

providers. It would also create a Medicare Provider Ombudsman to help physicians and other providers to address confusion, lack of coordination, and other problems or concerns they may have with Medicare policies.

Our bill reforms the Medicare contracting processes by consolidating the contracting functions for Part A and Part B of Medicare, permitting the Secretary to contract with separate Medicare Administrative Contractors to perform discrete functions, making use of the Federal Acquisition Rules in contracting, eliminating the requirements for cost contracting, and expanding the kinds of entities eligible for contracting. Our bill would permit consolidation of claims processing with fewer contractors, and it would permit separate contracting along functional lines—for beneficiary services, provider services, and claims processing.

Mr. Speaker, my support for combining the administrative contracting functions of Part A and Part B in no way implies my support for combining the Part A and Part B trust funds or otherwise combining the financing or benefits. I strongly oppose such a consolidation.

Mr. Speaker, I have tried for years to get CMS/HCFA to institute a single toll-free phone number for Medicare beneficiaries like the single toll-free phone number that Social Security has operated for years. Finally, in the BBA, the Congress mandated the establishment of a toll-free number, 1-800-MEDICARE. By all accounts, it has been a great success, and even CMS/HCFA now touts its success. However, CMS/HCFA has still been unwilling to permit Medicare beneficiaries to use this number as a single entry point to Medicare. The latest national Medicare handbook includes 14 pages of telephone numbers for beneficiaries to call with specific questions! Surely, if a beneficiary calls the 1-800-MEDICARE number, their call could be transferred to the appropriate number, rather than asking them to try to locate the correct number themselves from among 14 pages of numbers!

In addition to not having a single place to call for Medicare problems, beneficiaries also have no casework office whose responsibility is to help them with their Medicare problems. In the past, CMS/HCFA has relied on the contractors, but many of the problems beneficiaries face are with the contractors themselves. In addition, CMS/HCFA now relies on State Health Insurance Counseling and Assistance Programs (HICAP) organizations to help beneficiaries. I am a strong supporter of these organizations; however, these agencies are staffed with volunteers. It is absurd for a huge public program the size of Medicare to rely on volunteers to be the main source of assistance for its beneficiaries.

We should look to the Social Security Administration to identify ways to provide assistance for Medicare beneficiaries. For example, Social Security not only has regional tele-service centers to staff their national toll-free line and help beneficiaries with their questions, SSA also has Program Service Centers to perform casework for Social Security beneficiaries with specific problems. We need similar offices for Medicare beneficiaries to perform casework for them. Currently, Medicare casework is handled primarily by Congressional offices, since no casework office exists in Medicare.

I have proposed that Medicare staff be stationed in Social Security field offices to help

answer questions and provide assistance for Medicare beneficiaries. There are 1291 SSA field offices around the world, and I would like to see Medicare staff in many, if not all of them in the near future. I am pleased that the legislation we are introducing today authorizes a demonstration program to examine the value of placing Medicare staff in SSA field offices, and I hope it will be expanded if it is found to aid beneficiaries.

Finally, Mr. Speaker, let me address Medicare administrative resources. Two years ago, in the January/February 1999 issue of Health Affairs, fourteen of our nation's leading Medicare policy analysts—ranging from conservative to liberal—published an open letter titled, "Crisis Facing HCFA & Millions of Americans." The crisis they spoke about was the lack of resources to administer Medicare. Their letter is even more relevant today. As its administrative workload has increased, CMS/HCFA resources have not kept pace. The changes that we propose in our legislation today are important, but by themselves, they are not sufficient. We simply must get more resources into Medicare administration.

PERSONAL EXPLANATION

HON. ASA HUTCHINSON

OF ARKANSAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. HUTCHINSON. Mr. Speaker, I was inadvertently detained during several rollcall votes this week. If I had been present I would have voted in the following way: Rollcall No. 301—"yea"; No. 302—"nay"; No. 304—"yea"; No. 305—"yea"; and No. 320—"yea".

TRIBUTE TO THE HONORABLE WILLIAM E. LEONARD

HON. GARY G. MILLER

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. GARY G. MILLER of California. Mr. Speaker, I rise to pay tribute and honor the accomplishments of The Honorable William E. Leonard, member of the California Assembly, 63rd District.

Mr. Leonard earned a bachelor's degree in Business Administration from UC Berkeley in 1944, and served in the United States Army from 1943 to 1946 where he rose to the rank of First Lieutenant. After his military service, he joined his father at the Leonard Realty & Building Company. He served as a member of the California State Highway Commission from 1973 to 1977, and was appointed to the California Transportation Commission from 1985 to 1993, and served as its chair in 1990 and 1991. Prior to that he was a member of the state's Athletic Commission from 1956 to 1958. He currently serves on the state's High-Speed Rail Authority.

Mr. Leonard has been actively involved in a number of community organizations. He is a member and past director of the San Bernardino Host Lions, a founding member

and president of Inland Action, Inc., and a member of the National Orange Show Board of Directors, where he has served as President and Chairman of the Board of Governors. He is also a member and elder of the First Presbyterian Church of San Bernardino. He served on the San Bernardino Valley Board of Realtors, San Bernardo Valley Foundation, St. Bernadine's Hospital Foundation, and the University of California at Riverside Foundation.

In recognition of his outstanding service to the constituents of the 63rd Assembly District, and his involvement in bringing the Foothill Freeway to the Inland Empire, the California State Senate passed a resolution naming the interchange of I-15 and Route 210 as the William E. Leonard Interchange. A dedication ceremony will take place on July 20, 2001.

Mr. Leonard's exemplary record of service has earned the admiration and respect of those who have had the privilege of working with him. I would like to congratulate him on these accomplishments and thank him for the service he has provided to his community.

IN RECOGNITION OF THE COMMUNITY ACTION COUNCIL OF SOUTH TEXAS

HON. CIRO D. RODRIGUEZ

OF TEXAS

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. RODRIGUEZ. Mr. Speaker, today I would like to recognize the important contributions of the Community Action Council of South Texas (CACST) to the improvement of the general quality of life of the citizens of South Texas. CACST is a private, nonprofit corporation that provides high quality comprehensive primary health care to the medically underserved residents in Duval, Jim Hogg, Starr, and Zapata Counties in South Texas. These counties are currently medically underserved due to geographic isolation, financial barriers, and an insufficient number of health care providers.

The CACST has made great strides in the South Texas health care system, specifically by empowering communities to develop programs to meet their specific needs. This has strengthened the local communities and enhanced opportunities for children and families. In addition, the CACST has maintained a high standard of accountability and provided health care services in accessible low-cost environments.

They have worked to improve access to quality health care by providing trained professionals in areas that had previously been underserved and promote individual responsibility and health awareness in the communities. It is critical that the CACST remain a provider of primary health care and their host of support services, including transportation, case management, outreach, and eligibility assistance. Their presence in the South Texas community has been a tremendous benefit to the individuals that reside there. I commend their efforts to help achieve primary health care for everyone and end health disparities.

TRANSITIONAL MEDICAL
ASSISTANCE IMPROVEMENT ACT

HON. SANDER M. LEVIN

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. LEVIN. Mr. Speaker, today I am pleased to join with my colleagues MICHAEL CASTLE and HENRY WAXMAN in introducing the Transitional Medical Assistance Improvement Act. I am also pleased to partner with Senators LINCOLN CHAFEE and JOHN BREAU, who have introduced identical legislation in the other body. This bill is a critical next step toward making welfare reform work for families and for states. Improving access to health insurance for people leaving welfare is also a necessary component of any plan to reduce the number of uninsured people in the U.S.

When we passed the 1996 welfare reform bill, we agreed on a bipartisan basis that people who left welfare for work should not lose health insurance coverage. Unless Congress acts, the program which keeps that promise, the Transitional Medical Assistance program (TMA), will expire at the end of 2002. The TMA Improvement Act would permanently authorize this critical program and fix some of the problems that have kept it from living up to its potential.

We made the commitment to providing health insurance for people who leave welfare for work both because it was the fair thing to do and because health insurance is a critical work support. According to the Welfare-to-Work Partnership, which represents over 20,000 businesses that have hired former recipients, access to health insurance is one of the five most important things that keeps employees on the job. However, it can be difficult for some employers—especially smaller ones—to offer medical benefits to employees and their dependents. For example, while 74 percent of all The Partnership's members offer health benefits to their new workers, only 56 percent of the smallest employers—those with 50 employees or fewer—are able to do so. And health insurance sometimes isn't offered to part-time employees, or doesn't become effective for up to a year. Even when an employer does offer health care benefits, employees may not participate if they can't afford the premiums.

TMA fills the gap for former welfare recipients who aren't offered insurance or can't afford the coverage they're offered. Unfortunately, certain technical problems with the program have made it difficult for states to administer and even more difficult for eligible workers to access. Here are a few of the major problems the TMA Improvement Act would solve.

Our bill would give states the option of offering up to a year of continuous TMA coverage, without burdensome reporting requirements and excessive paperwork. Current law requires beneficiaries to re-apply for coverage every three months and have states redetermine their eligibility for benefits. The redetermination forms are often long, complicated, and difficult to fill out, requiring time and energy that a working parent in a new job may not have. The process also creates a significant burden for primary care providers by forcing them to re-verify insurance coverage each time they see a TMA patient, which makes them reluctant to serve this population.

Our bill would allow states to offer a second year of TMA coverage to workers who were still poor and uninsured. The Urban Institute estimates that 50% of people leaving welfare are uninsured a year after leaving the rolls. On average, those workers earn \$7 an hour and cannot afford to purchase private insurance. A few states are already trying to offer these workers a second year of Medicaid coverage, but current law makes doing so administratively complex.

Our bill would allow states to provide transitional health coverage to people who find work quickly. Ironically, current law restricts TMA coverage to those who have been receiving assistance for at least 3 months. This means that some of the most motivated people leaving welfare, those that find work the most quickly, are deprived of health coverage. I applaud my home state of Michigan for using state funds to cover this group, but I believe the federal government should be doing its part.

Our bill would make it easier for employers, community groups, schools, and health clinics to help us enroll working parents in health insurance programs. A recent survey of employers of welfare recipients found that 79% would be willing to help a new employee access information on these programs if they knew he or she were eligible. Many were even willing to help the employee enroll. Our bill would ensure that nonwelfare office sites were able to accept applications for TMA, greatly expanding access for working parents who are unable to go to welfare offices during business hours.

Tens of thousands of former welfare recipients have gone to work since 1996, exactly as we asked. I hope that my colleagues will join me in supporting the TMA Improvement Act, which will ensure that Congress keeps its promise of transitional health insurance for these hard-working parents and their children.

REGARDING THE 50TH ANNIVERSARY
OF BRANDY VOLUNTEER
FIRE DEPARTMENT

HON. ERIC CANTOR

OF VIRGINIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. CANTOR. Mr. Speaker, I rise today to honor the 50th anniversary of the Brandy Station Volunteer Fire Department, which has faithfully protected and served its community since 1951.

Throughout its five decades, this organization has served as a true testament to the spirit of volunteerism that makes America such a uniquely compassionate country. After receiving its charter in February, 1951, the department started off by obtaining a single fire truck through the generosity of the neighboring town of Culpeper. Over the course of the next two years, numerous dinners, dances, and bake sales held in order to raise enough money to finance the building of its first fire station in 1953. Although it does receive a small portion of its budget from Culpeper County, the department still operates primarily on the donations of its members and the Brandy Station community. In the year 2000 alone, the volunteers were able to answer seven hundred and twenty-three calls, which included everything from auto accidents and

house fires to plane crashes and hazardous chemical spills. Even while answering this extremely high number of calls, they were still able to keep their response time to an incredible low average of 4½ minutes. This is truly an exemplary group of individuals because of their outstanding commitment to the protection of Brandy Station and its citizens.

Mr. Speaker and members of the House, my words here do not do justice to the service of the men and women of the Brandy Station Volunteer Fire Department, but I ask that you join me in honoring their 50th Anniversary and wish them fifty more years of success.

INTRODUCTION OF THE CHILDREN'S LEAD SCREENING ACCOUNTABILITY FOR EARLY INTERVENTION ACT OF 1999
(CHILDREN'S LEAD SAFE ACT)

HON. ROBERT MENENDEZ

OF NEW JERSEY

IN THE HOUSE OF REPRESENTATIVES

Thursday, August 2, 2001

Mr. MENENDEZ. Mr. Speaker, I am pleased today to re-introduce the Children's Lead Screen Intervention Act. This important legislation will strengthen federal mandates designed to protect our children from lead poisoning—a preventable tragedy that continues to threaten the health of our children.

Childhood lead poisoning has long been considered the number one environmental health threat facing children in the United States, and despite dramatic reductions in blood lead levels over the past 20 years, lead poisoning continues to be a significant health risk for young children. CDC has estimated that about 890,000, or 4.4 percent, of children between the ages of one and five have harmful levels of lead in their blood. Even at low levels, lead can have harmful effects on a child's intelligence and his, or her, ability to learn.

Children can be exposed to lead from a number of sources. We are all cognizant of lead based paint found in older homes and buildings. However, children may also be exposed to non paint sources of lead, as well as lead dust. Poor and minority children, who typically live in older housing, are at highest risk of lead poisoning. Therefore, this health threat is of particular concern to states, like New Jersey, where more than 35 percent of homes were built prior to 1950.

In 1996, New Jersey implemented a law requiring health care providers to test all young children for lead exposure. But during the first year of this requirement, there were actually fewer children screened than the year before, when there was no requirement at all. Between July 1997 and July 1998, 13,596 children were tested for lead poisoning. The year before that more than 17,000 tests were done.

New Jersey has made some progress since then. In the year 2000, New Jersey screened 67,594 children who were one or two years of age. But that is still only one-third of all children in that age group.

At the federal level, the Health Care Financing Administration (HCFA) has mandated that Medicaid children under 2 years of age be screened for elevated blood lead levels. However, recent General Accounting Office (GAO) reports indicate that this is not being done. For