BUSH ADMINISTRATION'S HEALTH AND WELFARE PRIORITIES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED SEVENTH CONGRESS

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BUSH ADMINISTRATION'S HEALTH AND WELFARE PRIORITIES

WEDNESDAY, MARCH 14, 2001

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

The Committee met, pursuant to notice, at 10:02 a.m., in room 1100 Longworth House Office Building, Hon. Bill Thomas [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

CONTACT: (202) 225–1721

FOR IMMEDIATE RELEASE
March 7, 2001
FC–3

Thomas Announces Hearing Featuring HHS Secretary Thompson on the Bush Administration's Health and Welfare Priorities

Congressman Bill Thomas (R–CA), Chairman of the Committee on Ways and Means, today announced that the Committee will hold a hearing on the Bush Administration's health and welfare priorities. **The hearing will take place on Wednesday, March 14, 2001, 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 Secretary Thompson only. 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:

The Bush Administration has put forward a bold agenda on modernizing Medicare, enacting a patient bill of rights, and continuing welfare reform. This hearing begins the dialogue between the Administration and Congress about its agenda and priorities in these areas.

In announcing the hearing, Chairman Thomas stated: "As Governor of Wisconsin, Secretary Thompson's record on health and welfare policy implementation is an innovative model for other states. I look forward to working with him as he brings his ideas and enthusiasm to bear on the range of important challenges facing us this year, beginning with the need to strengthen and improve the Medicare program."

FOCUS OF THE HEARING:

Secretary Thompson will present the Administration's health and human services priorities to the Committee.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label,* by the *close of business,* Wednesday, March 28, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Committee office, room 1102 Longworth House Office Building, by close of business the day before the hearing.

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. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

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

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

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

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

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

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

Chairman THOMAS. It is now my pleasure to welcome to the Ways and Means Committee the Health and Human Services Secretary, former Governor Tommy Thompson. Secretary Thompson has had a long and distinguished career in both health and welfare, as he presided over a record-setting 14 years as Governor of Wisconsin. This hearing marks the beginning of a dialog between the Bush administration and Congress, and the administration's priorities and Congress' desires in both the health and the welfare areas.

I was pleased to see the Bush administration issue a set of principles, focusing on Patients' Bill of Rights. These principles send Congress the right message, that we have to have a real patient protection legislation that covers all Americans and ensures that individuals get the care that they need. It is our anticipation, based upon an announcement by the President last week, that this Committee will also receive principles on Medicare modernization, including prescription drugs. We look forward to that guidance and working in a bipartisan manner in this Committee to take those principles, translate them into legislation, and move them hopefully to the President's desk this year.

That challenge is pretty formidable. Under current law, as we have seen in terms of the new numbers from the Congressional Budget Office, Medicare spending will more than double over the next 10 years. At the same time, notwithstanding that doubling of costs, the services provided by Medicare are simply not contem-

porary today with what any individual would expect to receive from a comprehensive health care program.

Secretary Thompson, we want to work with you over the next several weeks to identify the kinds of improvements that we would like to see in the Medicare program. Some of the improvements, I am quite sure that as you put your structure together at Health and Human Services, you will be able to implement administratively. We do want to know where there need to be changes legislatively, but in short we want to work with you. We want to help move this program forward. It is important to all of us and our seniors are depending on us.

With that, I would recognize——

[The opening statement of Chairman Thomas follows:]

Opening Statement of the Hon. Bill Thomas, M.C., California, and Chairman, Committee on Ways and Means

It is my pleasure to welcome Health and Human Services Secretary Tommy Thompson to the Ways and Means Committee. Secretary Thompson has a long and distinguished record in both health and welfare reform in his 14 year tenure as governor of Wisconsin.

For example, while Governor, welfare caseloads in Wisconsin declined more than 80 percent. Overall, the number of families receiving cash welfare fell from about 95,000 to fewer than 17,000 through June 2000 as you created a new program focused on work. We understand it has fallen even more since then. In some Wisconsin counties, cash welfare has simply ceased to exist. That required a complete revolution in how government helps needy families, and you truly were a pioneer in this effort. As we take the next steps in reforming welfare nationwide, we are excited to have your vision and expertise to assist us.

In the health care area, Governor Thompson initiated the "Badger Care" waiver, which used Medicaid managed care to dramatically increase health insurance coverage in Wisconsin. In addition, you pushed the States' Children Health Insurance Program (S–CHIP) to cover parents of poor kids.

This hearing begins a dialogue between the Bush Administration and Congress about the Administration's priorities in the health and welfare areas.

I was pleased to see the Bush Administration issue a set of principles on the patient bill of rights. Those principles send Congress the right message—we must have "real" patient protection legislation that covers all Americans and ensures that individuals get the care they need. The principles also make clear that, while we want to give patients their day in court, we are not interested in writing blank checks to trial lawyers, and increasing the cost of health care.

What I find most heartening is this Administration's respect for Congress's role in the legislative process. Rather than sending us 1,400 pages of detailed legislative language and expecting us to rubber stamp it, the Administration has the confidence that, once provided a framework, Congress should be trusted to make specific policy decisions.

Last week, President Bush announced his intention to issue principles on Medicare modernization and prescription drugs. We look forward to that guidance, and to working in a bipartisan manner in this Committee to translate those principles into legislation that will be enacted into law this year.

Our challenges are formidable. Under current law, Medicare spending will more than double over the next 10 years. At the same time, Medicare has not kept up with changes in health care, most notably incorporating out-patient prescription drugs.

Secretary Thompson, we want to work with you over the next several weeks to identify the types of improvements that have to be made to the Medicare program. Some of those improvements you can accomplish on your own, administratively. Other changes have to be done legislatively. But, in short, we want to work with you to make these changes this year. Our seniors are depending on us.

Secretary Thompson, we look forward to your testimony.

Mr. KLECZKA. Mr. Chairman.

Chairman THOMAS. The gentleman from Wisconsin.

Mr. KLECZKA. Will the Chairman yield?

Chairman THOMAS. I would tell the gentlemen that following the ranking member's remarks, it is the chair's intention to recognize both the gentlemen from Wisconsin for an opportunity to welcome the former Governor.

Mr. KLECZKA. Thank you, Mr. Chairman. Very perceptive. In fact, my remarks are longer than your explanation.

Chairman THOMAS. With that, I would call on the gentlemen from New York.

Mr. RANGEL. Thank you, Mr. Chairman.

Secretary Thompson, welcome to our Committee. I think our Nation is fortunate to have someone of your caliber and experience to be willing to serve in this very sensitive position. There are some sharp differences philosophically that we have in the Congress, but I do not think those differences mean that we do not want Americans to get the best possible health care that we can.

Some people believe that health care is not a Federal government responsibility, that it should be left up to private organizations and individuals; others believe you should keep the Federal government out of it as much as possible and let the decisions be made by States and those closer to their constituents. Nevertheless, as this battle goes on and we have to deal with the budget problems, there are some serious questions as to whether the Medicare surplus, as we call it, is adequately protected and whether it is in a lock box, whether it is a slush fund, whether it is an emergency fund, whether it can be used for a variety of other purposes.

Some feel more strongly than others. Throughout these hearings, we hope that we will be able to get your assurances that no matter what legislative decisions we make, we do know that in the next decade we expect the number of beneficiaries to double. We do not want to create a crisis, a fiscal crisis, for those people who will come looking for their benefits, and I know you do not. But sometimes bookkeepers and economists have different ways of explaining our fiscal situation, and since you are right in the middle of it, we hope that you will be able to clarify just what the President and the budget people mean when they say we do not have anything to worry about with the Medicare surpluses.

We look forward to working with you, and I hope that our differences will not always have to be resolved at these type of hearings. I encourage the chairman to try to get the ability to work out these things without the glare of the television lights, and to do whatever else is necessary to resolve these issues for the benefit of the beneficiaries of this. Welcome to the Committee. I look forward to working with you.

Chairman THOMAS. Thank the gentleman, and I will call then for a brief introduction from the gentlemen from Wisconsin, Mr. Ryan.

Mr. RYAN. Thank you, Mr. Chairman. It is very much a great pleasure to be here to help introduce Secretary Thompson. As many of you know, Tommy was the former Governor of my State, the State of Wisconsin. I think it is important to reveal a few important points about the kind of accomplishments that Tommy Thompson has had. He served four consecutive terms as our Governor. He was picked by President Bush because of his unique

abilities. Time and again as Governor, he threw out the traditional approaches to government and experimented with innovative ideas. This kind of openness to innovative ideas is going to make him a successful HHS Secretary.

His innovative W–2 program served as a model for the Nation. He drastically reduced the welfare rolls in Wisconsin. His ideas to extend health care to working poor families in what we call Badger Care, and to bring the disabled population into the work force through the Pathways to Independence Program, built on the success of welfare reform. These kinds of can-do ideas is what we now have at the Department of Health and Human Services, and it is just a distinct honor to be here, to introduce the most qualified person in the country for this job. Thank you. I yield.

[The opening statement of Mr. Ryan follows:]

Opening Statement of the Hon. Paul Ryan, M.C., Wisconsin

Thank You, Chairman Thomas. I am pleased to be here today to introduce the Secretary of the Department of Health and Human Services, and the former Governor of my state, the State of Wisconsin, Tommy Thompson.

Secretary Thompson was the first Governor in the history of Wisconsin to be elected to serve four consecutive terms as Governor. I am pleased that President Bush recognized his ability to make change and I am confident he will use this ability to get things done for the people of this nation.

Time and again as Governor, Secretary Thompson was willing to throw out the traditional approaches to government and experiment with innovative ideas. I believe this openness to innovative ideas will make him a successful HHS Secretary.

His innovative W–2 Program, which served as a model for the nation, has drastically reduced the welfare rolls in Wisconsin. His ideas to extend health care to working poor families in Badgercare and bring the disabled population into the workforce through Pathways to Independence further built on the success of welfare reform in Wisconsin.

The Secretary's contributions in health and welfare in Wisconsin will serve the nation well. He is a mentor and a good friend and I ask you all to join me in welcoming Secretary Tommy Thompson.

Chairman THOMAS. The other gentleman from Wisconsin.

Mr. KLECZKA. Thank you, Mr. Chairman. My colleague from Wisconsin, Mr. Ryan, took the words right out of my mouth. They were not as glowing, though. I want to join with the chairman and the Ranking Member and my colleague from Wisconsin in welcoming you, Governor, to the Ways and Means Committee. Wisconsin's loss is the Federal government's gain. I am unsure whether or not we should still call you Tommy. Jay Leno had a couple of things to say about that the other night and he thought it was not the most respectful, so maybe we can try out Secretary Thomas Thompson. How does that grab you? Back in Wisconsin, no one would know who we are talking about, though.

But Governor, it is a real pleasure to welcome you. Paul indicated many of the innovations that you pushed through for the State of Wisconsin, that included a lot of waivers, some of which you got; some of which you did not get. I enjoyed working with you to ensure the waivers that we did finally get out of the department, and now, under your tenure, I am sure the waivers will be much easier to come by.

Mr. STARK. Would the gentleman yield?

Mr. KLECZKA. I will yield to a former Wisconsinite, Pete Stark.

Chairman THOMAS. The chair is constrained to ask how many others claim roots in Wisconsin, prior to the Secretary——

Mr. KLECZKA. We have Marcy Kaptur and others coming in. She went to the University of Wisconsin, so it will be a long intro.

Mr. STARK. Mr. Chairman, as a fourth-generation Wisconsinite, I, too, would like to welcome the Secretary and point out that I, too, when I was a youngster, as the Secretary is, was a Republican in Wisconsin, and I hope as he gets older, as I have, that he will see the error of his ways and join with us. Thank you, Mr. Chairman.

Mr. KLECZKA. In closing, Mr. Chairman, let me welcome Governor Thompson to the Committee, and I surely hope that with some of the issues facing us, issues that come out of your department, that we will work in a bipartisan way. There has been a lot of talk about bipartisanship from this new administration. I have yet to see any of it. Hopefully working together we will see some of it coming out of your agency.

So thank you very much, Mr. Chairman.

Chairman THOMAS. Mr. Secretary, I stand in awe. Your reputation precedes you. Without uttering a word, you have created one of the biggest bipartisan love-ins this Committee has ever seen. Clearly you are a miracle worker. We welcome you to the Committee. Any written statement that you may have will be made a part of the record and you may address us in any way you see fit. I do want to caution the members of the Committee, the Secretary will return next Tuesday with the Secretary of the Treasury, as we look at the Social Security trust reports. So if you are not able to get a question in to the Secretary today, he is anxious to be with us again on Tuesday. With that, Mr. Secretary, welcome to the Committee.

[The opening statements of Messrs. Matsui, McDermott, and Ramstad follow:]

Opening Statement of the Hon. Robert T. Matsui, M.C., California

Mr. Chairman, thank you for calling Chairman Thomas, thank you for providing the Ways and Means Committee with the opportunity to talk with the new Secretary of Health and Human Services, Tommy Thompson. Over the next two years, the Ways and Means Committee will reauthorize many important health and welfare programs that Secretary Thompson now administers. Secretary Thompson is also responsible for the nation's two largest health insurance programs, Medicare and Medicaid. I look forward to working with Secretary Thompson and my fellow members of this Committee as we work to improve these programs, which touch the lives of almost every American.

Welcome, Secretary Thompson. As Governor of Wisconsin, you have been a pioneer in bringing health insurance to low-income children and families through the expansion of your Medicaid program, Badgercare. My home state of California has just announced plans to expand its CHIP program, Healthy Families, to cover parents of low-income children. I hope that more states follow the lead of Wisconsin and California and take this approach to providing health insurance to people without it.

Wisconsin's welfare program has invested in the supports that people need to make the transition from welfare to work successful, including child care, health care, transportation, food stamps, education, and training. You have also led efforts to encourage people with disabilities to return to work through the Pathways to Independence Program. Wisconsin's Program of Assertive Community Treatment has opened up new possibilities for the treatment of people with severe mental illnesses

With the help of programs such as these, Wisconsin has one of the lowest child poverty rates in the nation and one of the lowest percentages of children without

health insurance. I hope that we can learn from your accomplishments at the state level and decrease child poverty and uninsured rates across the nation.

The largest program you now oversee as Secretary of Health and Human Services is Medicare. I have some serious concerns with the way that the President's budget uses the Medicare surplus. As you know, the Medicare Hospital Insurance Trust Fund is used to pay Part A benefits. Currently, the Trust Fund is running a surplus. The Office of Management and Budget projects that this surplus will total $526 billion over the next 10 years. But this surplus is only temporary. In a few years, we will need to draw on this surplus to finance Part A benefits for a growing number of seniors.

The most prudent use of the Medicare surplus would be to help pay down the national debt. However, the President's budget uses this surplus to finance a "contingency fund," which the President suggests could be spent on national defense, aid for farmers, or a Medicare drug benefit. While these initiatives may well require additional funds, we shouldn't use the Medicare surplus to pay for them. When the time comes for us to draw down that Medicare surplus to pay Part A benefits, and if we've already used to surplus to finance something else, we're going to have to cut Medicare benefits, cut spending in other areas, or put our country back into debt.

The President's budget makes a serious error that could have repercussions not only for Medicare but all government spending. It goes against promises made by both parties to put the Medicare surplus in a lock box and prepare our country for the retirement of the baby boom generation. I hope that the Administration reconsiders the budget's use of the Medicare surplus, because this move not only hurts our nation's seniors and baby boomers but our children and grandchildren as well.

Opening Statement of the Hon. Jim McDermott, M.C., Minnesota

As a former member of the National Bipartisan Commission on the Future of Medicare, as a member of this subcommittee and as a physician, I have been intimately involved with the debate over Medicare reform.

I do not believe that the traditional Medicare program is fundamentally broken. I *do* believe that we must take steps to ensure the program's solvency. Any Medicare reform proposal must ensure that beneficiaries in tomorrow's world have access to the same basic benefits that already exist in today's program. We must improve the status quo by including an affordable prescription drug benefit and establishing a cap on out-of-pocket costs.

I have great reservations about the approach the Administration takes with respect to the Medicare program. It misleads the public by putting the Part A Hospital Insurance trust fund surplus into its contingency fund, making it available for other spending needs. Further, the Administration combines Parts A and B, and portrays a crisis with the program facing a $645 billion deficit over the next ten years.

In reality, there is no deficit. The financing structure of the program dictates that 25% of Part B is paid by beneficiary premiums and 75% from general revenues. Withdrawing from general revenues is intended—it is not a crisis!

The 2000 Hospital Insurance Trustee's Report places the Part A insolvency date at 2025. Combining Parts A and B as the Administration proposes would speed up the date of insolvency by 20 years, to 2004.

The President's proposal to set aside $156 billion for Medicare reform and a prescription drug benefit. This is woefully inadequate.

I want to protect the traditional Medicare program. Additional revenues are needed to meet the future financial obligations. I hope we can work together on Medicare reform so we can mend the program and improve benefits for *all* beneficiaries.

Opening Statement of the Hon. Jim Ramstad, M.C., Minnesota

Mr. Chairman, thank you for calling this important hearing today to learn about the Bush Administration's agenda for health care and human services.

I want to start by commending President Bush and Secretary Thompson for accepting the challenge of modernizing Medicare, enacting a patients' bill of rights and continuing to reform welfare.

I strongly believe that Medicare needs to be *comprehensively* reformed and modernized. We cannot focus on simply tinkering around the edges, and we must not

take the easy road of simply adding a prescription drug benefit to an already overburdened program. I am pleased the Administration is working with Congress to develop a plan to provide seniors with prescription drug coverage, and I am also pleased that the President has pushed for comprehensive reform this year.

As a representative from a state hurt by the unfair and unjust inequity in the Medicare managed care reimbursement formula, I know firsthand the difficulties faced by seniors when irrational decisions at the federal level deny them the choices they deserve. This is also true in the medical device industry. Small businesses, their employees and seniors all suffer when the federal system irrationally delays or denies coverage of their innovative products. Only through comprehensive reform and modernization of the Medicare program can these endemic problems be fixed.

I'm also supportive of the Administration's efforts to forge consensus on a patients' bill of rights. Last year, we had an opportunity to find common ground and were thwarted by the previous Administration. This year, with the President's obvious commitment to this issue, I am hopeful we can work together for all Americans.

I also strongly support continuing the progress we've made in recent years on welfare reform. We cannot let the success of welfare reform make us complacent for the future.

I want to thank Secretary Thompson and President Bush for their leadership. I look forward to today's testimony and thank you Mr. Chairman for calling this important hearing.

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

Secretary THOMPSON. Good morning, Chairman, and thank you so very much for your kind words in introduction.

Congressman Rangel, thank you for your kind words; and, Congressman Stark, it is great to have somebody with four generations living in Wisconsin. I probably will not become a Democrat, but I thank you for your solicitation.

Congressman Ryan, thank you for your kind words; and Congressman Kleczka, a friend for a long time, I appreciate that and we will be bipartisan; I thank you very much for your kind words and working with you as a legislator and also as a Governor, and now, hopefully, as Secretary. I appreciate that.

All of the Members of the Committee, I am here today and honored very much and humbled to appear before you to discuss the framework of the President's fiscal year 2002 budget for the Department of Health and Human Services.

Mr. Chairman, the written testimony I submitted was broader than the jurisdiction of this Committee. Since the hearing today is on President Bush's budget framework, I felt it was important to give you an overview of the priorities for the entire department. Today, however, I will focus my remarks on items in the budget that will be coming in front of your Committee. I will also say that we have begun to talk about Medicare reform, Mr. Chairman and members.

I know all of you have been involved in this issue far longer than I have. We in the administration look forward to working with you and the Members of this Committee to bring about a true modernization of this vital program. The department's goal is to build a healthier America by improving the quality of health care and the quality of life for all American families.

President Bush has outlined a very ambitious agenda for the Nation, and especially for the Department of Health and Human Services; and we will play a major role. There are great challenges before us, but I am very confident that we will be able to work together in a bipartisan fashion to successfully meet them. If we are

to succeed, we must be willing to re-examine the way we do things on the national level. We must no longer be content with the status quo simply because that is how we have always done it.

The HHS budget proposes new and innovative solutions for meeting the challenges that face the Nation. Through this budget, we will modernize Medicare, including providing access to prescription drugs. We will improve access to quality health care, increase support for America's families, and strengthen the way the department operations are truly managed. This blueprint reflects the President's commitment to protecting Social Security, Medicare and other priority programs, while continuing to pay down the national debt and providing tax relief for all Americans.

The budget request for HHS for fiscal year 2002 is $471 billion, an eight percent increase for all programs, and $55.5 billion for discretionary programs, or a 5.1-percent increase. Let me now highlight some of our major proposals that will be coming before your Committee. Of all the issues confronting this department, none has a more direct effect on the well-being of our citizens than the quality of health care. We want to modernize Medicare to make sure that it is the best program possible for our senior citizens, protecting the quality benefits our seniors currently receive, while making sure the program is able to provide quality benefits to future generations, as well.

I know this is very important, especially to you, Mr. Chairman, and to other members on the Ways and Means Committee. Part of modernizing Medicare is adding a prescription drug benefit because drugs are such a major component of health care today; from prevention to treatment of illness. When Medicare was created in 1965, prescription drugs were not the integral part of health care that they are today. Drug coverage was not included as part of the Medicare benefit package. But what was acceptable 35 years ago is simply unacceptable today. It just does not make common sense for a 21st century health care program to exclude a prescription drug benefit.

Many of America's seniors do not have access to prescription drugs today, and a new study released earlier this week shows a growing gap in the number of prescriptions filled for seniors with access to coverage than those without access. That clearly is not because seniors without drug coverage have less of a need for prescriptions. That is why the President has put forward the Immediate Helping Hand prescription drug proposal. This proposal gives immediate financial support to States so that they can provide prescription drug coverage to our neediest citizens.

The President believes comprehensive Medicare reform needs to be enacted at the same time as the prescription drug benefit. The President wants to devote $153 billion over the next 10 years on Medicare modernizations that will help improve the financial help of the program and add a prescription benefit for all Medicare beneficiaries. We will protect Medicare. These improvements and modernizations will strengthen Medicare and will not be done at the expense of other aspects of the program.

As the President said in his budget address, every penny of the Medicare trust fund will be used for Medicare. Let me repeat that. Every penny of the Medicare trust fund will be used for Medicare,

period. As we modernize and strengthen Medicare, we must also reform the way its principal agency, HCFA, works. The demands of the Health Care Financing Administration have grown dramatically, and we must ensure that it has the necessary resources to run the all-important Medicare, Medicaid and SCHIP, the State Children's Health Insurance Programs. At the same time, we recognize that patients, providers and States have legitimate complaints about the scope and the complexity of the regulations and the paperwork that govern these programs. As I have said many times, HCFA needs to undergo a thorough examination of its missions, its competing demands, and, yes, its resources.

We are currently in the process of undertaking just that kind of comprehensive, aggressive review. For example, HCFA has a budget of $375 billion, yet it still does not have a double-entry bookkeeping system. The single-entry bookkeeping system went out in the early 1900s. So it is no understatement to say that the largest health insurance company in the world needs to be modernized. Along those lines, we also need to upgrade the computer system so that everyone will be able to say that we are doing and operating HCFA in the most efficient way possible. A lot of our computer systems were installed in 1970.

We also need to create a concrete schedule on rule changes. Instead of just blind siding participants with new rules that they know little or nothing about, we should be able to time the rules so everyone is aware of the changes. We should be able to alert everyone, whether it be on a quarterly, semi-annual or annual basis, to smooth out the transition. This administration also is committed to strengthening long-term care in this country. In Wisconsin, we created a program called Family Care that allowed the elderly and the disabled to receive the best and greatest number of choices possible for long-term care.

I look forward to working with each of you and the States to continue to develop innovative solutions on long-term care. We also recognize that we have some decisions to make in the coming years about the future of welfare reform and how we go to the next step. The President has offered significant proposals this year, including a $200 million increase to expand the Safe and Stable Families program, and $67 million in new grants for mentoring children of prisoners, to help our youth through the time that their parents are in prison.

The President also has proposed a $400 million after-school care program that will allow families to have access to quality child care, which is so vital to parents being able to remain in the workforce. Again, I look forward to working with every member of this Committee as we begin to explore the future of welfare reform.

Mr. Chairman, the budget I bring before you today contains a number of different proposals, but one common thread binds them all together, that is the desire to improve the lives of all American citizens. All of our proposals are put forward with the one simple goal in mind, and I know that is a goal that all of us share on a bipartisan basis. I look forward to working with each of you to ensure that we develop a budget for this department that effectively serves the national interest and all of our citizens.

Thank you, and now I would be extremely happy to answer any questions that you may have.

[The prepared statement of Secretary Thompson follows:]

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

Good Morning, Chairman Thomas, Congressman Rangel, and Members of the Committee. I am honored to appear before you today to discuss the framework of the President's FY 2002 budget for the Department of Health and Human Services.

As I have noted on other occasions, I accepted the position of Secretary of this Department because I believe that there is no other job in America where you have a greater opportunity to help people—to actually make a difference in people's lives and improve the quality of life they lead. President Bush has outlined an ambitious agenda for the nation, and I take great pride in the fact that this Department will play a major role in carrying out his plans. I would be less than candid if I did not acknowledge the vast scope of the challenges that lie ahead of us, but I am confident that we will be able to work together in a bipartisan fashion to successfully meet them.

If we are to succeed in improving the lives of the people of this great nation, we must be willing to take another look at the way we do things on the national level. We must no longer be content to do things a certain way because "that's how we've always done it"; but must instead be willing to reform our business practices and seek innovative ways to manage our programs. And while we know that the federal government has an important role to play, we must also recognize that we must look to others—to State and local governments, to community faith-based organizations, to academic and religious institutions—for new and creative approaches to solving public problems. The President and I share this view, and I am proud to say that it is reflected in the budget framework he has put forward.

The framework I present to you today keeps the promises the President has made and proposes new and innovative solutions for meeting the challenges that face the nation. It seeks to enhance the groundbreaking research being conducted at the National Institutes of Health; modernize Medicare and expand access to quality healthcare; increase support for America's families; and reform the way the Department's operations are managed. Our proposals also reflect the President's commitment to a balanced fiscal framework that puts discretionary spending on a more reasonable and sustainable growth path, protects Social Security and other priority programs, continues to pay down the national debt, and provides tax relief for all Americans.

Mr. Chairman, the total HHS request for FY 2002 is $ 471 billion (budget authority) and $468 billion (budget outlays). The discretionary component totals $ 55.5 billion (budget authority). Let me now highlight some of our major proposals.

ENHANCING RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH

The National Institutes of Health (NIH) is the largest and most distinguished biomedical research organization in the world. The research that is conducted and supported by the NIH, from the most basic research on biological systems to the effort to map the human genome, offers the promise of breakthroughs in preventing and treating any number of diseases. A top priority for this Department is ensuring that the NIH continues to have the resources necessary to help turn these promises into a reality.

To this end, the framework I present to you today includes a Presidential Initiative to double NIH's FY 1998 funding level by FY 2003. For FY 2002, we are proposing an increase of +$2.75 billion, which will be the largest increase ever for NIH. This funding level will enable NIH to support the highest level of total research grants in the agency's history.

With any large increase in resources, there also comes the increased challenge of making sure that those resources are managed properly. I take this responsibility very seriously, and NIH will be working to develop strategies to ensure that we are managing taxpayer dollars in the most efficient and effective way.

MODERNIZING MEDICARE AND EXPANDING ACCESS TO QUALITY HEALTHCARE

Of all the issues confronting this Department, nothing has a more direct effect on the well-being of our citizens than the quality of health care. Our budget framework proposes to improve the health of the American people by beginning the process of modernizing Medicare, including the addition of a prescription drug benefit; and by expanding access to quality health care.

Immediate Helping Hand

For thirty-five years the Medicare program has been at the center of our society's commitment to ensuring that all of our seniors enjoy a healthy and secure retirement. But the Medicare program is more than just a social contract between the government and the elderly, it is a commitment that our society has made to our seniors, as well as to the disabled. Honoring this commitment means not only making sure that the program is financially prepared for the wave of new beneficiaries that the aging of the baby-boom generation will bring, but ensuring that current beneficiaries have access to the highest quality care.

When Medicare was created in 1965, prescription drugs were not the integral part of health care that they are today and coverage for them was not included as part of the Medicare benefit package. But what was acceptable thirty-five years ago is simply unacceptable today. As a first step toward remedying this situation, the President has put forward an Immediate Helping Hand (IHH) prescription drug proposal. This proposal gives immediate financial support to States so that they can provide prescription drug coverage to beneficiaries with limited incomes or high drug expenses.

The IHH proposal would complement and build on plans that are currently available in almost half the states, and under consideration in most others. The IHH would be fully funded by the Federal government and would provide States with the flexibility to choose how to establish coverage or enhance existing plans. Individuals with incomes up to $11,600 and married couples with incomes up to $15,700 who are not eligible for Medicaid or a comprehensive private retiree benefit would pay no premium and no more than a nominal charge for prescriptions. Individuals with incomes up to $15,000 and married couples with incomes of up to $20,300 would receive subsidies for at least half the cost of the premium for high-quality drug coverage. The IHH plan also includes a catastrophic component that would cover any Medicare beneficiaries with very high out-of-pocket drug costs. The President's proposal would provide immediate coverage for up to 9.5 million beneficiaries while we work to enact broader Medicare reform.

The Immediate Helping Hand is a temporary plan to help our Nation's seniors who are most in need of assistance with their prescription drug costs. The benefit will sunset in four years or as soon as a comprehensive Medicare reform and prescription drug benefit is implemented. However, this plan is critical because it provides assistance to millions of Americans *this year*. The President is committed to providing a prescription drug benefit to all Medicare beneficiaries and wants to work with Congress in a bipartisan fashion to see this happen.

The President believes comprehensive Medicare reform needs to be enacted at the same time as a prescription drug benefit. As I have already mentioned, the Medicare program has not kept pace with modern medicine. Today, Medicare covers only 53 percent of the average senior's annual medical expenses and the program's benefits package is lacking. In addition, Medicare is facing a looming fiscal crisis. A full assessment of the health of both the Part A and Part B Trust Funds reveals that spending exceeds the total of tax receipts and premiums dedicated to Medicare and that gap is expected to widen dramatically. Even without the financing problem, Medicare modernization would be necessary to ensure beneficiaries get high quality health care. President Bush wants to devote $153 billion over the next ten years on urgently needed Medicare modernizations that will help improve the financial health of the program and the addition of a prescription drug benefit for all Medicare beneficiaries.

Expanding Community Health Centers

While modernizing Medicare is the cornerstone of our healthcare agenda, we are also proposing steps to strengthen the health care safety net for those most in need. Community Health Centers provide high quality, community based care to approximately 11 million patients, 4.4 million of whom are uninsured, through a network of over 3,000 centers in rural and urban areas. The President has proposed to increase the number of health center sites by +1,200 by FY 2006. As a first installment of this multi-year initiative, we propose to increase funding for Community Health Centers by +$124 million. We will also be looking at ways to reform the National Health Service Corps so as to better target placement of providers in areas experiencing the greatest shortages.

Increasing Access to Drug Treatment

The problems caused by substance abuse affect not only the physical and mental condition of the individual, but the well-being of society as a whole. Nationwide, approximately 2.9 million people with serious substance abuse problems are not receiving the treatment they desperately need. To help close this treatment gap, we

propose to increase funding for substance abuse treatment by +$100 million. These funds will be used to increase the Substance Abuse Block Grant, the primary vehicle for funding State substance abuse efforts, and to increase the number of Targeted Capacity Expansion grants, which seek to address the treatment gap by supporting strategic and rapid responses to emerging areas of need; including grants to organizations that provide residential treatment to teenagers.

INCREASING SUPPORT FOR AMERICA'S FAMILIES

William Bennett once said that "the family is the original Department of Health, Education, and Welfare," and while the name of this Department may have changed, the truth of this statement has not. America's families are its strength, and this Department is committed to doing everything in its power to help better the lives of America's families and children. We are proposing a number of new initiatives to help improve the quality of life of our nations' families; as well as to increase support for the charitable organizations that can make such a difference in people's lives.

After School Certificates

One of the lessons I learned during my years as Governor of Wisconsin was that for people to move from dependency to success in the workforce, you had to be willing to invest in programs that support working families. One of the most important things that we as a government can do to help working families is to assist them in obtaining high-quality child care. Last year the Congress voted to provide a substantial increase in child care funding, and this year we are asking you to take another step to help working parents, and their children, be successful. The President has proposed to specifically dedicate $400 million for After School Certificates within the Child Care and Development Block Grant. This would help low income working parents to pay for the costs of after school care for their children. We expect these after school activities to also have a strong educational component, helping children to achieve success in school.

Promoting Safe and Stable Families

Our budget framework takes a number of steps to help protect our most vulnerable and at-risk children and to help them live safe and productive lives. First, we propose a +$200 million increase for the Promoting Safe and Stable Families program, which supports State and Tribal child welfare agencies in carrying out family preservation and support services. These additional funds will be used to help keep children with their biological families, or if it is not possible for them to safely remain with them, to place them with adoptive families. We will also provide an additional $2 million to expand collaborative Federal/State child welfare monitoring efforts. Second, we propose to create a new $67 million initiative within the Promoting Safe and Stable Families program to assist children of prisoners. This initiative will provide grants through States to assist faith and community-based groups in providing a range of activities to mentor children of prisoners and probationers, including family-rebuilding programs, that serve low-income children of prisoners and probationers. Finally, we propose an additional +$60 million for the Independent Living program. These funds would be used to provide vouchers, worth up to $5,000, to youths who are aging out of foster care so that they can obtain the education and training they need to lead productive lives. Funds could be used to pay for either college tuition or vocational training.

Maternity Group Homes

One of the toughest problems we face in trying to end the cycle of dependency is children having children. These teenage mothers have often suffered abuse or neglect themselves and may not have a safe and supportive family environment in which to raise their babies. To begin removing the obstacles to success that these mothers and their children face, we are proposing $33 million for a new Maternity Group Homes program. This program will support State efforts to work with organizations that operate community-based, adult-supervised group homes for teenage mothers and their children as well as to provide certificates to young mothers to obtain supportive services. These homes will provide a safe and nurturing environment for young mothers while offering the support necessary to help them and their children to improve their lives.

Promoting Responsible Fatherhood

Helping young mothers is an important part of our program to assist America's families, but it is also important that we recognize the critical role that fathers play in the lives of their families.

Our budget framework includes $64 million to begin an initiative to promote responsible fatherhood by providing competitive grants to faith-based and community-based organizations that work to strengthen the role that fathers play in their families' lives. These funds will be used to support programs that help low-income and unemployed fathers and their families to avoid dependence on welfare, and to fund programs that promote successful parenting and marriage. Of these funds, $4 million will be used for special projects of national significance.

Compassion and Charitable Giving

The President has been a leader in recognizing the important role that charitable organizations play in delivering services to the public, and we are proposing a number of steps to increase federal support for these groups. First, we are requesting $67 million to establish a Compassion Capital Fund. Through public and private partnerships, these resources will be used to provide start-up capital and operating funds to qualified charitable organizations so that they can expand or emulate model social services programs. To complement this Compassion Capital Fund, we also propose to create a $22 million fund to support research on "best practices" among charitable organizations. Our budget framework also includes $3 million to establish a Center for Faith-Based and Community Initiatives in the Department in accordance with the President's recent Executive Order. Finally, we have included a proposal to encourage states to provide tax credits for contributions to designated charities that work to address poverty. Under this proposal, States would be allowed to use federal funds provided through the Temporary Assistance for Needy Families program to partially offset revenue losses that resulted from the tax credits.

REFORMING THE MANAGEMENT OF THE DEPARTMENT'S OPERATIONS

For any organization to succeed, it must be willing to change. We must never stop asking ourselves how can we be doing things better. But we must also recognize that we do a disservice to all that rely on this Department if we do not provide the resources necessary to effectively administer our programs. In preparing our budget framework, we began the process of evaluating the programs and business practices of this Department and identifying the areas where we can do a better job of managing taxpayer resources, as well as those areas where new investments are required if we are to successfully administer our operations.

Health Care Financing Administration Reform

One of the top priorities of this Administration is improving the management of the Health Care Financing Administration (HCFA). The demands on this organization have grown dramatically in the last few years, and we must make sure that they have the necessary resources to successfully administer the Medicare, Medicaid, and State Children's Health Insurance programs on which so many people depend. At the same time, we must recognize that patients, providers, and States have legitimate complaints about the scope and complexity of the regulations and paperwork that govern these programs. During my confirmation hearings, I said that HCFA needed to undergo a thorough examination of its missions, its competing demands, and its resources. We are currently in the process of undertaking just this kind of comprehensive review, and we will consider any and all options for improving the agency and making it a more responsive and effective organization.

Investing in Departmental Infrastructure

The only way that this Department can effectively serve its many clients is if we commit to making the necessary investments in our management and infrastructure. One of the challenges in a large, decentralized Department such as HHS is finding ways to bring together diverse activities and to develop coordinated systems for managing our programs. Our budget framework provides the resources necessary to continue modernizing our facilities, and proposes steps to begin the process of streamlining our financial management and information technology systems so that we can enhance coordination across the Department and eliminate unnecessary and duplicate systems.

It is critical that we invest in the modernization of the laboratories and office facilities in which many of our most important activities occur. With this goal in mind, we are requesting $150 million to continue a major revitalization of labs and scientific facilities at the Centers for Disease Control and Prevention. We have also included funding for the Food and Drug Administration to finish construction of the Los Angeles laboratory and to continue development of the new headquarters facility in White Oak**,** Maryland.

For financial management, we propose to invest an additional $50 million to move toward a unified financial accounting system. The Office of Inspector General has

cited major problems with the Department's current system structure, which involves five separate accounting systems operated by multiple agencies. We plan to replace these antiquated systems with one or two unified financial management systems that will increase standardization, reduce security risks, allow HHS to produce timely and reliable financial information needed for management decision-making, and provide accountability to our external customers.

In the information technology arena, we are proposing $ 30 million for a new Information Technology Security and Innovation fund. Currently, the Department's information technology systems are highly decentralized, heterogeneous, and vulnerable to exploitation. Funds would be used to implement an Enterprise Infrastructure Management approach across the Department that would minimize our vulnerabilities and maximize our cost savings and ability to share information. With this approach, we will be able to reduce duplication of equipment and services and be better able to secure our systems against viruses and network intrusion.

As the largest grant-making agency in the Federal Government, this Department will also continue to play a lead role in the government-wide effort to streamline, simplify, and provide electronic options for the grants management processes. As part of the Federal Grant Streamlining Program, we will work with our colleagues across the government to identify unnecessary redundancies and duplication in the more than 600 Federal grant programs, and to implement electronic options for all grant recipients who would prefer to apply for, receive, monitor, and close out their Federal grant electronically.

Redirecting Resources

Being a wise steward of taxpayer resources means not only recognizing where you need to invest, but also where resources can be redeployed to more effective uses. In preparing our budget framework, we carefully reviewed each agency, identified areas where funding could be redirected, and made targeted reductions in selected programs. Funds for one-time projects and unrequested activities were also eliminated, and the monies redirected to higher priority programs. These decisions, which were made in accordance with the President's overall fiscal goals, will help to moderate the growth of the Department's budget and put it on a more sustainable path.

Last year, Congress took an important step to protect the integrity of the Medicaid program by passing legislation to address the "upper payment limit" loophole, which allowed states to draw down billions of dollars in federal matching payments for hospitals and nursing homes without any assurance that these payments were used for their intended purposes. But this legislation only partially addressed the problem, because it created a higher upper payment limit for non-State government operated hospitals. Our budget proposes to go even further in closing the loophole, by prohibiting new hospital loophole plans that were deemed approved after December 31, 2000 from receiving the higher upper payment limit proposed in the Department's final rule implementing the upper payment limit legislation.

In addition to taking steps to further address the Medicaid "upper payment limit" loophole, the Administration plans to work with States to develop ideas that will improve States' ability to provide quality health care through their Medicaid and State Child Health Insurance Programs. Within this framework of increased State flexibility, the Administration also plans to work with States to stem the growth of Medicaid costs and ensure the fiscally prudent management of the Medicaid and SCHIP programs**.**

WORKING TOGETHER TO BUILD A BETTER NATION

Mr. Chairman, the budget I bring before you today contains a number of different proposals, but one common thread binds them all togther—a desire to improve the lives of the American people. All of our proposals, from enhancing scientific research to modernizing Medicare, from expanding access to care to increasing support for the nation's families, are put forward with this one simple goal in mind, and I know this is a goal we all share.

As you begin to consider our proposals, let me leave you with one final thought. Senator Everett Dirksen said of the legislative process: "You start from the broad premise that all of us have a common duty to the country to perform. Legislation is always the art of the possible. You could, of course, follow a course of solid opposition, of stalemate, but that is not of the interest of the country." Starting from this premise, I am prepared to work with each of you to ensure that we develop a budget for this Department that effectively serves the national interest. I would be happy to address any questions you may have.

Chairman THOMAS. Thank the Secretary very much. The chair knows we are going to be engaged in a number of long working sessions, and so rather than engage in any questioning at this time, it is my pleasure to turn the chairman's question time over to the chairman of the Health Subcommittee, the gentlewoman from Connecticut, Mrs. Johnson.

Mrs. JOHNSON OF CONNECTICUT. I thank the chairman, and welcome, Secretary Thompson. It is a pleasure to have someone at the helm of this important agency that has the breadth of experience that you have had, and has shown throughout their career, a real sensitivity and responsibility to the impact of public policy on people's lives. I am very glad to hear the words that you are saying today about the very comprehensive and aggressive review of the structure of HCFA that you are undertaking. Indeed, as recently as 3 weeks ago, I sat with a group of home health providers in my district who were absolutely panicked at a directive from HCFA that would, in fact, close them up in 10 days. Now, luckily, the people in Washington—and we have lots of good people in our employ—did listen, did respond. We talked about it and we avoided actual closures, but we do have a ways to go down the track of trying to figure out how the sheer complexity of these regulations can be implemented in such difficult circumstances as those home health agencies that serve intercity neighborhoods.

So we must review this and we are going to have to really work hard at the issue of simplification of the regulations or America will not have the small provider sector on which, right now, most of our seniors depend. We will not have the little nursing homes. We will have only chains. Then may be good or bad, but I think it is not adequate. We will not have the small practices in the rural areas. We will not have the home health agencies in the rural areas and in the small towns that have done such a wonderful job over many years. So this issue of reviewing the regulatory structure that we have put in place and making it simpler and less burdensome is an urgent issue, not as sexy as many, but I am glad that you understand its importance and will take it on with us.

I also want to commend you on your clear commitment to including prescription drugs in Medicare. As you say, they are essential to prevention. They are essential to treatment. We absolutely must do it. We made some pretty good progress last year, but I would like to ask you if your department has begun to think about how to structure premium and cost sharing levels to encourage participation in the drug benefit program while, at the same time, keeping some kind of overall program spending in check. As we have worked on this issue in the past, we have really struggled with how to structure the program so that group that has no coverage now, whose incomes are just above the poverty level, can actually afford to participate in the benefit and yet we can afford to control the overall cost. So is this particular issue of cost availability and therefore real access to low-income seniors something that you are focusing on as you begin your work on prescription drugs?

Secretary THOMPSON. Thank you very much for the question, but first could I just quickly respond to HCFA? We have some wonder-

ful people at HCFA and they want to do the right thing. The problem has been there has been a lot of new programs, new additional responsibilities placed upon HCFA and they really have not had the added resources to do the job. I am not here to complain. I am here just to state a fact. We have a computer system that is lacking as far as power and efficiencies to run that program. Most of it was operational in 1970. It has been added to but we need a new system to replace; a bookkeeping system that is outdated and has not been kept up-to-date. We are making lots of mistakes.

We pass rules and regulations willy nilly, and they are very complex. I am trying to get them to understand it is simpler just to put the rules out either on a quarterly or semi-annual basis so people will actually be able to respond and understand them instead of anytime throughout the year. We are expecting to do that. We are also trying to change the attitude at HCFA. Instead of trying to find a way to say no, we are trying to convince them it is just as easy to say yes and be flexible and be very, very much involved.

We are going to be coming back to this Committee and to other Committees in Congress with the results of our examination, and I am sure that you will be supportive of those changes. In regards to Medicare, we are just getting started in making those changes. What you have asked is a question that we have not been able to resolve. I am looking for, hopefully with suggestions from you, Congresswoman Johnson, who I know has studied this probably much more than I have—and I am looking for suggestions. But we are trying to put together a statement of principles on what Medicare reform should have in it, and we are talking and working with the White House at the present time, and I will be discussing that with you in the future.

Mrs. JOHNSON OF CONNECTICUT. Thank you, also let me say that our Subcommittee will be holding hearings on the issue of long-term care legislation and also how we help, through the Tax Code, people who have access to affordable health insurance. I was pleased with the President's comments on that during the campaign, his obvious interest in helping individuals and families that are uninsured get insurance, and we look forward to working with you on adopting those changes that are under this Committee's jurisdiction to help this Nation reduce the number of uninsured dramatically, and to shift the financing of long-term care into the insured structure, rather than the pay-as-you-go structure that currently exists under Medicaid.

Truly, with 40 cents of every Federal dollar now going to people over 65, there is simply no way that we can guarantee Social Security benefits, Medicare benefits, and a pay-as-you-go long-term care system when the number of retirees doubles with the retirement of the baby boom generation. So those are issues we also will be looking forward to working with you on, Secretary Thompson, and thanks so much for being with us today.

Secretary THOMPSON. Thank you, Congresswoman Johnson. Let me just quickly respond to the uninsured. I think the best opportunity for us is to look at ways to allow the SCHIP program to be more flexible. There is a lot of innovation at the State level that is helping to expand and to give more people coverage, the uninsured, and I would love to work with you on it.

Chairman THOMAS. Does the gentleman from New York, the Ranking Member, wish to inquire?

Mr. RANGEL. Thank you, Mr. Chairman, and thank you again, Mr. Secretary. Thank you for your emphasis that every penny of Medicare money will be spent for Medicare. To get clarification of that, it is my understanding that you estimate a Medicare surplus of $526 billion. Does that agree with your figures?

Secretary THOMPSON. That is correct, although as I understand it, CBO has got a scoring of $388 billion for the surplus.

Mr. RANGEL. When we talk about the Medicare surplus, we are talking about the surplus in the trust fund supported by the payroll tax for part A; right?

Secretary THOMPSON. The payroll tax in part A, yes, that is the one that has the surplus. Part B is a 75–25 split, as you know full well.

Mr. RANGEL. So when you talk about every cent being spent for Medicare, your talking about the part A part of Medicare, for which the payroll tax is being paid.

Secretary THOMPSON. That is correct.

Mr. RANGEL. So when we hear that people from the administration refer to this $526 billion Medicare surplus as part of the contingency reserve fund which can be spent for, quote, "additional needs contingency purposes and further debt reduction," that is not your opinion? That is not your thinking, or, in your opinion, the administration's thinking with respect to every penny of Medicare being used for Medicare?

Secretary THOMPSON. The $526 billion; the law is quite clear and I do not know anybody that is asking to change the law. The law says that the money that goes into the trust fund is a credit to the trust fund, plus interest, and it is going to be used for Medicare, and this administration believes in that. This administration also believes further that the $842 billion contingency fund, if Medicare needs more money, that the $842 billion should be used for prescription drugs and for Medicare reform, if we can get to that point.

Mr. RANGEL. But this Medicare part A surplus, whether it is estimated by the CBO or OMB, is going to be used for hospitals and other part A benefits, right?

Secretary THOMPSON. The $526 billion is a credit to the Medicare trust fund and will be used for Medicare completely.

Mr. RANGEL. part A only. Well, we have got to keep saying it until we make certain that we are reading from the same page. Now, as far as the Helping Hand prescription drug program, it is my understanding that very few people will be eligible for assistance, and that even a widow with $16,000 annual income will not be eligible. Could you give me any idea as to what level of income would cut off a person from receiving benefits under the administration's proposed prescription drug program?

Secretary THOMPSON. No, I cannot because we want to leave that flexibility up to the States. There are 26 States that have already passed prescription drug proposals in America. We are asking for the Helping Hand proposal, of $12 billion a year, $48 billion over 4 years, which would be able to be added to what the States are already doing. It would also mean that two-thirds of the American seniors already have prescription drug coverage—we want to make

sure we can immediately get to the rest of the seniors in America and provide some help for prescription drugs.

Then we hope we are going to be able to come back and get Medicare reform with prescription drugs for all seniors, Congressman.

Mr. RANGEL. You mean that we will have different income eligibilities in different States for different senior citizens?

Secretary THOMPSON. I did not hear that, Congressman.

Mr. RANGEL. You mean that will have different income eligibilities in different States?

Secretary THOMPSON. The eligibility will be 170 percent of poverty for the Helping Hand.

Mr. RANGEL. I am trying to find out at what income—you say that is left up to the States. I want to find out——

Secretary THOMPSON. It is left up to the States up to 170 percent of poverty. But this is for Helping Hand. This is to cover those most in need right now for prescription drug coverage, while we are working on Medicare reform including a prescription drug benefit and Medicare reform that will help all seniors.

Mr. RANGEL. Will there be a national income cutoff, forgetting the States, that will make you ineligible for this relief in the proposal that you are working on to present to the Congress? Whether it is 175 percent of poverty or whether it is left up to the States, is it possible, as a national Secretary, to tell us, notwithstanding you want input from the States, at what income level would senior citizens and other Medicare beneficiaries not be entitled to Helping Hand relief for prescription drugs?

Secretary THOMPSON. Well, the Helping Hand right now is proposed for seniors most in need.

Mr. RANGEL. I understand that. You are talking about poor people. I understand that. It is means tested and limits benefits for poor people, but I am trying to find out what level you call poor?

Secretary THOMPSON. 170 percent of poverty.

Mr. RANGEL. How does that work out in dollars and cents?

Secretary THOMPSON. I am not exactly sure.

Mr. RANGEL. Can you give us just a guesstimate? I cannot go to my district and tell them that if you have 175 percent of poverty, that you will be able to get relief. I want to know whether it is $14,000, $24,000—what do you consider to be 175 percent of poverty? Maybe a staffer can help you out on this.

Secretary THOMPSON. I am sure they can, but I am not exactly sure of the dollar amounts.

Mr. RANGEL. Just a guesstimate. I want to find out if you make $24,000, can your staffers say we can go home and say forget about it, they are not talking about you? If you make $15,000, can we say, well, maybe you are in the range?

Secretary THOMPSON. It is $20,300, up to 175 percent of poverty.

Mr. RANGEL. So if you make up to $20,000, you should be eligible for some type of relief?

Secretary THOMPSON. Yes, but that is only temporary.

Mr. RANGEL. I know.

Secretary THOMPSON. We are hoping that we are going to come back with Medicare and cover everybody.

Mr. RANGEL. And then that will be total inclusion under the Medicare program?

Secretary THOMPSON. That is correct.

Mr. RANGEL. My time has expired, but I understand that $20,000 is for a couple. Someone may want to ask what would the income cutoff would be for a single person.

Chairman THOMAS. Thank the gentleman. The chair wants to make sure, because I can pick up the drift of the questions, a number of them may be more appropriate when we deal with the Medicare Trustees' Report on Tuesday, but I want all of us to remember that Medicare is funded not only from the part A trust fund, which is a payroll tax called the HI trust fund, but it is also funded from the general fund, with a premium paid 75 cents on the dollar by the taxpayer, 25 cents on the dollar by the recipient. The argument that the Part A trust fund should be reserved only for one particular segment of Medicare is to belie the recent history of the Congress and the past administration.

In 1997, Medicare was funded 66 percent out of Part A and 33 percent out of Part B. The Clinton administration was successful in transferring one of the fastest-growing programs in cost, of Medicare, the home health care program, from Part A to Part B, funded out of the general fund. Now, this year, the split between Part A and Part B is about 60 percent Part A and about 40 percent Part B. By the end of the decade, it is going to be basically a 50–50 split if the current trends continue.

The argument that Part A should be reserved for some historical argument as to what Part A was reserved for, and not available to benefit and improve all of Medicare, is to simply ignore the recent history of the recent administration's willingness to transfer. In fact, that transfer was one of the primary reasons the so-called solvency of Part A was extended a number of years when, in fact, the costs were simply transferred from the payroll fund to the general fund. This transfer of cost from the payroll fund to the general fund probably is a falsity that we ought to forget about, and this is an editorial comment by the chair, and we really ought to talk about combining A and B so we can get an honest evaluation of the total cost of the program, since from its inception it has been shared both from the payroll tax and from the general fund.

Mr. RANGEL. Mr. Chairman, just on that issue, I appreciate your philosophical view about what we should do in the future, but nothing that you said should be interpreted as not segregating the payroll tax to be protected as being for Part A; is that correct?

Chairman THOMAS. Quite the contrary. What occurred in the Clinton administration was that they took a program that was funded out of Part A and shifted it over to Part B, so that if the argument is we need to keep Part A sacrosanct in some way, then we will simply shift another program funded by Part A over to the general fund, then we can keep the myth alive that the Part A trust fund is for one purpose and the general fund is for another. It seems to me that what occurred in the last administration is something that should not be repeated in this administration, but that we should look at the Medicare funding program more holistically, rather than some artificial separation which is split and

broken anytime someone feels that they want to conveniently say the Part A trust fund has more solvency in it.

Shifting a program from A to B does not reduce the taxpayer obligation to funding those programs. It is, in fact, a budgetary sleight of hand.

Mr. RANGEL. Mr. Chairman, you have joined the issue as to whether or not the administration is talking about protecting and not spending one cent out of the Medicare surplus. We believe that the Medicare surplus belongs to Part A and obviously you believe it could be merged into general revenue funds, and so at least the Secretary should know that is going to be a major political discussion.

Chairman THOMAS. I would tell the gentlemen to underscore that, if, in fact, there is a surplus in one fund and the rest of it is general fund entitlement, and therefore you do not worry about whether or not there is adequate funds, if there is money available to assist us in building a better prescription drug program for our beneficiaries, the argument as to whether those funds to build that better program comes out of Part A or Part B is not as worthy a subject of discussion, in the chairman's opinion, as it is how good is the prescription drug program that we are going to be putting together for our seniors.

With that, I would recognize the gentlemen from Illinois.

Mr. CRANE. I thank the gentleman for yielding.

Mr. Secretary, given the uncertainty about and the recent surge in drug prices, how confident can we be about future projections relating to the cost of a Medicare prescription drug benefit?

Secretary THOMPSON. You know, Congressman, as well as anybody does, that I do not know how secure we can be. The cost of drugs are escalating at an alarming rate and new drugs are coming on the market each and every day. The bill that was introduced by Chairman Thomas last year was scored by CBO at $160 billion over 10 years. This year, it is being scored at $213 billion, or a $60 billion increase.

We think that where we are going to save some money, Congressman Crane, is through the efficiencies hopefully that we will be able to put into a Medicare reform proposal with a prescription drug component.

Mr. CRANE. Medicare spending is mandatory. Is there any way the Bush tax cut can be threatening to the Medicare Program as we know it today?

Secretary THOMPSON. I do not see how it can be because the underlying law, the Medicare law, says that every person that reaches age 65 is going to be covered by Medicare. All the money that goes into the trust fund is credited to the Medicare trust fund, and any money that goes out of the trust fund has to be repaid, plus interest, and to be used for Medicare. I do not know anybody in Congress, and I know for sure in the administration, that is looking at ways to change that law. So the law is sacrosanct. The law is there to protect and to make sure that every Medicare recipient will be covered, and that the money going into the trust fund will be credited to the trust fund and will be used only for Medicare dollars.

Mr. CRANE. How much smaller would the surplus have to be for Medicare reform to be at risk?

Secretary THOMPSON. How much smaller will——

Mr. CRANE. Would the surplus—the projected surplus have to be for Medicare reform to be at risk?

Secretary THOMPSON. Well, Medicare reform is very important to this administration, and we are going to be working extremely hard with you and with this Committee to try and get a bipartisan Medicare reform proposal passed, which includes a prescription drug component for all seniors in America.

Mr. CRANE. My concern on that issue stems from some of the uncertainty of the state of the economy right now, and the fact that we keep getting re-evaluations of what the projected surpluses may be, looking down the road. I mean, they have been escalating, but they could be dropping very dramatically within a short period of time.

Secretary THOMPSON. I understand that the figures are still holding, according to OMB's figures. I talked to the director just yesterday, and he felt very comfortable with the figures put forth in the blueprint, and I asked him if there was any change, and he said no.

Mr. CRANE. Can you explain to me how the administration arrived at the $153 billion figure for Medicare reform?

Secretary THOMPSON. First off, the $153 billion, $48 billion over 4 years, $12 billion a year, is set aside for Helping Hand, and the balance was figures that OMB received from the actuarial division of the department—of the operating division of HCFA, and it is numbers that they had projected. I know that CBO has scored it higher than $153 billion, but we feel that there are some savings, especially in the Breaux-Frist bill, which Congressman Thomas worked on last year.

If you were able to open it up for purchasing and for competition, the out-year figures would have a savings of 1 percent, and that 1 percent savings would be enough, we think, with the $153 billion, with a Medicare reform, to pay for the prescription drugs.

Mr. CRANE. With respect to Medicare, what do you believe are the biggest challenges to reforming the program?

Secretary THOMPSON. Biggest challenges to what?

Mr. CRANE. Biggest challenges to reforming the program.

Secretary THOMPSON. The biggest problems are to be able to get bipartisan support. I think you know that the Breaux-Frist proposal that the Medicare Commission came up with is a good starting point, and I think you need choices. I think competition is good. I think you need prescription drugs, and that is where we are starting out, Congressman Crane, and we are going to be soliciting ideas from this Committee on a bipartisan basis to try and incorporate a bipartisan proposal that we can introduce and hopefully get passed this year.

Mr. CRANE. We thank you and we look forward to working with you toward that goal, and with that, I yield back the balance of my time.

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

Mr. SHAW. Yes, Mr. Chairman, and Mr. Secretary, I would like just for a moment to reflect on welfare reform, of which your tracks are all through the works of this Committee. I recall, back when

we were in the infant stage of drawing the welfare reform bill and meeting with you and some of the other Governors, in order to try to formulate a welfare reform plan that really reflected the teamwork that was going to be necessary between the Federal Government and the State government, recognizing the Governors of this country as partners, not as just servants of the Federal government, to distribute the monies in the ways that we might direct.

I remember a comment that you made at one of the meetings in which you said how refreshing it was to come to Washington and not to have to kiss the rings of Congress, and I replied that was probably not all you were kissing in coming to the Congress. But I think it shows the tremendous success that we can obtain when we do recognize the wisdom and the experience of this Nation's Governors in formulating the legislation. I think that same thought would move over toward prescription drugs and some of the other things that we have, so that we are not trying to micromanage these systems as they go to the States. I think, in that regard, that we could not have a better Secretary than you, with your background not only as a Governor, but also as a Governor that has worked closely with the Congress in formulating legislation.

One thing that I would like to just express by way of concern; I am very concerned that we not only reflect on the tremendous problems that seniors have with meeting their bills, but I would hope through all of this that we do recognize that the next generation and the generation to follow them also has to be considered in whatever we do, not necessarily in expanding Medicare to apply to them, but also being sure that we do not treat them differently as they become seniors.

It concerns me greatly that many of the plans that we have seen for Social Security reform would treat the next generation not quite as kindly as we are treating today's seniors, and therefore creating another notch. I hope we can avoid that, and I hope we can recognize that these people that are paying into the system are not taxed twice for their benefits, and then their benefits are lessened. That is of great concern to me in trying to reform Social Security. I would hope that it would be of great concern also to the administration in putting together the prescription drug bill, which is so vitally, vitally necessary, particularly that first step of the Helping Hand that you are referring to, of those in greatest need and those who have the greatest burden.

Secretary THOMPSON. Thank you so very much, Congressman, and thank you for your kind words, and I would also like to congratulate you for your leadership on the welfare reform proposal, because I know full well how hard you worked and I know that we would not have been as successful without your leadership, and I applaud you for that. In regards to Medicare, we want to be able to be as cost-effective and efficient as we possibly can in developing a Medicare reform.

We think there are some efficiencies to be built in and we think choice is one of those that we should look at. A Prescription drug benefit is very difficult, especially when you are trying to include it in Medicare reform, because it is very difficult to gauge the expenses and the overall cost of prescription drugs, evidenced by the fact that this past year, the bill that was introduced and passed in

the House went from $160 billion to $213 billion in a short period of time.

So we have to be cognizant of that and we have to work together, hopefully on a bipartisan basis, to accomplish what everybody wants to accomplish, Medicare reform with prescription drug coverage included.

Mr. SHAW. Thank you, Mr. Secretary.

Chairman THOMAS. Thank the gentleman. Does the gentlemen, the ranking member on the Health Subcommittee, currently but not historically from California, wish to inquire?

Mr. STARK. Yes, Mr. Chairman. Thank you.

Mr. Secretary, just to review this for a moment, you have been asked several times if the $526 billion surplus is currently in the part A trust fund, and you have suggested that that would only be spent for Medicare, but I just want to go through this again. Can you envision any of the part A trust fund, $526 billion, being spent for a prescription drug benefit?

Secretary THOMPSON. We are hoping that the $153 billion that we set aside is going to be utilized for that, and we are hoping that will be enough. If it is not, we are hoping that the extra money in the contingency fund, between the $526 billion and the $842 billion, would be used for that, Congressman Stark.

Mr. STARK. How about part B benefits? Would you see any of part B benefits being paid for as you envision it, out of the $526 billion Medicare part A trust fund?

Secretary THOMPSON. It is my understanding that there is a 75–25 percent split, and that the 25 percent is paid on a monthly premium of approximately $50 a month, and the 75 percent is paid out of the general fund. That is the way it has been and I do not anticipate that changing. The only way it could change is if Congress decided to do so, and I do not think Congress is going to do that.

Mr. STARK. In other words, let me say it again in a different way. The $526 billion in the part A trust fund appears in the budget figure on page 185 as part of the contingency fund. In other words, in the $842 billion, $526 billion of that is the part A trust fund?

Secretary THOMPSON. That is correct.

Mr. STARK. The budget is outlined so that the contingency fund could be spent for defense or roads or a whole host of things. As the budget outlines it, not according to current law, that contingency fund has been alluded to be spent on other programs than Medicare; is that not correct?

Secretary THOMPSON. That is correct, Congressman Stark, but if I could just expand, but it is also true, is it not, that everything that is taken out of the Medicare trust fund has got to be repaid with interest and it is a credit to the Medicare trust fund, and it is there for anybody to be used, but it will only be used for Medicare when it is needed.

Mr. STARK. OK. But for it to be used to pay for a part B benefit or a drug benefit, or commingled, if that is the right word, as the chairman has suggested, there would have to be a change in law. Is it your intention to ask us for legislation, at this point, to commingle the trust funds or to use the Medicare part A $526 billion for anything other than basically the current hospital and part A benefits?

Secretary THOMPSON. It is not my intention to do that at all, and I do not know anybody else that is advocating that, either, Congressman Stark.

Mr. STARK. My worry is this, Mr. Secretary, and I am sure you would agree with me. If we did use the part A surplus, that $526 billion, to offset the aggregate Medicare spending would we in effect shorten the trust fund by 20 years, to just 3 years from now? You understand that using that $526 billion in the part A surplus for other benefits or drugs would pretty much collapse the security we have now. Now, that is not to say we do not have to find money for Part B. There are even some Democrats who might say we may have some data, have people pay more, either in taxes or premiums, but nonetheless, I just want to make sure we are all on the same page, that the Bush budget outline treats the Part A trust fund somewhat differently than Social Security.

Social Security, we put up here as a special surplus, but here we are using the Medicare trust fund as a contingency. While you and I understand it is protected by law, it is buried in these figures and, to the extent the budget is an illustrative document, it is being used as a potential funding source for several other programs, and it would take a change in law to do that.

Secretary THOMPSON. It would take a change in law and I do not anticipate that happening. It is $526 billion, and if, in fact, it is a credit to the Medicare trust fund and if any money is taken out of there, it has to be repaid plus interest. The administration is going to adhere to that, and I cannot imagine anybody willing to change the law, Congressman Stark.

Mr. STARK. Just one final question.

Chairman THOMAS. The gentleman's time has expired.

Mr. STARK. Why would it be buried here in the contingencies and not set up alongside the Social Security surplus to make old people like me more comfortable? Why wouldn't you illustrate it in the budget and keep the AARP and the senior citizens and everybody more comfortable? Why wouldn't you set it up there as $526 billion part A trust fund and leave it up there alone and not commingle it in those contingencies?

Secretary THOMPSON. I do not know why it was done that way. I am the Secretary of Health and Human Services, Congressman Stark, and all I know is what the law—I read the law and the law is very clear. It is there for Medicare and it is going to be there for Medicare, and that is the administration's position.

Mr. STARK. Mr. Chairman, could I just thank him for one other thing?

Chairman THOMAS. Sure.

Mr. STARK. Thank you.

I do notice that you have made a statement that we do need, in HCFA and the management of this operation, some more resources. I know this Committee does not make that decision, but many of us feel we have loaded an awful lot of work on them, whether you like the way HCFA is running or not. It has been overburdened and needs some resources, and there are a lot of people there that you are going to depend on and I wanted to thank you for recognizing that we ought to let them have a little increase in their overhead to handle the increased burden.

Mr. Chairman, I hope we can work toward that with the Secretary.

Secretary THOMPSON. Congressman Stark, thank you for your comments. You are absolutely correct. We are going to have to put some new resources into HCFA and modernize it, if we expect them to be able to improve. The computer system is outdated and anybody knows a computer system that was installed in 1970 and today is very underutilized and not——

Mr. STARK. It is probably so antique that even I could run it.

Secretary THOMPSON. Thank you.

Chairman THOMAS. Does the gentlemen from New York wish to inquire?

Mr. HOUGHTON. Yes. Thank you, Mr. Chairman.

Mr. Secretary, great to have you here. Thank you very much for doing this job and sharing your knowledge and your wisdom with us all. I would like to shift the focus just a little bit, away from health and HCFA and HCFA and Medicare, to the younger people.

Now, there is an awful lot of talk these days about education in this country, emphasizing younger people. But when I take a look at the budget figures here, despite the statements made of strengthening families and younger people, I do not know what difference is going to come out of your program than happened in the past, always the younger people are squeezed out. It is the older people who have the demands, and when you take a look at the compounding effect of some of the mandatory outlays, I do not know where the money—I do not know where the emphasis—what is different with your program?

Secretary THOMPSON. What we are hopeful is different—are you talking about Medicare reform?

Mr. HOUGHTON. I am talking about the younger people reforms. There are whole series of things about strengthening the family. There is a Safe and Stable Families program. There are after-school programs.

Secretary THOMPSON. What we are trying to do, Congressman, is we are trying to be more on the edge of prevention, rather than intervention after the problem has already started. We are trying to take a fresh look at the families, families after-school. We are trying to find ways in which children after school will be able to use the extra dollars which will be block-granted to States, to be able to assist them, some for education, some for after-school security, other school activities. We are trying to put aside $67 million to counsel children who have one or both parents imprisoned, so that the children will be taken care of.

We are trying to put together $64 million to make sure that children that are in foster care or adoption are taken care of faster, and better than they have been in the past. We are putting aside $33 million for maternity group homes, especially for single mothers who need help, and to be able to be protected. We are putting aside $124 million for community health centers across America, so that we can double the number of community health centers and double the number of individuals, especially minorities, that are going to be able to get health care. That is what we are trying to do. We are putting a bigger emphasis in the Federal government and in the Department of Health and Human Services for preven-

tion, to try and develop programs that are going to be more supportive of the families, especially the children, so that they can be helped before they get into trouble or before they get into an unhealthy kind of situation. That is what the emphasis is going to be on, Congressman.

Mr. HOUGHTON. Thanks very much. Thank you, Mr. Chairman.

Chairman THOMAS. Thank the gentleman. Does the gentlemen from California, the Chairman of the Human Resources Subcommittee, wish to inquire?

Mr. HERGER. Thank you very much, Mr. Chairman. Mr. Secretary, even though I am not from Wisconsin and I have my roots in California, I join in the enthusiastic welcome to this Committee.

Secretary THOMPSON. Thank you.

Mr. HERGER. I am looking very much forward to working with you on issues that will come before the Human Resources Subcommittee, which I have the privilege of chairing, and as you know, next year we will be reauthorizing TANF, or the Temporary Assistance to Needy Families program, that was created under the 1996 welfare reform law, which replaced the former troubled AFDC system.

I would like to extend an invitation that you not only testify before this Committee, but also work with us in coming up with the very best policies that we can, in order to take welfare reform to the next level, and would certainly appreciate any comments you might have. Again, this reauthorization is not till next year. We will be having hearings this year. I know you have a lot on your plate right now, but any general comment you might have on that.

Secretary THOMPSON. Well, first, thank you very much, Congressman, for your chairmanship and your leadership. I appreciate it. As you know, TANF is not going to be reauthorized until next year, and so we really have not put that much emphasis at the department on TANF reauthorization yet. We will be looking at that later on this summer and early fall, and I would appreciate the opportunity to come in front of your Committee and testify and I also appreciate the opportunity in working with you and Congressman Shaw, and anybody else that wants to work on this issue.

I think the next step in welfare reform has got to be how do we make sure, especially welfare mothers, are able to stay in their jobs and be able to use the educational system to be promoted, and to be able to use the educational system to get ahead and keep the family together. Those are going to be issues that I have got many ideas on, that I would like to come back in front of you after I have had an opportunity to study them a little bit more, flesh them out a little bit better, and give you the opportunity to hear them, but also to ask you for your advice, as well.

Mr. HERGER. Well, I appreciate that very much. Again, maybe later this summer and particularly as we get into next year, I will be looking forward to working with you. Thank you. Thank you, Mr. Chairman.

Secretary THOMPSON. Thank you very much, Congressman.

Chairman THOMAS. Thank the gentleman. Does the gentlemen from California, Mr. Matsui, wish to inquire?

Mr. MATSUI. Thank you, Mr. Chairman. Thank you very much, Mr. Secretary. We appreciate it and congratulations on your appointment.

Secretary THOMPSON. Thank you.

Mr. MATSUI. Certainly we look forward to working with you. I just want to follow up on a question that Chairman Herger asked. I want to talk about Medicare in a moment, but one of the other things that was very critical to the success of the 1996 bill, which I was not particularly in favor of—in fact, I opposed it—was the fact that the earned-income tax credit was greatly expanded so that many of those women who went into the work force, even at minimum wage levels, were obviously able to have that supplement through the EITC, and it is my hope that you would be very strongly in support of continuing the current program and perhaps, in future times, if, in fact, it is warranted and after your review, that we can look at it, perhaps even to expand it, because I think the extension of the health care, Medicaid, and also obviously the EITC has put many people in a position now where they can work and actually earn a living and say this is much better, in terms of my financial needs, than the welfare program was.

I just make that observation.

Secretary THOMPSON. If I could quickly respond, Congressman, I agree with you.

Mr. MATSUI. I appreciate that.

Secretary THOMPSON. In fact, I agree with you enthusiastically, because I was able to get through an increase in the earned income tax credit at the State level. So in Wisconsin you have got a Federal earned-income tax credit plus a very nice upper in the State earned-income tax cut, and it is extremely helpful and it is an integral part of welfare reform, and I appreciate your support.

Mr. MATSUI. I appreciate your involvement in that, as well, because I think you actually were—because of the success of your program—had a lot to do with the passage of the legislation, and obviously, in the current position you are in now, you can undoubtedly help continue that progress, and there will be opportunities later to talk about this. But if there should be a dip in the economy and unemployment should go up, which all of us hope not to happen, certainly we hope that we will be able to keep the programs that are attendant to those that are on welfare, such as training programs and others, and obviously continue the benefits, as well.

I know that will be a challenge for all of us, given our constraints. I just want to follow-up on what Mr. Rangel and Mr. Stark talked about in terms of Part A and Part B, and I think you were pretty clear, but I want to make sure I understand it.

There will be no attempt, from your perspective, that any of the funds in the contingency funds committed to Medicare under Part A, through the payroll tax, will be used anything but for Part A; is that my understanding? I think you were very clear, but I want to make sure that I understand it, as well.

Secretary THOMPSON. The Medicare money is going to be used strictly for Medicare. Every penny of it is going to used for Medicare.

Mr. MATSUI. I understand that, but Part B of Medicare is Medicare, as well, and that is why—and you may not have intended to

create this confusion in my mind, but if you would say your intent is to keep it for Part A, I would feel much more comfortable. When you say Medicare, Medicare Part A and Part B, and I just want to make sure——

Secretary THOMPSON. I intend to keep it for Part A, Congressman Matsui. The only people that can change it, to the best of my knowledge, are people that are up there.

Mr. MATSUI. I understand that, but your recommendation.

Secretary THOMPSON. My recommendation is to keep it.

Mr. MATSUI. So it would not have any diminution, in terms of the life of the Medicare program. Now, in terms of the prescription drug part of it, and maybe I misunderstood, is it your understanding that there might be an effort, through the contingency fund, if the balance of whatever it was——

Secretary THOMPSON. $842 billion is the contingency fund, less $526 billion for Medicare.

Mr. MATSUI. Right, so you have 316 for prescription drugs or whatever other contingencies there are. If, in fact, prescription drugs should cost more than that over a period of time, is it your intent then to perhaps go into the Part A fund for that?

Secretary THOMPSON. No.

Mr. MATSUI. In other words, you would look for other sources of funding, either——

Secretary THOMPSON. It is my understanding, Congressman, that is what we would do.

Mr. MATSUI. You know what? If I may make a recommendation—I know my time is running out and it may not even be in your position to do this—but perhaps OMB should re-examine the budgetary lines that they speak of this. I think a lot of folks, including the seniors, as Mr. Stark said, would feel much more comfortable if that $526 billion was in the category with Social Security, because contingency fund, it could lead to a situation where we could make observations that this could be used for the missile defense system or something of that nature, and I think even for the administration, it would make more sense to put it in a category that really, really defines it as for Part A and for Part A only, because obviously that is where you, as a Secretary, is coming from. So I really think it makes a lot of sense.

Secretary THOMPSON. That is where I am coming from, but I am coming as the Secretary of Health and Human Services and I am telling you my position.

Mr. MATSUI. I appreciate that. I really do. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you. Does the gentlemen from Louisiana wish to inquire?

Mr. MCCRERY. Yes. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. Just on this Part A, Part B stuff, you know, there might be some people out in the United States watching on C–SPAN, and they do not really understand Part B and Part A, and I do not think it really matters to them. What matters to them is that we deliver to them a quality health-care program that provides them some help and financial security in their old age.

So I hope, when we get into Medicare reform, we will not get bogged down on all this technical mumbo-jumbo and instead try to create a program that works for the elderly in this country. Having said that, and I hope we get off of this now, Part A and Part B stuff, let's talk about cost for just a minute, because I am concerned about the escalating cost of health-care. In fact, your own actuaries at HCFA have recently written that, as a percentage of our gross domestic product, health-care expenditures will rise from approximately 13.1 percent in 2002 to 15.9 percent in 2010. Drug spending is going to increase, they estimate, at about 14 percent a year.

Those figures, particularly coupled with the looming retirement of the baby boomers, are frightening figures, not only in terms of the resources that will go toward health-care generally in the country, but obviously the budgetary effects here at the Federal level. So I hope that as you go through these exercises of Medicare reform and maybe even general health-care reform, you will keep an eye out for these looming cost to the country and to the Federal budget.

One of the cost drivers, Mr. Secretary, I am convinced, in the health-care system is medical malpractice, not only in the direct cost of premiums for insurance that doctors and hospitals have to purchase, and in the awards that they have to pay, but also the indirect cost, the defensive medicine, if you will, that has to be practiced, at least in the minds of physicians and hospitals, to prevent being sued.

You are, I know, working right now, trying to perfect a Patients' Bill of Rights, and while the goals of that legislation are laudable, I feel that the implementation of such will increase cost in the health-care system, and they will increase cost substantially if we do not put reasonable caps on damages in that legislation. I was wondering if the administration has developed a position yet on caps on damages in the Patients' Bill of Rights, and if they would accept and favor attaching to that legislation general medical malpractice reform for the entire health-care system?

Secretary THOMPSON. There is no question that this administration is very concerned, as you are, Congressman McCrery, about runaway litigation cost. In the Patients' Bill of Rights, the President has spoken very elegantly about the need to hold down on litigation and to make sure that every person has their rights protected, has a way to defend those rights, but at the same time hold down costs. But the administration has not taken, at this point in time, a position on the limits. They have discussed it, but they have not come to a conclusion on that.

I know there are many different proposals being bandied around, but the administration has not chosen any one at this point in time. They are working very hard and diligently, especially in the White House, to develop a proposal that will not allow for litigation runaway cost.

Mr. MCCRERY. What about general medical malpractice reform?

Secretary THOMPSON. The administration has not taken a position as far as putting it in the Patients' Bill of Rights, and I think that is what your question was, and I doubt very much if a general malpractice reform proposal will be in the Patients' Bill of Rights. I have not heard that being discussed.

Mr. MCCRERY. Is the administration in favor of medical malpractice reform?

Secretary THOMPSON. The administration is certainly concerned about the cost factors, and medical malpractice is one of those.

Mr. MCCRERY. Well, Mr. Secretary, if you are concerned about the cost factors, I would urge the administration to quickly adopt a position in favor of medical malpractice reform, and if we are able to attach such to the Patients' Bill of Rights, I would urge the administration to support that effort.

Secretary THOMPSON. Thank you very much, Congressman. I appreciate that, and I will carry that to the appropriate people.

Chairman THOMAS. Does the gentlemen from Pennsylvania wish to inquire?

Mr. Coyne.

Mr. COYNE. Thank you, Mr. Chairman.

Welcome, Mr. Secretary, and thank you for your testimony. Mr. Secretary, a report was recently published by the Institute of Medicine and it finds that there is a great need for information technology in our health-care system overall, and it points out that our health-care system has safety and quality problems because it relies on outdated systems of work.

The University of Pittsburgh Medical Center, which is in the district that I represent, is investing more than $500 million over 5 years on information technology. Those initiatives are designed to drastically improve patient care and outcomes, as well, while reducing the overall cost of health-care in the country. I would like to be able to submit some questions for the record to you about the specific recommendations in the institute's report, and would appreciate it if you could respond to those questions.

[Questions submitted by Mr. Coyne, and Secretary Thompson's response, follow:]

Question: According to the Institute of Medicine report, the meticulous collection of personal health information throughout a patient's history can be one of the most important inputs to the provision of proper care. Yet, most of the time, this information is dispersed in a collection of illegible and poorly organized paper record. Often times, they are unable to be found. Growth in clinical knowledge and technology has been profound. However, many health care settings lack basic information technology systems that would provide clinical information or would support clinical decision making. As well, the report also states that information technology will play a critical role in the automation of clinical, financial, and administrative information and the electronic sharing of such information among clinicians, patients, and others that are appropriate within a secure environment are critical for the health care systems of the future. Furthermore, the report says that information technology must play a central role in redesigning out health care system if a substantial improvement on quality is going to ever be achieved. Information technology will enhance consumer confidence and improve efficiency. How would you respond to these recommendations? Will the government be willing to assist the health care system in implementing these new Information technologies?

Answer: The Department of Health and Human Services and other federal agencies including the Department of Defense and Veterans Health Administration have been actively engaged in identifying ways that information technology can serve as a vehicle to improve health care quality. For the past thirty years, our Agency for Healthcare Research and Quality (AHRQ) and its predecessors supported the seminal research on the use of information technology to improve the care provided to patients at the bedside, to support long-term outcomes research, and most recently, to address issues of patient safety. This year AHRQ will fund $5 million in grants and contracts to identify the key elements of information technologies that provide

the greatest benefit in improving patient safety. The agency is also working closely with the Institute of Medicine on the development of standardized vocabulary and coding of data that will assist states to develop effective computerized systems to assess patient safety information.

As you point out, the investment now being made by the University of Pittsburgh is considerable and several bills have been introduced that call upon the Department to provide assistance for such efforts. In light of the potential costs of such a national commitment, we need to assess the roles that private purchasers, as well as public purchasers, can and should play. Our Centers for Medicare and Medicaid Services (CMS) is currently assessing the potential roles that we can play in facilitating, supporting, or providing incentives for the expanded use of information systems with proven effectiveness in improving health care quality.

Question: The internet has enormous potential to transform health care through information technology applications in areas such as consumer health, clinical care, administrative and financial transactions, public health, professional education and biomedical and health services research. Many of these applications are currently within reach, including consultation with a patient from home, clinician and consumer access to medical literature and creation of communities of patients and clinicians with shared interests. Will the government assist in helping bring the internet as a widespread tool to be used within the health care industry?

Answer: The Federal Government currently supports the use of the Internet and other information technology applications for advancing the accessibility and quality of health care through a variety of programs. One of the leaders in this field is the National Library of Medicine (NLM) at the National Institutes of Health (NIH). NLM produces MEDLINE, the world's most-used medical literature resource containing 11 million references and abstracts culled from more than 4,000 journals that cover the worldwide literature going back to the early 1960s. MEDLINE is accessible for free through an easy-to-use Web-based program, known as PubMed. The PubMed system also links to 1800 participating publishers Web sites so that users can retrieve the full text versions of the articles identified. Health professionals, scientists, librarians, and the general public are expected to perform close to 400 million MEDLINE searches this year.

To respond to the growing public interest in health information, NLM created MEDLINEplus and ClinicalTrials.gov, which are specifically designed for consumers and freely available via the Internet. MEDLINEplus selects and organizes a variety of consumer health information issued by NIH, professional medical societies, and voluntary health agencies on more than 475 diseases and health conditions. In addition, MEDLINEplus has an extensive medical encyclopedia, detailed information about prescription and non-prescription drugs, directories of health professionals and hospitals, health-related articles from the daily news media, patient education modules, and links to a variety of organizations that disseminate information on various health problems. NLM and the National Institute on Aging will be introducing a new Web-based resource this Fall that relates to the health of seniors and will be in a format that is easily accessible by that segment of our population. MEDLINEplus has become so popular that it now logs about 5 million page hits per month.

The associated Web site ClinicalTrials.gov is a registry of more than 5,000 federally and privately funded trials of experimental treatments for serious or life-threatening diseases or conditions. The database includes a statement of purpose for each clinical research study, together with the recruiting status, the criteria for patient participation in the trial, the location of the trial, and contact information. ClinicalTrials.gov is linked closely with MEDLINEplus, so that anyone looking for information about a particular disease or condition can easily tell if it is the subject of any clinical trials.

The U.S. National Network of Libraries of Medicine, created by NLM in the sixties, is another aspect of the medical information infrastructure supported by the NLM. The NNLM, as it is called, is an organization of 4,500 member institutions that provide vital information services to American health professionals and, with NLM support and encouragement, increasingly to the public. Within this network the NLM works to improve information services, including access to health resources on the Internet, in areas that disproportionately affect minority groups, such as HIV/AIDS and toxicology and environmental health.

The most rapidly growing segment of the NLM is the National Center for Biotechnology Information, which plays a pivotal role in integrating, and disseminating the growing body of data now being generated by the sequencing and mapping initiatives of the Human Genome Project. These efforts are complemented by the inclusion of genomic sequences from over 75,000 organisms, submitted by scientists

worldwide, as well as data generated through collaborative projects aimed at sequencing the genomes of other model organisms. The Center has also designed a novel system for linking its genomic resources to the biomedical literature. Thus, these readily accessible genomic and literature databases represent a true "international information infrastructure" designed to propel the biomedical research advances that will ultimately lead to better health for the American public.

Because the NLM depends to a great extent on the Internet for disseminating its many health information services, it is a supporter of the infrastructure initiative known as the Next Generation Internet. This is a cooperative effort among industry, academia, and government agencies that seeks to provide affordable, secure information delivery at rates thousands of times faster than today. Resolving issues of reliability, availability, speed and especially privacy will be instrumental if the health care industry is to take full advantage of rapidly developing information technology.

Some NLM health applications, for example those involving the Visible Humans and telemedicine, require more bandwidth and more reliable service than are currently available. The Visible Human male and female data sets, consisting of MRI, CT, and photographic cryosection images, are huge, totaling some 50 gigabytes. They are being used by scientists around the world in a wide range of educational, diagnostic, treatment planning, virtual reality, artistic, mathematical, and industrial uses. Projects run the gamut from teaching anatomy to practicing endoscopic procedures to rehearsing surgery. One new project, being carried out by NLM scientists, is AnatLine, a web-based image delivery system that provides retrieval access to large anatomical image files of the Visible Human male thoracic region, including 3D images. Another is the collaborative project with other NIH Institutes to develop a super-detailed atlas of the head and neck. The Visible Human Project is an example of a program that requires both advanced computing techniques and the capability of the Next Generation Internet if it is to be maximally useful.

The Library also funds innovative medical projects that demonstrate the application and use of the capabilities of the Next Generation Internet. These projects span the spectrum of medical disciplines, geographic areas, and target audiences. One example is to evaluate the potential of telemedicine applications on the health care system in rural Alaska as a way of improving the quality of health care while at the same time containing costs. Another project, in rural Iowa, is measuring the effectiveness of video consultations for patients with special needs, including children with disabilities and persons with mental illness. In addition to supporting such advanced applications, the NLM continues its research on evaluating the performance of today's Internet pathways between and among health institutions and users. This research gives us a glimpse into what the future holds.

Finally, research supported by the Agency for Healthcare Research and Quality (AHRQ) has begun to demonstrate the potential benefits of some uses of internet technology. For example, the Comprehensive Health Enhancement Support Systems (CHESS) developed by Dr. David Gustafson at the University of Wisconsin, found that women with breast cancer who had access to on-line support groups had better patient outcomes. AHRQ has just released a program announcement on Patient-Centered Care that outlines the agency's interest in supporting research proposals that examine the impact of informed and empowered patients (through a variety of mechanisms, including the internet) on health care decision-making and the outcomes. In addition, the agency has been actively engaged in Internet applications for patients and providers, including the National Guideline Clearinghouse (NGC). The NGC allows providers and patients to look up up-to-date clinical guidelines for care for given conditions at the point-of-care.

Question: The Institute of Medicine recommends that "Congress, the executive branch, leaders of health care organizations, public and private purchasers, and health information association and vendors should make a renewed national commitment to building an information infrastructure to support health care delivery, consumer health, quality measurement and improvement, public accountability, clinical and health services research and clinical education. This commitment should lead to the elimination of most handwritten clinical data by the end of the decade. How would you respond to this recommendation?

Answer: The Department is approaching the need for such developments simultaneously from several directions. Strategic planning and information dissemination within HHS in this area is handled by the HHS Data Council which meets monthly to deal with all health data related issues.

Our federal advisory committee on such issues is the National Committee on Vital and Health Statistics (NCVHS). They have been working for several years on the concepts necessary to support such a National Health Information Infrastructure

(NHII). In their recent report <http://ncvhs.hhs.gov/NHII2kReport.htm> the NCVHS describes the NHII as the set of technologies, standards, applications, systems, values, and laws that support all facets of individual health, health care, and public health. The Chair of the NCVHS meets with the HHS Data Council monthly and has presented this report. The broad goal of the NHII is to deliver information to individuals—consumers, patients, and professionals—when and where they need it, so they can use this information to make informed decisions about health and health care.

The NHII can also deliver other benefits, including enhanced access to consumer health information, peer and support services; greater choice of care; tracking of health histories over a lifetime; and increased accountability for quality and costs. New tools, such as automated reminders and decision-support systems will encourage patient adherence to treatment and health maintenance plans and improve the quality of care. The NHII will also improve community health by taking seemingly isolated events, identifying patterns and trends, and suggesting public health actions to safeguard populations.

The National Library of Medicine (NLM) has been working for many years on the Unified Medical Language System (UMLS) <http://www.nlm.nih.gov/research/umls/> which attempts to bring together all the various systems of medical terminology. Researchers find the UMLS products useful in investigating knowledge representation and retrieval questions. The resulting system is seen as the basis of concept representation that can be used to exchange meaningful health information between environments that implement different systems.

The NLM is also conducting cooperative research with other institutions to design and implement health oriented projects to demonstrate the value of the Next Generation Internet (NGI) <http://www.nlm.nih.gov/research/ngiinit.html>, which will enable the massive and rapid data transfers required for health applications in the future. This effort is described above in more detail.

Secretary THOMPSON. Absolutely, Congressman. I would be more than happy to, and it is an area that I am more than concerned about and very interested in. As you know, the Institute of Medicine also suggested that we develop 15 systems on how to diagnose and to provide treatment for 15 different types of illnesses that would be sort of uniform throughout America. I think that is a very good step forward. We should explore that and we will.

I also compliment your hospital for investing in computers and new information techniques. That is what we would like to do and encourage you to also allow us to do that at the Department of Health and Human Services. We have over 200 different computer systems in the department, most of which cannot communicate with one another, and even in the Humphrey Building, there are different computers from the fifth floor, the sixth floor and the seventh floor, which does not make any sense to me if you want to run an efficient operation.

So I am throwing that out. I agree with you wholeheartedly and enthusiastically. I only hope that when I come back and suggest that maybe we should upgrade the computer systems at HCFA and the department, that you would also be willing to support that, as well.

Mr. COYNE. Well, I would be very happy to be able to support it. Thank you.

Secretary THOMPSON. Thank you very much, Congressman.

Chairman THOMAS. Thank the gentleman. Does the gentleman from Michigan, Mr. Camp, wish to inquire?

Mr. CAMP. I do. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. In 1995 and 1996, I served on the Human Resources Subcommittee and worked with you and other

Governors on legislation that dramatically transformed the American welfare system, and since then we have seen welfare caseloads decline, poverty is down, child support collection is up, teen pregnancy is down, and I think more importantly than some of those statistics that go along with those trends, are that the focus of the welfare system has literally been transformed from one that just determined eligibility and cut checks to one that really is delivering a comprehensive package of both employment and family support assistance, based on a recipient's specific needs.

I just want to say that as we look forward to the reauthorization of the 1996 law, I want to work with you particularly on trying to continue the flexibility provided in the 1996 legislation, and to ensure that the States continue to have the ability and flexibility to continue to create innovative programs that will enhance the efforts to assist low-income families. There are a couple of other items in the budget that I want to support, and one is the adoption tax credit, which I want to say the President's plan to increase it from $5,000 to $7,500, and make it permanent, there are over 100,000 children nationwide, and while parents do not need financial incentives, adoption can be very expensive and this will help a great deal, so I want to work with you on that.

Last, I also want to mention the Safe and Stable Families program, which there will be additional resources provided in the President's budget for that very valuable program, which really helps keep children with their families if it is safe and appropriate, or will help provide for adoption if that is the appropriate avenue, as well, and I think the additional effort to help the children of families with prisoners is really commendable. So I look forward to working with you and thank you for coming to the Committee.

Secretary THOMPSON. Thank you so very much, Congressman, and thank you also for your courtesy when I was coming in front of your Committee and your support and help on welfare reform. I am passionate about it. We have got some things to do. We can improve it considerably and I want to work with you on that. With regard to adoptions, the credit, I think, is good, and we have a lot of children out there that need to be adopted, and this administration is very concerned about them and wants to do everything we possibly can. The Safe Families budget has gone up from $305 million to $505 million, a $200 million increase, which is a tremendous increase, but the President wants to go up to $1 billion. He wants to make sure that we go in and help families stay together and be able to provide the kind of services that they need, and I am looking forward to working with you on that.

The counseling for children with parents in prison is very important to me. It is a subject I got very much involved in when I was back being Governor of the State of Wisconsin, and I will be looking forward to working with you.

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

Chairman THOMAS. Does the gentlemen from Michigan wish to inquire? Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman.

Welcome, Mr. Secretary. Mr. Secretary, let me just take a minute. We have gone over this a few times, but I think it is so important, because I was looking at page 185 of the budget presen-

tation. You have said here, I think in clear terms, what your position is. Medicare money is only for Medicare, Part A only for Part A. The clear result of that is on this table, S1, the President's 10-year plan. When you take 526, which is Part A, from 842, the figure for contingencies, it reduces this contingency fund, or the rainy day fund, as I subtract it, to $316 billion. That is why I am suggesting there be complete clarity by OMB.

I think the issue was discussed yesterday in the Senate, and there was an effort to essentially move the 316 up to the line under the Social Security surplus. So I take it, it is clear what your feeling is or your belief is; Medicare money is only for Medicare and Part A only for Part A; is that correct? You are unequivocal about that?

Secretary THOMPSON. That is correct, but it is also true that I do not see how you can just segregate Part A from Part B. We want to overhaul all of Medicare and make it much more efficient and include prescription drugs, and that includes a complete overhaul of Medicare Parts A and Part B.

Mr. LEVIN. But that does not mean, as I understand your previous statement, that you would use Part A moneys for a prescription drug benefit?

Secretary THOMPSON. Does not.

Mr. LEVIN. Let me just ask you quickly to switch to an area that you care so much about and you have been instrumental in its development, and that is TANF. Transitional Medicaid, you know, for so many people, and the data are not clear for all of the States—for so many people, they have not accessed transitional Medicaid. So you have a large percentage, some think as much as 50 percent after a short period of time, when they leave TANF or are receiving partial payments from it, who have no health care.

I take it you are vitally concerned about that.

Secretary THOMPSON. I am very concerned about it. There are four things that really prevent a person from leaving the system to go and get a job. Health coverage, daycare, transportation and training are the four things. In order to really develop a good program, you have to be willing to support those four items.

Mr. LEVIN. Good. Let me just ask you then about training. Have you reached a conclusion whether you favor, in the reauthorization process, full-funding for TANF?

Secretary THOMPSON. I have, but that does not mean that OMB has, Congressman. I have found since I have been out here that OMB is much more powerful than a Secretary. So I have learned quickly that I am no longer a Governor, sir.

Mr. LEVIN. OK, because you know the figures. You have worked on this.

Secretary THOMPSON. Yes, I do.

Mr. LEVIN. For so many people who have moved from welfare to work, which was a critical part of welfare reform and one I very much favored, there are—and we do not know the percentages in most States, but huge numbers have moved from welfare to work and remain at the same income levels as when they were on AFDC or TANF. So retraining the upgrading part of it is critical.

Secretary THOMPSON. It is critical.

Mr. LEVIN. Quickly, you know the contingency fund does expire this year.

Secretary THOMPSON. That is correct.

Mr. LEVIN. I hope we could have some discussions about it, because if there is a recession, we cannot wait till next year, in terms of the contingency fund or at least arguably so. So I would hope that we could engage in some discussions on the Human Resources Subcommittee, under Mr. Herger and Mr. Cardin, to look at this issue and not necessarily wait till next year. I hope we do not wait till next year on any of the welfare—the TANF reauthorization issues, because it is so critical, these issues we have talked about, health care, training, upgrading, as well as the contingency fund, need a lot of attention before next year.

Secretary THOMPSON. Congressman, I agree with you. I do not know what more I can say except I agree with you. I only wish that we could move a little bit faster so I could get my assistant secretaries and the deputy in, so that I could spread out the work. I am still the only one at the department and it would be nice if I had some assistants, so that somebody else could take on some of these responsibilities. But in saying that, I am not being critical. I am just telling you, yes, I agree with you. We are looking at welfare reform, but there are a lot of other issues we are also looking at, at the same time, sir.

Mr. LEVIN. Thank you.

Chairman THOMAS. Does the gentleman from Minnesota, Mr. Ramstad, wish to inquire?

Mr. RAMSTAD. Thank you, Mr. Chairman. Mr. Secretary, as your neighbor from Minnesota, I know what an outstanding Governor you were.

Secretary THOMPSON. Thank you.

Mr. RAMSTAD. I know you will be an equally outstanding Secretary. People from Minnesota, like people in Wisconsin, appreciate your direct, no-nonsense, bipartisan approach to governing, and I am looking forward to working with you. Also, Governor Ventura and I want to thank you for your recent decision to approve two technical changes in Minnesota's Medicaid program. Because of that decision you made, Minnesota special-needs children who are eligible for Medicaid will find it easier to get both medical and rehabilitative services through their schools, and this is a big deal for kids with physical and developmental disabilities, to have their special needs addressed during the schoolday. So thank you for making that happen.

I hope, Mr. Secretary, you are just as successful in helping us right the wrongs that have been done and are currently being done to Minnesota seniors and Minnesota providers, through the arcane, unfair Medicare reimbursement formula. Minnesota seniors are being cheated. Minnesota providers are being cheated because we have had a history of cost-efficient health care in Minnesota, keeping our cost over the last decade at 3 percent below the national average. As a result, the reimbursement levels, as you know, are less than in less efficient States and counties.

Just in the couple minutes that we have, how do you believe this problem of the Medicare reimbursement formula and inequalities,

how can they be rectified within the context of comprehensive Medicare reform?

Secretary THOMPSON. First off, I want to thank you for your leadership of Minnesota and thank you also for pushing hard on those waivers. We are going to change the way waivers are handled in the department. They are going to be much more streamlined, and I have got a lot of ideas on how to do that, and I also know that your Governor was in to see me already on the waiver that you are talking about, and we are already discussing it. So hopefully we can make some good headway in regards to that.

In regards to the reimbursement formulas, you know better than I do that formulas in Congress are the most divisive thing there is, because it basically depends on how much money you can get. I do not think you can solve the inequitable situation in one State by taking from another State. You are going to have to find additional money in order to make sure that all of the State that is getting more is held harmless, so that you are going to be able to build up a more equitable distribution of dollars in States like Minnesota and also States like Wisconsin.

Mr. RAMSTAD. Mr. Secretary, do you favor scrapping the AAPCC formula and going to a different reimbursement system?

Secretary THOMPSON. I am not ready to scrap it until I see what the replacement is, but we are looking at that and we are looking at ways in which we can make it more efficient and more equitable.

Mr. RAMSTAD. Those are the needs, to make it more efficient and more equitable, and I appreciate your recognition of that, of the incredible inequities in the current system. Like the chairman, I know you are committed to working in a bipartisan way to try to change that. The other question I wanted to ask you, I noticed from the President's budget an increase in drug and alcohol treatment, by $100 million. I could not help of thinking of former President Richard Nixon, when he first declared war on drugs back in the seventies, he directed 60 percent of the Federal dollars in that war on drugs to treatment. Today, we are at 16 percent. So any increase is helpful and soon I will reintroduce my legislation, which had 95 bipartisan cosponsors last year, including the former chairman of the House Budget Committee, to provide parity for substance abuse treatment, people in the health plans who are being discriminated against, who cannot get access to treatment, even though the policies ostensibly provide such treatment. I hope you will be willing to work with me on that legislation.

Secretary THOMPSON. I want to work with you, Congressman, and I appreciate the opportunity and the invitations. So you let me know when you are going to have a meeting and I will be more than happy to try and make myself available.

Mr. RAMSTAD. I appreciate that can-do spirit that governed Wisconsin so well for your terms in office, and it is refreshing to see you in this important position. I really do not believe the President could have chosen anybody more qualified to head the department, Governor.

Secretary THOMPSON. I do not know about that, but I thank you very much.

Mr. RAMSTAD. Well, even my Governor agrees with that. So that is a pretty good recommendation, from Governor Ventura.

Secretary THOMPSON. Jessie and I get along just fine. When anybody is that big, I listen to them very intently.

Mr. RAMSTAD. Me, too. Thank you, Mr. Secretary.

Chairman THOMAS. Does the gentleman from eastern Maryland, Mr. Cardin, wish to inquire?

Mr. CARDIN. Thank you, Mr. Chairman. I am glad you finally recognize the importance of Maryland to our country.

Governor Thompson, first, let me tell you I am very encouraged by your statements here and your record on the human resource issues. I am the ranking Democrat on the Subcommittee that will deal with TANF and human resources, working with Mr. Herger, and I must tell you I am one of those now who feels maybe you should slow down on getting an assistant secretary, because I like what you say. I want you to stay directly involved on these issues. We need you, because we want to come out with a strong bipartisan product on the next tier or the next level of what welfare reform is all about.

I appreciate the fact that many of these battles will be fought next year when we come up with the reauthorization legislation for welfare, but there are some important issues that we are going to have to deal with this year, and one of them may very well be the fight with OMB or with the budget people to make sure that the resources are in the budget so that we can continue to maintain the Federal partnership in dealing with welfare in our states.

So I think we may need to deal with TANF this year in order to make sure we have the resources available. Let me just mention one area that is in the President's budget, that concerns me, and I would hope you would take a look at this, and that is to allow the states to use their TANF money to finance the State deductibility for charitable gifts. I am one of those who believe that we should give tax preferences to charitable gifts at the Federal and State levels, but they should not come at the cost of poverty funds that are so desperately needed to deal with poverty issues in our country. So I would hope that you would take a look at that, and perhaps we can find a better way to finance that rather than using TANF funds.

Let me also point out that, as Mr. Levin pointed out, we do have the issue of supplemental funds to the states that needs to be dealt with in this year, because that expires and affects many of our states, not the State of Maryland which I represent, but many of the states are directly affected.

Secretary THOMPSON. I think 17.

Mr. CARDIN. Seventeen States. So I think we need to take a look at that. It is not in the President's budget, and we need to see whether we can find the resources to make sure we do, in fact, finance those supplemental funds—reauthorize those supplemental funds. So I hope we can work together this year in order to accomplish that.

Let me mention two other issues that have been in our Subcommittee, that have enjoyed very strong bipartisan support in this Congress, and have been passed by the House by lopsided votes. One, you are directly familiar with, to give the States the ability to pass through child support funds to the families. Wisconsin is the model for the Nation. You have the opportunity to do that. No

other state can do it without losing both the state share and the Federal share. I would hope that you would help us in seeing that legislation through, so all states have the ability to pass through child support to the families without having to repay the Federal share.

Secretary THOMPSON. I was lucky in getting a waiver for that, Congressman, and it was something I felt strongly about, so I do not know how I can divorce myself from my prior position and now say that it is not a good idea. I think it is an excellent idea and should be more widely utilized.

Mr. CARDIN. Thank you, and we will have some legislation in this session, in a bipartisan way, and I expect it will enjoy some strong support and we just need to get it through and enacted into law. As connected to that, Mrs. Johnson and I came up with the fatherhood initiative, which is in the President's budget, to provide some additional funds for fatherhood initiatives. We all know the states can use their TANF money to deal with non-custodial parents, but we think it is important to highlight that we have not done that with the non-custodial parent.

Secretary THOMPSON. Congressman, we really have not, and it is really a failure in the current provisions, and I compliment you and Congresswoman Johnson for your leadership on that, and I am very pleased that we took some of your bill and put it in this blueprint budget for the future, because I think we have not done enough for fatherhood, and we have got to get more of the non-custodial parents back into the family unit, and things will be much better if we are able to accomplish that.

Mr. CARDIN. I guess my last point is—again, I appreciate everything you are saying. I think welfare will be a major issue this year, that we cannot wait until next year, as Mr. Levin has said. Your suggestion that we look at how, particularly, women are succeeding in the workplace, who have left welfare and have the educational resources available to them so they can move up the employment ladder, is a matter we need to really refine this year to see how we can make sure that is part of TANF reauthorization.

Secretary THOMPSON. It is not only education, it is training. Both go hand-in-hand and are very important.

Mr. CARDIN. Thank you.

Secretary THOMPSON. Thank you, Congressman.

Chairman THOMAS. Thank the gentleman. Does the gentlewoman from western Washington wish to inquire?

Ms. DUNN. You bet.

Welcome, Mr. Secretary. We sat opposite each other about 6 years ago, when you came to testify on welfare reform. It was very helpful then, and I am glad that I am now on the top-level, but I am very happy that you are the Secretary. I just want to support Ben Cardin's last point. Many of us have stayed in touch with welfare moms and dads through the years since we passed that reform bill, and I would be happy to give you some of the information. One of the points that Mr. Cardin made on education is one I hear over and over again, education and training.

Secretary THOMPSON. Thank you very much.

Ms. DUNN. I have a couple of questions on health care. The Health Insurance Portability and Accountability Act, the HIPAA

Act, I know that your folks are doing a review of the regulation on that act. There are some of us who are concerned and, in fact, all but one of the Members of the delegation from Washington State, my State, signed a letter to you, because our constituents have some concerns. We like where the administration is going on administrative simplification, but the implementation of the regulations is concerning us.

Specifically, we are concerned about the 2-year compliance rule for standardization of electronic transactions, and also the piecemeal release of different sets of regulations over time. I would like to submit some detailed questions to you that your folks can answer, but I wonder if you can give us a sense of where your review is taking you?

[Questions submitted by Ms. Dunn, and Secretary Thompson's response, follow:]

Question 1: There are a number of outstanding rules including security, enforcement, national provider identifier, and employer identifier that must be finalized so that health organizations can fully comply. Can you update me on the progress of those pending rules?

Answer: The Department has an on-going, concentrated effort to implement the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996. Of the nine rules that comprise Administrative Simplification, five Notices of Proposed Rulemaking have been issued. Two of these (Privacy and Transaction and Code Sets) have been issued in Final, with corresponding compliance dates. We hope to have the final Security and Employer Identifier rule published by this Fall.

The Notices of Proposed Rulemaking have generated a large number of comments by the covered entities, including 17,000 comments on the Transaction and Code Sets, and in excess of 50,000 comments on the Privacy Notice of Proposed Rulemaking. Significant progress has been made on issuing NPRMs, categorizing, reviewing and responding to the comments received, and issuing Final rules. We are working as quickly as we can to complete work on the remaining rules, including claims attachments and enforcement.

Regarding the regulation and implementation of provider identifiers, the Department is reviewing how best to achieve this goal, as well as evaluating the budget implications.

Question 2: Health care providers in my district have expressed concerns with the rules governing electronic transaction and code sets promulgated as part of the administrative simplification provisions of HIPAA. Can you update me on the progress of these pending rules?

Answer: The Electronic Transactions and Code Sets rule was published as a Notice of Proposed Rulemaking on May 7, 1998, issued in Final on August 17, 2000, and based on the two-year statutory implementation requirement for covered entities, compliance is required as of October 16, 2002. (Note: the statute provides an exception for small plans, giving them three years to comply rather than two.) Changes to the rule, as recommended by the statutorily recognized Designated Standards Maintenance Organizations (DSMOs), will go through the Department's regulations process. The Department will be published an NPRM proposing the DSMOs changes, which have been received.

Question 3: What actions has the Department taken to educate physicians, hospitals and other providers on these regulations?

Answer: There are on-going efforts to inform and educate all covered entities regarding the Administrative Simplification regulations. These include:

- Publication of all Notices of Proposed Rulemaking and Final Rules in the Federal Register, including any technical corrections;
- A comprehensive, up-to-update web site with all information relating to Administrative Simplification—available on the Web at: http://aspe.hhs.gov/admnsimp;
- Active participation in meetings of standard setting organizations such as the Workgroup on Electronic Data Interchange, as well as congressionally mandated advisors such as the National Committee on Vital and Health Statistics; and
- The issuance of Guidance Documents to help health care providers and health plans come into compliance with the regulations. The guidance is available on the Web at: http://www.hhs.gov/ocr/hipaa.

Listed below are specific outreach efforts by program area:

Medicare

The focus is on reaching providers, both directly and through the Medicare contractors. CMS Medicare contractors will be ready to begin testing of HIPAA transactions for claims and remittance information this fall.

Articles for contractor bulletins and websites have been prepared. The first article went out in the Fall of 2000, and dealt primarily with transactions. Additional articles are planned regarding privacy, the National Provider Identifier, testing, security, and claims attachments.

We offer web-based training for providers, which includes an overview of HIPAA. Self assessment guidance is also being developed. A draft of the full course will be completed in August; the course should be available by the end of 2001.

We offer several Web resources, a summary of which will be published on the Medlearn page by the end of July. Pointers to materials will be provided at Washington Publishing Company, WEDI, and other websites.

A satellite broadcast containing the same content as the web-based training and presentation materials is tentatively scheduled for the last quarter of the calendar year. These broadcasts typically reach several thousand providers at 600 satellite sites, and would be rebroadcast 3 or 4 times.

A HIPAA brochure to be distributed at provider conferences is being developed.

Medicaid

The Department's focus is on the state Medicaid programs and their critical intra and inter-state trading partners. This includes, for example, the State Departments of Human Services that provide health, screening, diagnostic and nutritional services to low income children, mothers, the elderly and disabled.

While we expect each state to conduct their own HIPAA outreach efforts with physicians, hospitals, laboratories, pharmacies, nursing homes as well as beneficiaries, our role is to support their efforts by serving as a national resource on Medicaid HIPAA. To that end, we are working with staff at all levels of state government, including Department heads, Commissioners of human service agencies, state CIO's, legislative staff and the Governor's offices, who can provide executive support and resources to state HIPAA implementation efforts.

We have developed, edited, published and distributed a 10-page bi-monthly newsletter, HIPAA Plus, covering news from national and regional sources.

The first annual National Medicaid HIPAA conference was held in April. Approximately 550 people from all 50 States and Guam attended the three-day conference. The second annual conference will be held in April 2002.

We have developed the Medicaid HIPAA Compliant Concept Model (MHCCM), an interactive tool states can use to conduct a HIPAA "gap analysis." This analysis will highlight areas where action will be needed for compliance. We have identified a model custodian in each state, and hold monthly conference calls to share information.

A working lunch will be held at the MMIS conference in New Hampshire to review the new Version 2 of the model.

The model is available on CD and on the web at Washington Publishing Company. Also,

Two brochures on the MHCCM have been distributed, and a new brochure is in development now. Ultimately, one brochure will include a detailed view of HIPAA, a second will explain the MHCCM, and a third will be tailored for audiences requiring basic information on HIPAA.

A letter to all governors is being considered.

Medicare Managed Care

Our focus is on the managed care plans themselves, with the expectation that they will conduct outreach with their providers and trading partners.

A managed care HIPAA conference is being planned for September in Baltimore.

A self-assessment tool specifically for managed care plans is being developed.

Question 4: Does the department plan to modify the rules or extend the two-year compliance period?

Answer: As mentioned above, the Electronic Transactions and Code Sets rule will be modified in response to the DSMOs recommendations that have been forwarded to the Centers for Medicare and Medicaid Services. Also, while the privacy rule is not expected to be modified prior to its effective date of April 14, 2003, the Department has issued a Guidance document (also available on the Web at: http://www.hhs.gov/ocr/hipaa) to help statutorily defined covered entities come into compliance.

The two-year compliance period for each of the Administrative Simplification rules is mandated in the HIPAA statute (except for small plans, which, as noted above, have three years to comply), thus is not subject to departmental modification.

Secretary THOMPSON. I can give you an overall sense, but I cannot answer your specific questions, I am sorry, Congresswoman. I appreciate you submitting the questions. I would be more than happy to answer them in a very diligent fashion. We are taking a look at all the rules and regulations in the department, and we want to try and find a way that we can make the rules and regulations of the Department of Health and Human Services much more easily understood, and therefore, able to be followed. We are trying also to take into consideration some of the questions you are having, in trying to find better ways.

I am not being critical of anybody in the past or anything in the present. We just want to make sure that our rules and regulations are much more responsive and much more easily understood.

Ms. DUNN. That is great, as our folks are doing their best to prepare for the new regulations, if they are put out in piecemeal fashion, they might spend a lot of money preparing for one set that would be later influenced by another set. So that is what we find we are running into.

Secretary THOMPSON. One of the things that really irritated me as a Governor is that they put out rules and regulations, and you never knew. All of a sudden, you would be operating and a rule comes out, and if you did not see it right away or did not adhere to it right away, you could be penalized. We are trying to put them out on a very uniform basis so that States and providers are going to be able to see these rules, maybe on a quarterly basis, maybe on a semi-annual basis, so that they have more lead time to be able to get ready for them and to be able to put their systems in place, so they are going to be able to comply with them.

Ms. DUNN. That would be great. Well, we welcome the results of your review. On Children's Hospital graduate medical education programs, a couple of years ago, Congresswoman Johnson and I sent an authorization—sent a letter supporting the authorization of funds for this. Last year, the Congress provided $235 million for the program. I am a supporter of increasing those dollars, but we are hearing some rumors that OMB is coming out with a cut in support, and I wonder if you know about that or what your thoughts are on it.

Secretary THOMPSON. Well, I know about it. At this point in time, we are still working on that budget and it will be coming out in April, and I am not at liberty to discuss it right now, because we are still negotiating on that item and a couple of other items with OMB.

Ms. DUNN. Great. Well, I hope that you will put in a pitch for them to increase that program, because we really do need to be training those physicians who deal directly with children.

Secretary THOMPSON. Thank you.

Ms. DUNN. I wanted also to ask you a question about HCFA. Our concern is the coding that HCFA has—is using and the payment process. The Institute of Medicine recently issued a report regard-

ing the lack of transparency, simplicity and efficiency, and also access by users of that coding system to do some improving in it. I am interested in updating this process, and we want to make sure that the appropriate and payments are assigned to the proper test. We are hopeful that you will work with us on this issue, so that the Institute of Medicine's concerns are adequately addressed and so that we can make sure that Medicare beneficiaries do have access to the very best clinical laboratory services.

Secretary THOMPSON. You know I will. I cannot tell you how eager I am to reform, and allow HCFA to be better able to perform their services. We have some great people at HCFA, that really want to be able to do the job that Congress has asked them to do. They are pretty much handcuffed with a lot of the procedures put in place, with arcane and archaic equipment, and we need all the help we can get. If you have got any suggestions, we will be more than happy to work with you and to take into consideration your suggestions.

Ms. DUNN. Great. Thank you, Mr. Secretary, and we look forward to the announcement of the new head of HCFA. Thank you, Mr. Chairman.

Chairman THOMAS. Does the gentleman from Washington, Mr. McDermott, wish to inquire?

Mr. MCDERMOTT. Thank you, Mr. Chairman.

Governor, we talked in the Budget Committee about the whole issue of Medicare. I have been thinking about it since then; I've gone over the numbers, and I would like to, maybe in a simple-minded way, ask a question, because I feel like I am at the county fair and I do not know where the money is. On page 14 of the budget, it says there is a $645 billion deficit in Medicare in the next 10 years.

I understand that earlier in this Committee hearing, you said that there will be a $526 billion surplus, I think in part A. You said that is going to be spent on Medicare, not being specific about whether it is going to be spent on part A or part B. So if you take that $536 that is in this deficit, and put it there, you have partially filled the glass—which represents the $645 billion deficit. Then I see in the budget that there is $153 billion more to be used for modernization and whatever.

Secretary THOMPSON. And prescription drugs.

Mr. MCDERMOTT. So if I put that in and you add that, you get a full glass of water. You have got the 645, give or take a few billion, which is close enough for government work, perhaps. But the question I have then is how do you come up with whatever you intended to spend on a prescription drug benefit? Was that included in this that is already there, or is that new money coming from somewhere else because I have looked through the book and I cannot make out in my own mind whether this 526 plus 153 includes the drug benefit money or is it coming from somewhere else. I would really like to hear your explanation.

Secretary THOMPSON. Well, let me try and explain where I am at, and hopefully that is where the administration is at.

Mr. MCDERMOTT. I hope they are with you, too. Your job will be easier.

Secretary THOMPSON. This chart that you are looking at on page 14 includes both Parts A and Parts B.

Mr. MCDERMOTT. Yes, I understand that.

Secretary THOMPSON. There was a very elegant dissertation by Chairman Thomas early on in the hearing, and he is right on. It says that part B has got a deficit of $1.2 trillion, and part A has a surplus of $526 billion. Combining those two, you have a deficit of $645 billion. But as you aptly pointed out last week in the Budget Committee, and educated me very intently on, part B is a subsidy, and 75 percent from the Federal government, 25 percent from the policyholder, and that continues. So part A has got the surplus. part B has got a deficit. If you call it a deficit—you call it a subsidy, a 75–25. That is a different nomenclature, but pretty much the same thing.

Mr. MCDERMOTT. Still money.

Secretary THOMPSON. Still money. The $153 billion is separate. That is money that the President put in his budget for reforming Medicare, making it more competitive, more efficient, and also a prescription drug component. Now, if there is need of extra money, and it is my understanding that the extra money for the prescription drugs would be the difference between the $842 billion and the $526 billion, which is the surplus, the contingency fund, part of that contingency, around $300 billion dollars, less than that, would come to subsidize and help fund the prescription drugs, Congressman McDermott.

Mr. MCDERMOTT. So what you are saying is that the 645 is a combined figure of a much larger deficit in part B, and a surplus in part A, and that gives you the 645; that is correct; right?

Secretary THOMPSON. That is my understanding.

Mr. MCDERMOTT. That you still owe. Now, the 526, is that money counted from the surplus in part A?

Secretary THOMPSON. Yes.

Mr. MCDERMOTT. That is. But haven't you already counted it over here when you subtracted it from the total deficit, to give 645? It seems to me you have subtracted it twice.

Secretary THOMPSON. No, it is not my understanding you subtract it at all. They are saying $526 billion is in Chapter *(sic)* A, and there is a deficit of $1.2 trillion in Chapter B—Title B.

Mr. MCDERMOTT. But when you combine them——

Chairman THOMAS. Go ahead. You have got one more shot. Your time has expired.

Mr. MCDERMOTT. I am sorry?

Chairman THOMAS. Your time has expired, but if you want to have one more conversation——

Mr. MCDERMOTT. We will talk about this when we get down the road a little bit.

Chairman THOMAS. He is coming back next Tuesday. It is the chair's intention to conclude this hearing. We reached Mr. Collins and Mr. Kleczka, and it is the chair's intention that when we reconvene next Tuesday with the Secretary of the Treasury and the Secretary of Health and Human Services once again, that we will begin the questioning at that point. We have two votes on the floor.

Mr. Secretary, it is a pleasure having you with us and we look forward to seeing you, along with the Secretary of the Treasury, next Tuesday.

The Committee stands adjourned.

[Whereupon, at 11:54 a.m. the hearing was adjourned.]

[A question submitted by Mr. Collins, and Secretary Thompson's response, follow:]

Question: The Bush Administration has reopened the comment period on the proposed patient confidentiality regulations. These regulations have been criticized as being unworkable and overly expensive to implement.

A major concern is that the regulations—as required by the Health Insurance Portability and Accountability Act—does not preempt state laws. This means that we will continue to see onerous state laws, such as those passed by Minnesota, which are unworkable and overly expensive to implement.

In light of these concerns, what is the status of the work that both has been done and is being undertaken right now on these privacy regulations? What expectations do you have for future enforcement and implementation of these privacy regulations?

Answer: During the March 2001, 30-day public comment period, the Department received thousands of letters and comments on the Privacy Rule. Many of these comments revealed confusion over what the regulation does or does not do. Other comments identified certain provisions as unworkable.

The Department is using the written comments received, as well as issues identified through other communications with stakeholders, to direct our technical assistance and modification efforts. Specifically, on July 6, 2001, we issued our first set of guidance on the Rule, which attempts to clear up many of the misconceptions about the Rule and eliminate some of the uncertainties surrounding implementation of the Rule's provisions. This guidance is only the first in a series of ongoing technical assistance materials that the Department will provide to help covered entities comply with the Rule.

The Department also is working to propose any necessary changes to the Rule as quickly as possible so as to ensure that quality of care does not suffer inadvertently. For example, as we acknowledge in the guidance, an unanticipated problem arises with the consent provisions in the final rule when an individual's first contact with a provider is not in person and the provider needs to use the individual's information to perform a service, e.g., a pharmacist needs to use the information to fill a phoned-in prescription. We will propose modifications to the Rule to fix this problem and ensure that such activities may continue.

We are aware of concerns regarding preemption of state laws. Generally, HIPAA provides that the Privacy Rule preempt contrary provisions of state law. However, under HIPAA, state laws that are more protective of privacy are not preempted. In order to provide for preemption of all state privacy laws, Congress would have to enact new legislation.

As to compliance and enforcement, our enforcement approach is to first and foremost seek voluntary compliance by covered entities. Accordingly, the Department is working with the health care industry and others to ensure effective implementation of the Privacy Rule through guidance and other technical assistance. In addition, we anticipate proposing an enforcement rule that would apply to the Privacy Rule and the other administrative simplification rules, which will address how the Department will handle complaints and implement the enforcement provisions in HIPAA.

[Submissions for the record follow:]

Statement of Advanced Medical Technology Association

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

AdvaMed strongly supports the President's commitment to the Medicare program, the National Institutes of Health (NIH) and medical research, improving access to technologies for people with disabilities and expanding access to health care cov-

erage for the uninsured. We look forward to working with the Administration to ensure that the medical research developed by the government and in the private sector not only improves the quality of the care delivered to patients in all settings and programs, but also the productivity of the health care system itself.

With great interest, we note that President Bush's budget blueprint states that "Medicare is not adapted to 21st Century medicine. Medicare is often too slow to incorporate technologies and methods of delivering care. * * * As in virtually all fields, technological and entrepreneurial innovation are among the keys to creating more value for the dollar in health care." In addition, the budget recognizes that "assistive and universally designed technologies can dramatically improve the lives of individuals with disabilities, and make it possible for them to engage in productive work and more fully participate in society."

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

Medicare Beneficiary Access to Technology

AdvaMed applauds Congress for the steps it took in the Balanced Budget Refinement Act of 1999 (BBRA) and the Benefits Improvement and Protection Act (BIPA) of 2000 to begin to make the Medicare coverage, coding and payment systems more effective and efficient. In addition, the Health Care Financing Administration (HCFA) has recently made some changes to modernize its coverage and payment systems.

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

As Cliff Goodman from the Lewin Group testified at a March 1st hearing in the Committee on Energy and Commerce, Medicare delays can total from 15 months to five years or more because of the program's complex, bureaucratic procedures for adopting new technologies. Keep in mind that all this is after the two to six years it takes to develop a product and the year or more it takes to go through the Food and Drug Administration (FDA) review. In addition, these delays are even more pronounced when you consider that the average life span of a new technology can be 18 months.

The impact on patients has been dramatic. As physician witnesses testified on March 1st, cancer patients have had to fight for years to get Medicare to cover positron emission tomography, a potentially lifesaving scanning technology that has been broadly available to people under private health insurance for a decade. In addition, tens of thousands of seniors and people with disabilities have not been able to receive advanced technologies like coronary stents (which reopen blocked arteries), cochlear implants (which restore hearing) and heart assist devices (which keep patients alive while waiting for a heat transplant).

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

Making Medicare's Coverage Process More Transparent and Timely

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

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

Reforming the Coding and Payment Processes

After coverage is approved, there are three separate coding processes that determine how a device or procedure is identified and to which payment bundle it is assigned. Each of these coding systems have significant time-lags in assigning and updating codes. Under the new hospital outpatient perspective payment system (PPS), HCFA now assigns and updates codes on a quarterly basis. To reduce coding delays of 15–27 months, HCFA should use the outpatient PPS system as a model for applying similar systems to other settings, such as the inpatient hospital setting and doctors' offices.

Coverage and codes mean very little, however, if the associated payment level is inadequate. HCFA's procedures for updating relative payment weights and reassigning technologies and procedures are informal and infrequent. For example, it took HCFA 5 years to ultimately decide that the applicable diagnosis related group (DRG) should be split into two DRGs for angioplasty with and without stent. During those 5 years, hospitals took significant losses on each stent procedure and the diffusion of this cost-saving technology was hampered.

As required by BIPA, HCFA should develop formalized procedures for expeditiously assigning codes, updating relative weights and reassigning technologies to recognize the value of new and substantially improved technologies. HCFA should also fully implement the BIPA requirement to provide a transitional payment mechanism for new technologies where the DRG payment is inadequate.

Conclusion

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

Statement of Alliance to Improve Medicare

The Alliance to Improve Medicare (AIM) is the only organization focused solely on fundamental, non-partisan modernization of the Medicare program to ensure more coverage choices, better benefits (including prescription drug benefits), and access to the latest in innovative medical practices, treatments and technologies through the Medicare system. AIM coalition members include organizations representing seniors, hospitals, small and large employers, insurance plans and providers, doctors, medical researchers and innovators, and others.

The structure of the traditional Medicare program has changed little in more than three decades and, consequently, has not kept pace with many of the dramatic improvements in health care delivery. AIM is dedicated to achieving comprehensive modernization of the traditional Medicare program through policy research and educational programs for Members of Congress and their staff, the media, and the American public.

Key Principles for Medicare Modernization

AIM has identified seven key principles to guide Medicare modernization efforts. These principles seek to improve both the administration of the Medicare program and the benefits provided to program beneficiaries.

First, AIM supports improvement of health care coverage through better coordination of care including health promotion and disease prevention efforts. The traditional Medicare program has not kept pace with private sector benefits and plans offering preventive health care and screening measures such as annual physicals, hearing and vision tests, and dental care. Medicare beneficiaries, more so than other population age groups, can benefit from these preventive measures which can help reduce long-term costs and ensure appropriate, early treatment of health problems. Private sector Medicare providers should have the flexibility to incorporate these measures as part of basic health care services. Unfortunately, an act of Congress

has previously been required to provide routine screening tests under the Medicare fee-for-service program. For example, health management programs are offered by a variety of health plans (including HMOs) and pharmaceutical benefit managers (PBMs), companies who supply and manage prescription drug benefits for health care companies. Health management programs reduce overall health costs and improve the quality of life by helping beneficiaries better understand and manage conditions such as asthma and diabetes.

Second, AIM supports improvement of health care coverage through increased consumer choice. Medicare beneficiaries should have the option to choose from a range of coverage options similar to those available to Members of Congress, federal employees and retirees, and millions of working Americans under 65 years of age who are covered by private plans. The Medicare managed care program, Medicare+Choice, seeks to provide these types of coverage options to seniors nationwide. Unfortunately, inadequate payments and excessive regulation of private sector providers participating in Medicare+Choice have seriously constrained the ability to expand coverage areas and have caused numerous plans to withdraw from coverage areas where reimbursement was inadequate to cover even the costs of basic care. Between 1998 and January 2001, these withdraws affected over 1.5 million beneficiaries. One Medicare+Choice program participant, Oschner Health Plan (OHP) of Louisiana, cited inadequate payments in July 2000 when announcing withdrawal from nearly 6,000 OHP Medicare+Choice beneficiaries or16% of OHP's Medicare+Choice beneficiaries in Louisiana. OHP projected 2001 losses of nearly $6.8 million as a result of inadequate payment rates for basic coverage for these beneficiaries.

Third, AIM supports improving coverage through increased competition among all plans and providers in the Medicare program. Medicare's managed care option, the Medicare+Choice program, is an alternative to and competitor with traditional fee-for-service Medicare. The federal government, through the Health Care Financing Administration (HCFA,), currently regulates Medicare+Choice plans while also acting as a participant itself through the traditional fee-for-service program. AIM believes this dual role is anti-competitive. Medicare reform and modernization efforts must be evaluated based on success in increasing market competition and availability of basic, affordable coverage to Medicare beneficiaries, not on increasing HCFA's regulatory powers and oversight activities. The U.S. General Accounting Office (GAO) and former HCFA Administrators have identified several areas of conflict between HCFA's broad responsibilities and management structure including the dichotomy of the traditional fee-for-service program with the Medicare+Choice program. These conflicts include the lack of separate management offices and directors for each program.

Fourth, AIM believes prescription drug coverage should be provided to all Medicare beneficiaries as part of comprehensive, market based Medicare modernization. The opportunity for reform and modernization is presented by the recognized need to cover prescription drug benefits for Medicare recipients. Congress should take this opportunity and not simply layer a new, stand-alone drug program onto the traditional Medicare program without addressing the program's outdated and inadequate financial and structural systems. The program in its current form cannot meet the coming challenges presented by the retirement of the baby boom generation which will more than double the number of Medicare beneficiaries. Any Medicare reform proposal must address the real structural and financial problems of the Medicare program. For example, Medicare currently does not cover simple screening tests to detect high cholesterol among beneficiaries. Without modernization, Medicare will pay for only the drugs to treat high cholesterol but will continue to deny payment for detection of high cholesterol problems in seniors. Under a drug benefit as part of modernization, Medicare would ensure early detection and treatment, including drug therapy, as part of a comprehensive disease management approach.

Fifth, AIM urges Congress to continue to review and address the financial crisis facing health plans and providers. Adequate financing is necessary to establish a solid foundation upon which to build a better Medicare and ensure the long-term financial integrity and solvency of the Medicare program. Payment cuts in the Balanced Budget Act of 1997 (BBA '97) directly undermined patient care and progress toward a modernized program. These cuts were originally estimated to be $103 billion over five years but recent Treasury Department and Congressional Budget Office (CBO) reports project cuts of almost $300 billion-nearly triple what was intended. Health plans, hospitals and doctors have been hit hard and patient care has been and will continue to be affected. Congress recognized the damage caused by BBA '97 and has provided over $30 billion in restorations over the next five years. These small repayments represent a good start at addressing the financial crisis caused by the cuts. AIM encourages Members to ensure appropriate and timely pay-

ments for these providers and plans to ensure appropriate care for Medicare beneficiaries.

Sixth, AIM believes that the current rigid and outdated Medicare benefit structure and bureaucracy must be replaced. Program administrators must be provided with the flexibility to make new health care innovations and technologies more readily accessible to Medicare beneficiaries. Currently, Medicare beneficiaries wait a minimum of 15 months after patients in private health plans, including Medicare+Choice plans, to gain access to new medical devices and technologies, and sometimes the wait is as long as five years. HCFA's approval, coding and reimbursement procedures are largely responsible for this delay. Quality health care for Medicare beneficiaries requires these new technologies to be available for all patients. For example, more than half the patients who could use cochlear implants, which restore hearing to the profoundly deaf, are Medicare age. Unfortunately, few Medicare patients have received the device because HCFA hasn't updated its inadequate payment rate in 14 years. Current payment rates for cochlear implants cover less than half of actual costs.

Finally, AIM believes Medicare administrators must reduce excessive program complexity and bureaucracy caused by the more than 110,000 pages of federal rules, regulations, guidelines and mandates. While AIM supports the elimination of real fraud and abuse in Medicare, our members believe this can be achieved without relying on unnecessarily complex and heavy-handed regulation. Providers and plans must not be forced to divert resources from patient care in order to respond to ever-changing regulations. For example, Medicare+Choice plans announcing withdrawals in July 2000 frequently cited the large volumes of Operational Policy Letters (OPLs) as one reason for withdrawal. These plans reported increasing needs to devote additional employees to regulatory issues instead of health care delivery and management, increasing costs to plans at the same time as health care costs increased but payment rates from HCFA remained stagnant.

Conclusion

AIM urges the Committee to consider sensible, long-term solutions to the problems confronted by the Medicare program and by Medicare beneficiaries and we urge Members to work together on a bipartisan basis to achieve comprehensive Medicare reform. AIM appreciates the opportunity to submit this statement for the hearing record and we look forward to working with the Committee as they examine options for Medicare.