate Director for Science

As you know, Ambassador Peter Allgeier, the Deputy U.S. Trade Representative, chairs the TPRG. I believe he can provide detailed information regarding the representation of other Federal agencies, as well as any documentation of the deliberations of the TPSC and TPRG.

Framework Convention on Tobacco Control

Your letter also inquired about the HHS position on two issues related to the Framework Convention on Tobacco Control (FCTC)—proposals to ban certain terms and labeling and to impose reporting requirements to track tobacco products.

The U.S. Delegation supported having a strong provision in the FCTC that prohibits false, misleading or deceptive claims on the packaging of tobacco products. However; the Delegation did not support language that specifically bans certain words or descriptors. We prefer permitting each country to determine when and whether such terms are used in a deceptive fashion under its own legal standards and to determine the appropriate remedy necessary to prevent deception. Our position was consistent with Article 11 of the final draft of the FCTC, which on March 1 over 170 countries supported for submission to the World Health Assembly this May.

The U.S. Delegation also supported the labeling and reporting requirements now included in Article 15 of the FCTC text approved for submission to the World Health Assembly. The U.S. worked diligently with the European Union, Canada and many other countries on strong consensus language on these provisions. These include requirements that packets and packages of tobacco products sold on the domestic market carry the statement: "Sales only allowed in (insert name of country, sub-national, regional or Federal unit)." Other requirements include monitoring and collection of data on cross border trade and exchange of information among customs, tax, and other authorities.

China and India Reports

Regarding the status of the China report, a final draft is in the process of going through clearance within HHS. We will send you a copy of the report as soon as it is finalized.

With respect to the report on India, we have had to change the timeline for completion of the report, in part because of turnover in the political leadership within the Ministry of Health in India. The Centers for Disease Control and Prevention (CDC) has now begun the planning process for the India report with significant collaboration from the Ministry of Health, and staff from the Office on Smoking and Health within CDC will be traveling to New Delhi by the end of March to meet with the new Minister and continue discussions and project planning. We will share a copy of the report with you as soon as it is completed.

Global Tobacco Control Grant Program

With respect to your inquiry about the global tobacco control grant program at the National Institutes of Health (NIH), in July of 2002 the NIH Fogarty International Center (FIC) and eight partners announced 14 new research and training grants to combat the growing incidence of tobacco-caused illnesses and death in the developing world. This successful initiative demonstrates the commitment of different HHS agencies to global tobacco control. (Attach: Press Release)

Tobacco and U.S. Public Health

Your letter asked what initiatives has HHS undertaken since March 2002 to reduce tobacco use in the United States. I want to assure you that reducing tobacco use, particularly among youth, is key to my overall health prevention strategy. The following are some examples of our major initiatives:

HHS worked with the U.S. Office of Personnel Management to encourage Federal Employee Health Benefits Plans to include smoking cessation coverage in their plans. This action, which began on April 10, 2001, will provide access for Federal employees to cessation services that meet the Public Health Service clinical guidelines, published in 2000.

- The Centers for Medicare and Medicaid Services (CMS) has developed the Medicare Stop Smoking Program (MSSP), a demonstration study to determine the most feasible and effective smoking cessation intervention for older Americans. At my request, a Smoking Cessation Subcommittee had been established within the Department's Interagency Committee on Smoking and Health (ICSH). The Subcommittee, composed of leading experts in

the field of tobacco use cessation from the private and public sector, was charged with making recommendations on how best to promote smoking cessation. The Subcommittee met five times between October 2002 and February 2003, including three public meetings in which Members of the public and public health community gave testimony on effective approaches to cessation. The Report draft which came out of the Subcommittee outlines a series of science-based recommendations for a broad and comprehensive approach to tobacco use cessation, such as a Federally funded national quitline, a mass media campaign to encourage cessation, and partnerships between HHS and community organizations to put in place programs and policies that promote cessation.

- The *National Blueprint for Disseminating and Implementing Evidence-Based Clinical and Community Strategies to Promote Adult Tobacco Use Cessation* (National Blueprint) is a consensus document that is the result of a public-private collaboration of Federal agencies—the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the National Cancer Institute (NCI), the National Heart, Lung, and Blood Institute (NHLBI), the Health Resources and Services Administration (HRSA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Medicare and Medicaid Services (CMS); and non-Federal groups—the Robert Wood Johnson Foundation (RWJF), the American Legacy Foundation (Legacy), and the American Cancer Society (ACS). The National Blueprint provides a common framework for cooperation and coordinated action among all Federal, State, and local agencies as well as private-sector organizations and individuals interested in taking effective clinical and community steps to reduce tobacco use. We will share a copy of the report with you as soon as it is completed.
- The Youth Cessation Evaluation Project is a partnership between the CDC's Office on Smoking and Health, the National Cancer Institute and the Robert Wood Johnson Foundation, with scientific leadership from the University of Illinois at Chicago, to evaluate approximately 50 youth cessation programs across the country. This evaluation project will compare the relative effectiveness of these interventions and provide data to inform best practices for youth cessation programs.
- The National Institute on Drug Abuse (NIDA) supports research on the treatment of nicotine addiction by focusing on the testing of nicotine replacement and no nicotine medications in combination with behavioral strategies. NIDA is also studying individual and gender differences in cigarette abstinence. In addition, NIDA is supporting basic research on neurochemical and molecular mechanisms of nicotine addiction, the structure and function of nicotinic receptors (nAChRs) in the brain, and the pharmacologic basis of nicotine addiction. Finally, NIDA projects are examining genetic differences in nicotine sensitivity as well as behavioral genetic studies of smoking behavior.
- The CDC's National Tobacco Control Program (NTCP) funds 50 states, the District of Columbia, and seven U.S. territories. Many states are relying more than ever on NTCP to maintain the states' basic capacity to carry out effective tobacco prevention and control programs. The NTCP average funding per states is approximately \$1.2 million with total funding for the program at \$58 million.

Medicare Prescription Drug Coverage

I want to assure you that the Medicare Program is always concerned for and working on behalf of Medicare beneficiaries. Specifically regarding prescription drugs, we strongly support giving all seniors a prescription drug benefit, and the President's framework provides real relief, more choices, and better benefits. In 2004, it guarantees that seniors would benefit immediately from discounts of 10–25 percent or more through a Medicare-endorsed drug card. In 2006, the comprehensive drug benefit envisioned by the President encourages competition, protects the financial security of Medicare, and provides better benefits at a lower cost.

The President's plan encourages the use of effective tools—such as preferred drug lists and formularies that are already widely used by the private sector—to get lower prices to beneficiaries and reduce overall costs. And, under the President's plan, seniors will see lower costs by the collective pooling of their purchasing power. What we want to avoid are the restrictive features of a government-controlled sys-

tem that lead to (1) higher retail costs or (2) restrictions on access to valuable new drug treatments in order to control costs.

