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REVIEWING THE PRESIDENT'S FISCAL YEAR 2014 BUDGET PROPOSAL FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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REVIEWING THE PRESIDENT'S FISCAL YEAR 2014 BUDGET PROPOSAL FOR THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tuesday, June 4, 2013

U.S. House of Representatives

Committee on Education and the Workforce

Washington, DC

The committee met, pursuant to call, at 10:04 a.m., in room 2175, Rayburn House Office Building, Hon. John Kline [chairman of the committee] presiding.

Present: Representatives Kline, Wilson, Foxx, Price, Roe, Thompson, Walberg, Salmon, Guthrie, DesJarlais, Bucshon, Gowdy, Barletta, Roby, Heck, Brooks, Hudson, Messer, Miller, Andrews, Scott, Hinojosa, Tierney, Holt, Davis, Grijalva, Bishop, Loebsack, Courtney, Fudge, Polis, Yarmuth, Wilson, and Bonamici.

Staff present: Andrew Banducci, Professional Staff Member; Katherine Bathgate, Deputy Press Secretary; James Bergeron, Director of Education and Human Services Policy; Casey Buboltz, Coalitions and Member Services Coordinator; Owen Caine, Legislative Assistant; Molly Conway, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Benjamin Hoog, Senior Legislative Assistant; Marvin Kaplan, Workforce Policy Counsel; Rosemary Lahasky, Professional Staff Member; Nancy Locke, Chief Clerk; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Jenny Prescott, Staff Assistant; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Nicole Sizemore, Deputy Press Secretary; Alex Sollberger, Communications Director; Todd Spangler, Senior Health Policy Advisor; Alissa Strawcutter, Deputy Clerk; Juliane Sullivan, Staff Director; Joseph Wheeler, Professional Staff Member; Aaron Albright, Minority Communications Director for Labor; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Kelly Broughan, Minority Education Policy Associate; Jody Calemine, Minority Staff Director; John D'Elia, Minority Labor Policy Associate; Jamie Fasteau, Minority Director of Education Policy; Daniel Foster, Minority Fellow, Labor; Scott Groginsky, Minority Education Policy Advisor; Brian Levin, Minority Deputy Press Secretary/New Media Coordinator; Leticia Mederos, Minority Senior Policy Advisor; Megan O'Reilly, Minority General Counsel; Michele Varnhagen, Minority Chief Pol-

icy Advisor/Labor Policy Director; and Michael Zola, Minority Deputy Staff Director.

Chairman KLINE. A quorum being present, the committee will come to order. Before we start this morning I want to point out that our colleague from New York, Mrs. McCarthy, is not with us. Some of you probably saw the news this morning—Mr. Miller and I were just talking—she has been diagnosed with treatable cancer and she will be missing for some time while she is being treated. And, of course, our prayers are with here.

George, if you have any——

Mr. MILLER. Mr. Chairman, just thank you very much. I had an opportunity to talk to Carolyn yesterday evening and, as you pointed out, she has been diagnosed with what they believe is treatable lung cancer but she is in for a rough ride.

Told her we were all cheering for her and she would see us after Labor Day, and so thank you very much and we are going to miss her service on the committee in the meantime, but we all obviously wish her well. Thank you.

Chairman KLINE. Well, not always the happiest way to start off, but good morning, Secretary Sebelius. Welcome back to the Education and Workforce Committee.

Though the economic recovery began 4 years ago, countless Americans continue to face serious challenges. Roughly 12 million are searching for work. Families have recouped less than half of the household wealth lost during the recession. The economy continues to move along at an anemic pace and the national debt will soon reach an astonishing $17 trillion.

Congress has a responsibility to examine the programs and priorities of the federal government, not only to ensure we provide the best possible services to those in need and spend taxpayer dollars wisely, but also to deter policies that make it more difficult for businesses to hire new workers. That means asking tough questions to demand accountability for every dollar spent and each new rule imposed.

For example, is Head Start meeting the needs of students and taxpayers? Two studies released by the department suggest the answer is no. The gains students achieve in the program are essentially lost by the time they graduate from the first grade.

These findings are especially informative in light of the President's plan to dramatically expand the federal role in early childhood education. We should not be adding another program onto an already broken system. Our nation's youth deserve better.

Does the administration's welfare waiver scheme serve the best interest of low-income families? The answer is no.

The 1996 bipartisan welfare reform law has helped reduce poverty and strengthen the income security of millions of needy families. Last year the department announced a plan to end welfare reform as we know it by allowing states to waive the work requirements central to the law's success. This plan would create more dependency when 47 million individuals are already trapped in poverty.

And is the health care law living up to the promises the President made to the American people? Once again the answer is no.

The President promised to lower health care premiums for the average family by $2,500, but premiums rose 4 percent last year and 9 percent the year before. Meanwhile, insurance providers are warning of rate shock in the years to come.

The President also promised if you liked your health care plan you could keep it. However, the nonpartisan Congressional Budget Office estimates as many as 20 million individuals will lose their current plan. Many will be forced to pay more for health care they do not want or need in order to meet the mandates from Washington.

Finally, it was promised the law would create millions of new jobs, yet barely a day goes by when we don't read reports of the law wreaking havoc in workplaces across the country. Once small business owner testified the law will lead to either higher prices for his customers or fewer hours for employees. A human resources professional at a North Carolina community college warned they may have to cut the number of courses offered to students and described the law as a, "massive administrative burden that comes with unanticipated costs."

To prove these aren't just Republican accusations, here are a few recent headlines surrounding the law: "Like your health policy? You may be losing it," warns the Associated Press. "As health law changes loom, a shift to part-time workers," writes National Public Radio. "Some unions now angry about health care overhaul," also by the Associated Press. "Health insurers warn on premiums," reports the Wall Street Journal.

The litany of bad news goes on. As one senior Democrat and architect of the law stated, the law is headed for a train wreck, and still there are those who want to force every American to go along for the ride. Isn't it time for the President to admit we can do better than a flawed health care law that is raising costs and destroying jobs?

I look forward to your answers to these and other important questions, Secretary Sebelius.

With that, I will now recognize the senior Democratic member of the committee, my colleague, Mr. Miller, for his opening remarks?

[The statement of Chairman Kline follows:]

Prepared Statement of Hon. John Kline, Chairman, Committee on Education and the Workforce

Good morning. Secretary Sebelius, welcome back to the Education and the Workforce Committee. Though the economic recovery began four year ago, countless Americans continue to face serious challenges. Roughly 12 million are searching for work. Families have recouped less than half of the household income lost during the recession. The economy continues to move along at an anemic pace. And the national debt will soon reach a historic $17 trillion.

Congress has a responsibility to examine the programs and priorities of the federal government, not only to ensure we provide the best possible services to those in need and spend taxpayer dollars wisely, but also to deter policies that make it more difficult for businesses to hire new workers. That means asking tough questions to demand accountability for every dollar spent and each new rule proposed.

For example, is Head Start meeting the needs of students and taxpayers? Two studies released by the department suggest the answer is no. The gains students achieve in the program are essentially lost by the time they graduate from the first grade. These findings are especially informative in light of the president's plan to dramatically expand the federal role in early-childhood education. We should not be adding another program onto an already broken system; our nation's youth deserve better.

Does the administration's welfare waiver scheme serve the best interests of low-income families? The answer is a resounding no. The 1996 bipartisan welfare reform law has helped reduce poverty and strengthen the income-security of millions of needy families. Last year the department announced a plan to end welfare reform as we know it by allowing states to waive the work requirements central to the law's success. This plan would create more dependency when 47 million individuals are already trapped in poverty.

And is the health care law living up to the promises the president made to the American people? Once again the answer is no. The president promised to lower health care premiums for the average family by $2,500, but premiums rose 4 percent last year and 9 percent the year before. Meanwhile, insurance providers are warning of rate shock in the years to come.

The president also promised if you liked your health care plan, you could keep it. However, the nonpartisan Congressional Budget Office estimates as many as 20 million individuals will lose their current plan. Many will be forced to pay more for health care they do not want or need in order to meet the mandates from a few bureaucrats in Washington.

Finally, it was promised the law would create millions of new jobs. Yet barely a day goes by when we don't read reports of the law wreaking havoc in workplaces across the country. One small business owner testified the law will lead to either higher prices for his customers or fewer hours for employees. A human resources professional at a North Carolina community college warned they may have to cut the number of courses offered to students and described the law as a "massive administrative burden that comes with unanticipated costs."

To prove these aren't just Republican accusations, here are a few recent headlines surrounding the law:

"Like your health care policy? You may be losing it," warns the Associated Press.

"As health law changes loom, a shift to part-time workers," writes NPR.

"Some unions now angry about health care overhaul," also by the Associated Press.

"Health insurers warn on premiums," reports the Wall Street Journal.

The litany of bad news goes on. As one senior Democrat and architect of the law stated, the law is headed for a train wreck, and still there are those who want to force every American to go along for the ride. Isn't it time for the president to admit we can do better than a flawed health care law that is raising costs and destroying jobs?

I look forward to your answers to these and other important questions, Secretary Sebelius. With that, I will now recognize the senior Democratic member of the committee, my colleague Representative George Miller, for his opening remarks.

Mr. MILLER. Thank you, Mr. Chairman. And I join you in welcoming Secretary Sebelius back to the committee.

From educating our youngest children in Head Start to ensuring seniors access to health care through Medicare, the Department of Health and Human Services administers programs to make our nation stronger and healthier. The department is handling a number of important policies and proposals and I would like to focus my comments on just two of these efforts.

First, I believe that President Obama's child care and early childhood education proposals recognize the overwhelming evidence that investments in early education more than pay off down the line. We know that providing greater access to high-quality preschool, child care, and voluntary home visitations with mothers of newborns are proven ways to close the achievement gap and strengthen school readiness. These programs and proposals have received bipartisan support in the past and they should have bipartisan support today and in the future.

In the meantime, we should be working hard to stop the automatic cuts to the Head Start program. They have been having a devastating impact on tens of thousands of children and their families.

Despite this, the Republican majority refuses to restore these cuts. They have already voted to double down on the sequester with even more cuts in the Republic budget, and when there were threats to—excuse me—but when there were threats for the waits of members of Congress at the airports we broke the land speed record and passed legislation to stop that sequester. However, when it comes to 70,000 kids' future, the urgency to restore these cuts haven't received the committee hearing, let alone a vote. These kids can't afford to lose access to Head Start.

Likewise, playing politics with the Affordable Care Act has become something of an Olympic sport for the majority. The majority has tried in one way or another to repeal the Affordable Care Act 37 times.

This is outrageous, especially at a time when the Affordable Care Act is coming into full effect. Already, more than 6 million young adults have been allowed to stay on their parents' health plan; 54 million Americans with private health insurance have been able to get preventative health screening with no copayment; 6.3 million seniors have saved more than $6 billion in the cost of their prescription drugs; nearly 13 million Americans have received more than $1 billion in rebates and lowered premiums from insurance companies that were spending more on overhead rather than on health care.

The federal government is recovering billions of dollars by reducing Medicare fraud, and growth in health care costs have slowed and the Affordable Health Care Act has been partially responsible for that—so much so that CBO says that we are realizing billions of savings in Medicare and the Medicaid programs, more expected to come. And beginning in October, Americans without access to affordable insurance will be able to shop for health care plans in the transparent marketplace for the first time.

And there has been good news on that front from the number of states, including California, which has been one of the most proactive states implementing reform, and it is going to pay off for our citizens. In the states that have published the 2014 health insurance premiums, where insurance companies are competing and offering affordable premiums, contrary to the predictions of the majority.

For instance, in California's published premiums have come in or are much lower than plans today and comparable benefits. This is all good news and stands in contrast to claims that we have been hearing from the other side for 3 years.

And this also stands in stark contrast to the Republican health care agenda. More than 3 years ago House committees, including this one, were to report alternative health care reform proposals. We have seen none from any committee; all we have seen is repeal.

And in those 3 years we have produced nothing but these 37 attempts at repeal, and there is more to be done to secure Medicare in the long term and there is more to be done to ensure the Affordable Care Act is fully implemented, but these reforms should be allowed to work because the alternative is unacceptable. Repeal is unacceptable because it will take away the important benefits already in the law.

Repeal means working families going bankrupt because of an expensive illness like cancer. Repeal means sick children will be denied coverage. Repeal means millions of young adults losing access to their parents' coverage. And repeal means that all of the other patient's rights set to go into law in a few months will never happen, like completely ending the use of preexisting conditions to deny care or pricing Americans out of coverage, like ensuring that all Americans have access to quality and affordable health insurance that is not dependent on whether or not your employer offers it or not or whether or not you become unemployed.

Mr. Chairman, the Affordable Care Act is already making a difference. I applaud Secretary Sebelius for the monumental efforts that she has made to implement this law in the face of endless obstruction from this House.

America tried to enact meaningful health care reform for nearly a century. We have debated it. Republican Presidents and Democratic Presidents have offered proposals for national health care. But it couldn't have happened until President Obama and the Democratic Congress finally made it happen.

Now is not the time to reverse course and go back to the days when insurance companies were in charge. Our nation's businesses, families, and governments can't afford it.

Once again, thank you, Secretary Sebelius, for making yourself available to the committee and I look forward to your testimony.

[The statement of Mr. Miller follows:]

Prepared Statement of Hon. George Miller, Senior Democratic Member, Committee on Education and the Workforce

Good morning Mr. Chairman. I join you in welcoming Secretary Sebelius back to the committee.

From educating our youngest children in Head Start to ensuring seniors' access to health care through Medicare, the Department of Health and Human Services administers programs that make our nation stronger and healthier.

The department is handling a number of important policy priorities and proposals. I would like to focus my comments on just two of these efforts.

First, I believe that President Obama's child care and early education proposals recognize the overwhelming evidence that investments in early education more than pay off down the road.

We know that providing greater access to high-quality pre-school, child care, and voluntary home visitation with mothers with newborns are proven ways to close achievement gaps and strengthen school readiness.

These programs and proposals have received bipartisan support in the past. And they should have bipartisan support today and in the future.

In the meantime, we should also be working to stop the automatic cuts to the Head Start program. They are having a devastating impact on tens of thousands of children and their families.

Despite this, this Republican majority refuses to restore these cuts. They have already voted to double-down on the sequester with even more cuts in the Republican budget.

But when there were threats of waits for members of Congress at airports, we broke a land-speed record and passed legislation to stop it. However, when it comes to 70,000 kids' future, the urgency restore these cuts haven't received a committee hearing, let alone a vote.

These kids can't afford to lose access to Head Start. I hope we can get past this fiscal cliff politics and restore funding to this and other very important programs.

Likewise, playing politics with the Affordable Care Act has become something of an Olympic sport for the majority. The majority has tried in one way or another to repeal the ACA 37 times.

This is outrageous, especially at a time when the Affordable Care Act is coming into full effect.

Already, more than 6 million young adults have been allowed to stay on their parents' health plan. 54 million Americans with private health insurance have been able to get preventive health screenings with no co-payment. 6.3 million seniors have saved more than $6 billion on the cost of their prescription drugs. Nearly 13 million Americans have received more than a billion dollars in rebates or lower premiums from insurance companies that spent more on overhead rather than health care. The federal government is recovering billions more by stopping Medicare fraud.

Growth in health care costs have slowed dramatically since the Affordable Care Act became law.

So much so, that the CBO says that we are already realizing billions in savings in the Medicare and Medicaid programs with more expected to come.

And, beginning in October, Americans without access to affordable insurance will be able to shop for a health plan in a transparent marketplace for the first time.

There has been good news on that front from a number of states, including California, which has been one of the most pro-active states implementing reform. And it's going to pay off for our citizens.

In the states that have published the 2014 health insurance premiums, insurance companies are competing and offering affordable premiums—contrary to the predictions of the majority. For instance, California's published premiums have come in at or much lower than plans today with comparable benefits.

This is all good news and stands in contrast to the claims we've been hearing from the other side for three years. And this also stands in stark contrast to the Republican health care agenda.

More than three years ago, House committees—including this one—were to report alternative health care reform proposals. But three years later, we have produced nothing but 37 attempts to repeal the ACA and efforts to end the Medicare guarantee.

There is more to be done to secure Medicare for the long-term, and more to do to ensure that the Affordable Care Act is fully implemented. No piece of legislation is perfect. There will be bumps in the road. But these reforms should be allowed to work because the alternative is unacceptable.

Repeal is unacceptable because it will take away these important benefits already in law.

Repeal means working families going bankrupt because of an expensive illness like cancer.

Repeal means sick children can be denied coverage.

Repeal means millions of young adults losing access to their parents' coverage.

And repeal means that all of the other patient rights set to go into law in a few months will never happen.

Like completely ending the use of preexisting conditions to deny care or pricing Americans out of coverage. Like ensuring all Americans have access to quality and affordable health insurance that is not dependent on whether your employer offers it or not.

Mr. Chairman, the Affordable Care Act is already making a difference. I applaud Secretary Sebelius' monumental task to implement this law in the face of endless obstruction from this House.

America tried to enact meaningful health reform for nearly a century but we couldn't make it happen until President Obama and a Democratic Congress finally made it happen.

Now is not the time to reverse course and go back to the days where insurance companies were in charge. Our nation's businesses, families, and our government can't afford it.

Once again, thank you, Secretary Sebelius, for making yourself available to the committee.

I look forward to your testimony.

Chairman KLINE. Thank the gentleman.

Pursuant to committee rule 7(c), all committee members will be permitted to submit written statements to be included in the permanent hearing record. Without objection, the hearing record will remain open for 14 days to allow statements, questions for the record, and other extraneous material referenced during the hearing to be submitted in the official hearing record.

Again, Madam Secretary, welcome back to the committee. It is my pleasure to introduce our witness, but everybody here knows who you are and knows your background and we are eager to hear your testimony.

So, Madam Secretary, floor is yours.

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Sorry. Chairman Kline, Ranking Member Miller, members of the committee, thank you for the opportunity to discuss the President's 2014 budget for the Department of Health and Human Services.

This budget supports the overall goals of the President's budget by strengthening our economy and promoting middle class growth. It ensures that the American people will continue to benefit from the Affordable Care Act; it strengthens education and services for our children during their critical early years to help ensure they can live healthy lives and succeed in a 21st century economy; provides much-needed support for mental health services and takes steps to address the ongoing tragedy of gun violence; and it helps reduce the deficit in a balanced, sustainable way.

I look forward to answering the committee members' questions about the budget, but first I would like to briefly cover a few of the highlights.

The Affordable Care Act is already benefiting millions of Americans and our budget makes sure we can continue to implement the law. By supporting the creation of new health insurance marketplaces, the budget will ensure that starting next January Americans in every state will be able to get quality health insurance at an affordable price.

Our budget also supports the President's call to provide every child in America with access to high-quality early learning services. It proposes additional investments in new Early Head Start child care partnerships. And it provides more funding for child care to complement our recent proposed rules to strengthen child care health and safety standards.

Together, these investments will create long-lasting positive outcomes for families and provide huge returns for the children who benefit from these programs and for society at large.

Our budget also addresses another issue that has been on all of our minds recently: mental health services and the ongoing epidemic of gun violence. We know that the vast majority of Americans who struggle with mental illness are not violent. Recent tragedies have reminded us of the staggering toll that untreated mental illness can take on our society, and that is why this budget proposes a major new investment, to help ensure that students and young adults get the mental health care they need, including training 5,000 new mental health professionals to join our behavioral health workforce.

Even as our budget invests for the future, it also helps reduce the long-term deficit by making sure programs like Medicare are put on a more stable fiscal trajectory. Medicare spending per beneficiary grew at just four-tenths of 1 percent in 2012 thanks in part to the $800 billion in savings already in the Affordable Care Act.

And the President's 2014 budget would achieve even more savings. For example, the budget will allow low-income Medicare beneficiaries to get their prescription drugs at lower Medicaid rates, resulting in savings of more than $120 billion over the next 10 years.

In total, this budget would generate an additional $371 billion in Medicare savings over the next decade on top of the savings already in the Affordable Care Act.

To that same end, our budget also reflects our commitment to aggressively reducing waste across the department. We are proposing an increase in mandatory funding for the Health Care Fraud and Abuse Control program, an initiative that saved taxpayers nearly $8 for every dollar spent on it last year. And we are investing in additional efforts to reduce improper payments in Medicare, Medicaid, and CHIP, and to strengthen our office of inspector general.

Now, this all adds up to a budget guided by this administration's North Star of a thriving middle class. It will promote job growth and keep our economy strong in the years to come while also helping to reduce the long-term deficit.

Now, I am sure many of you have questions and I am happy to take them now.

Thank you again, Mr. Chairman, for inviting me today.

[The statement of Secretary Sebelius follows:]

Prepared Statement of Hon. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Chairman Kline, Ranking Member Miller, and Members of the Committee, thank you for the invitation to discuss the President's FY 2014 Budget for the Department of Health and Human Services (HHS).

The Budget for HHS provides critical investments in health care, disease prevention, social services, and scientific research in order to create healthier and safer families, stronger communities, and a thriving America.

The President's fiscal year (FY) 2014 Budget for HHS includes investments needed to support the health and well being of the nation, and legislative proposals that would save an estimated $361.1 billion over 10 years. The Budget totals $967.3 billion in outlays and proposes $80.1 billion in discretionary budget authority. With this funding HHS will continue to improve health care and expand coverage, create opportunity and give kids the chance to succeed, protect vulnerable populations, promote science and innovation, protect the nation's public health and national security, and focus on responsible stewardship of taxpayer dollars.

Improving Health Care and Expanding Coverage

Expanding Health Insurance Coverage. Implementation of the Exchanges, also referred to as Marketplaces, will expand access to affordable insurance coverage for 25 million Americans. Marketplaces make purchasing private health insurance easier by providing eligible consumers and small businesses with one-stop-shopping where they can compare across plans. New premium tax credits and rules ensuring fair premium rates improve affordability of private coverage. Marketplaces will be operational in 2014; open enrollment begins October 1, 2013 for the coverage year beginning January 1, 2014. The Budget supports operations in the Federal Marketplaces, as well as oversight and assistance to State-based and Partnership Marketplaces.

Beginning in January 2014, Medicaid coverage rules will be simplified and aligned with rules for determining eligibility for tax credits for private insurance in the Marketplaces, and millions of low-income people will gain coverage. The Centers for Medicare & Medicaid Services (CMS) is committed to working with states and other partners to advance state efforts that promote health, improve the quality of care, and lower health care costs.

Also beginning in 2014, consumers will benefit from a number of new protections in the private health insurance market. Most health insurers will no longer be allowed to charge more or deny coverage to people because of pre-existing conditions. These new protections will also prohibit most health insurers from putting annual dollar limits on benefits and from varying premiums based on gender or any factor

other than age, tobacco use, family size, or geography. In addition, new plans in the individual and small group market will be required to cover a comprehensive package of items and services known as Essential Health Benefits, which must include items and services within ten benefit categories. Finally, most individuals choosing to participate in clinical trials will not face limits in health insurance coverage. This protection applies to all clinical trials that treat cancer or other life-threatening diseases.

Expanding Access to Care through Health Centers. The FY 2014 Budget includes $3.8 billion for the Health Centers program, including $2.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund. In FY 2014, 23 million patients will receive health care through more than 8,900 sites in medically underserved communities throughout the nation. The Budget funds 40 new health center sites for the provision of preventive health care services, expanding outreach and care to approximately 1.5 million additional patients.

Increasing Access to Mental Health Services

The FY 2014 Budget includes over $1 billion for mental health programs at the Substance Abuse and Mental Health Services Administration (SAMSHA), including the $460 million for the Community Mental Health Services Block Grant. This block grant provides States flexible funding to maintain community based mental health services for children and adults with serious mental illnesses, including rehabilitation, supported housing, and employment opportunities. The Budget also proposes funding within the block grant to encourage States to build provider capacity to bill public and private insurance. This will support States in an effective transition in the first year of the Affordable Care Act, which will include expanded coverage for mental health and substance abuse treatment services.

Expand Prevention and Treatment for Youth and Families. While the vast majority of Americans with a mental illness are not violent, and are in fact more likely to be the victims of violence, recent tragedies have brought to light a hidden crisis in America's mental health system. The Budget addresses these issues by investing $130 million to help teachers and other adults recognize signs of mental illness in students and refer them to help if needed, support innovative state-based programs to improve mental health outcomes for young people ages 16- 25, and train 5,000 more mental health professionals with a focus on serving students and young adults.

Helping Families and Children Succeed

In his State of the Union Address, President Obama proposed a series of new investments to create a continuum of high-quality early learning services for children beginning at birth through age five. As part of this initiative, HHS and the Department of Education are working together to make high-quality preschool available to four-year olds from low- and moderate-income families through a partnership with states, expand the availability of high-quality care for infants and toddlers, and increase highly-effective, voluntary home visiting programs to provide health, social, and education supports to low-income families. Specifically, the FY 2014 HHS Budget includes:

Early Head Start—Child Care Partnerships. The Budget proposes $1.4 billion in FY 2014 for new Early Head Start—Child Care Partnerships that will expand the availability of early learning programs that meet the highest standards of quality for infants and toddlers, serving children from birth through age three. In addition to the new Partnerships, the Budget provides $222 million above FY 2012 to strengthen services for children currently enrolled in the program, avoid further enrollment reductions, and support the Head Start Designation Renewal System. Together, these investments total $9.6 billion, an increase of $1.7 billion over FY 2012.

Head Start Reform. The Budget proposes a $197 million cost of living adjustment in FY 2014 which will strengthen existing services for children currently enrolled in Head Start and avoid further reductions in enrollment. Additionally, the Budget proposes $25 million in FY 2014 to minimize potential service disruptions by providing new grantees funding for start-up costs associated with transitioning from an incumbent grantee as a result of recompetition in the Designation Renewal System. Under the Designation Renewal System, Head Start grantees who do not meet quality thresholds established by the department have to compete for their continued funding with other potential providers from the community. Requiring grantees who are not meeting quality benchmarks to compete for funding will improve the quality of the program.

Improving the Safety and Quality of Child Care. The Budget provides $500 million above FY 2012 in mandatory funds to serve 1.4 million children, approximately 100,000 more than would otherwise be served. In addition to this funding, the re-

quest includes $200 million above FY 2012 in discretionary funds to help states raise the bar on quality by strengthening health and safety measures in child care settings, supporting professional development for providers, and promoting transparency and consumer education to help parents make informed child care choices.

The additional funding to improve child care quality also will support changes that may come as a result of a new regulation that the department recently issued for public comment that will better ensure children's health and safety in child care and promote school readiness. Under the proposed rule, states, territories and tribes would be required to strengthen their standards to better promote the health, safety and school readiness of children in federally funded child care. While states can use their existing funds to implement potential changes in these areas, these new resources dedicated to quality improvement would help states that have further to go in improving their programs.

We also will continue to work with Congress to reauthorize the Child Care and Development Block Grant, which was last reauthorized in 1996.

Child Support and Fatherhood Initiative. Additionally, the Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to Temporary Assistance for Needy Families recipients. Recognizing that healthy families need more than just financial support alone, the proposal requires states to include parenting time provisions in initial child support orders, to increase resources to support, and facilitate non-custodial parents' access to and visitation with their children. The Budget also includes new enforcement mechanisms that will enhance child support collections.

Home Visiting. The Budget extends and expands this voluntary evidence-based program that has shown to be critical in improving maternal and child health outcomes in the early years, leaving long-lasting, positive impacts on parenting skills; children's cognitive, language, and social-emotional development; and school readiness. The Budget proposes a long-term $15 billion investment beginning in FY 2015.

Protecting Vulnerable Populations

Addressing the Unique Needs of Communities. The Administration for Community Living (ACL) was formed in April 2012 as a single agency designed to help more people with disabilities and older adults have the option to live in their homes and participate fully in their communities. The FY 2014 Budget reflects the creation of ACL by bringing together the resources for the Administration on Aging, the Office on Disability, and the Administration on Intellectual and Developmental Disabilities, into a consolidated request. This newly organized agency works across HHS to harmonize efforts to promote community living, which can both save federal funds and allow people who choose to live with dignity in the communities they call home. ACL's Older Americans Act programs, as an example, last year served nearly 11 million seniors and their caregivers through home and community-based services. These critical supports complement medical and health care systems, help to prevent hospital readmissions, provide transportation to doctor appointments, and support some of life's most basic functions, such as assistance to elders in preparing and delivering meals, or helping them with bathing. It is important that we continue to support alternatives to institutional care that are person-centered, consumer-driven and support individuals in their homes through the best evidence-based practices.

Promoting Science and Innovation

Advancing Scientific Knowledge. The FY 2014 Budget includes $31.3 billion for the National Institutes of Health (NIH), an increase of $471 million over the FY 2012 level, reflecting the Administration's priority to invest in innovative biomedical and behavioral research that spurs economic growth while advancing medical science. In FY 2014, NIH will focus on investing in today's basic research for tomorrow's breakthroughs, advancing translational sciences, and recruiting and retaining diverse scientific talent and creativity. Investment in NIH also helps drive the biotechnology sector and assure the nation's place as a leader in science and technology.

Alzheimer's Disease Initiatives. The Department continues to implement the National Plan to Address Alzheimer's Disease, as required by the National Alzheimer's Project Act. In FY 2014, the Budget includes a $100 million initiative targeted to expanding research, education, and outreach on Alzheimer's disease, and to improving patient, family, and caregiver support.

Included in this initiative is $80 million within the NIH budget to be devoted to speeding drug development and testing new therapies. Also, the request for the Prevention and Public Health Fund (Prevention Fund) includes $20 million for the Alz-

heimer's Disease Initiative. Of this, ACL will use $15 million to strengthen state and local dementia intervention capabilities and for outreach to inform those who care for individuals with Alzheimer's disease about resources available to help them. HRSA will use the other $5 million to expand efforts to provide training to healthcare providers on Alzheimer's disease and related dementias.

Focusing on Responsible Stewardship of Taxpayer Dollars

Contributing to deficit reduction while maintaining promises to all Americans. The HHS Budget makes the investments the nation needs right now, while reducing the deficit in the long term and ensuring the programs that millions of Americans rely on will be there for generations to come. While it maintains ongoing investments in areas most central to advancing the HHS mission to the Budget reduces support for lower priority areas, reduces duplication, and increases administrative efficiencies. Overall, the FY 2014 Budget includes nearly $2.3 billion in discretionary terminations and budget reductions.

The Affordable Care Act has already helped to slow rising costs through innovations that tackle the underlying health care costs that have been driving Medicare and Medicaid spending. In fiscal year 2012, per beneficiary Medicare spending grew by only 0.4 percent, and total per beneficiary Medicaid spending actually decreased by 1.9 percent. For the first time in a decade, overall health care costs grew more slowly than the economy. We are driving down costs while improving quality for patients by building a smarter system—for example, after decades stuck at 19 percent, avoidable hospital readmissions fell to 17.8 percent in Medicare last year with the help of payment reforms and assistance to hospitals. The Budget invests in programs and policies that enable HHS to build on this work.

Combating fraud, waste, and abuse in health care. The FY 2014 Budget makes cutting fraud, waste, and abuse a top Administration priority. In addition to the base discretionary Health Care Fraud and Abuse Control (HCFAC) funding in FY 2013 and FY 2014, the Budget seeks new mandatory funding to support these efforts. Starting in FY 2015, the Budget proposes that all new HCFAC investments be mandatory spending, consistent with levels in the Budget Control Act. This investment supports initiatives like the Fraud Prevention System and screening for Medicare providers and suppliers to reduce improper payments in Medicare, Medicaid and CHIP; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team initiatives, including the Medicare Strike Force teams and the Fraud Prevention Partnership between the federal government, private insurers, and other key stakeholders.

From 1997 to 2012, HCFAC programs have returned more than $23 billion to the Medicare Trust Funds, and the current three-year return-on-investment of 7.9 to 1 is the highest in the history of the HCFAC program. The Budget's 10-year HCFAC investment yields a conservative estimate of $6.7 billion in Medicare and Medicaid savings.

The Budget includes $389 million in discretionary and mandatory funding for the Office of Inspector General (OIG), an increase of $101 million above the FY 2012 level. This increase will enable OIG to expand CMS Program Integrity efforts for the Health Care Fraud Prevention and Enforcement Action Team and improper payments, and also enhance investigative efforts focused on civil fraud, oversight of grants, and the operation of Affordable Care Act programs.

The Budget also includes $82 million for the Office of Medicare Hearings and Appeals (OMHA), an increase of $10 million from FY 2012, to address OMHA's adjudicatory capacity and staffing levels and maintain quality and accuracy of its decisions. The increase allows OMHA to establish a new field office in the Central time zone supported by additional Administrative Law Judge teams and attorneys, and operational staff.

Thank you for the opportunity to testify. I will be happy to answer any questions you may have.

Chairman KLINE. Thank you, Madam Secretary.

Madam Secretary, it gets very frustrating, of course, for us here as we look for information from the departments—all the departments—of the administration. We asked in the Child Abuse Prevention and Treatment Act—CAPTA—Reauthorization Act of 2010 for your department to conduct three studies on child abuse prevention and treatment activities.

One was examining whether state and local laws and regulations on immunity from prosecution facilitate or deter individuals from cooperating, consulting, or assisting in reporting known instances of child abuse and neglect. The report was due December 2011.

Another one was examining efforts to improve coordination of child abuse and neglect organizations. The report was due December 2011.

Third was examining the effectiveness of reports of programs receiving state grants for child abuse and neglect prevention and treatment. That report was due December 2012.

In July of 2012 Mr. Miller and I sent you a letter asking for an update on the status of the reports. At the time just two of the three were overdue. In August your department responded, stating that it planned to complete them by the end of December 2012, and of course, that hasn't happened.

So some frustration is coming through here, but we put these things in law. We need information, we have responsibilities here to legislate and provide oversight, and we don't get the answers.

I appreciate there was an apology for not complying. When can we expect to get these reports?

Secretary SEBELIUS. Mr. Chairman, you will have the three reports by the end of the month.

Chairman KLINE. Congressional record. We are writing it down. Okay.

Secretary SEBELIUS. June 2013 you will have all three reports.

Chairman KLINE. I got it. And I certainly hope you are not hearing from me on July 1st about that.

Secretary SEBELIUS. Me too.

Chairman KLINE. All right.

Head Start: The first round of the recompetition of Head Start grantees is almost complete. After almost a year of delays the potential grant winners announced this spring will be finalized this summer. I have a couple of questions about that.

The first round of recompetition consists of the lowest-performing grantees. Is that right?

Secretary SEBELIUS. That is correct.

Chairman KLINE. How many of these grantees will receive a new grant?

Secretary SEBELIUS. I can't tell you the exact number, Mr. Chairman, off the top of my head. I know some of the recompeted grants were given back to the original grantees; in some cases they were the only grantees applying.

Chairman KLINE. Well, we have seen some reports that an overwhelming majority of the 125 grantees that compete in the first round will continue to receive federal funding. If these grantees are the lowest-performing grantees, how does that fit in with the rest of the program? If an overwhelming majority of the lowest-performing grantees are going forward I am a little—you can see where I am going——

Secretary SEBELIUS. Sure.

Chairman KLINE. I am a little concerned about how that would play out.

Secretary SEBELIUS. Well, Mr. Chairman, first of all, as you know, the recompetition is a first of its kind effort to make sure

that grants are just not automatically rolled over, which had been the case in the past. I can tell you that in all cases the lowest-performing grantees have a series of steps that they need to continue to take as well as additional oversight visits to make sure that the quality standards are on an improvement plan.

We did have situations where in some cases they were the only re-applicant, and the choice of having the children put out of a Head Start program or working with the existing grantee to improve standards seemed to be a pretty easy question to answer.

I share your concerns that we need to constantly look at the quality and improvement. We do have the authority and we do take that authority to pull grant applications in the case where there are health or safety issues at risk. We will not put a child in a program that is putting that child at risk.

In most of these cases it could be a lack of oversight of financial management; it could be that they haven't raised the standards in a quality way. And we are putting improvement plans and extra visits in place for the recompeting grantees that got the awards back.

Chairman KLINE. Well, I am certainly pleased that we are going to pay attention to health and safety, but that is not the only reason that Head Start exists so I hope that you are going to put in place or have in place a system to make sure that we are not just throwing money down the drain, that these kids are getting the head start that they are supposed to get.

A reminder to my colleagues: While the secretary has unlimited time—and she very graciously limited that time in her comments—we don't. My time is expired. I yield back.

Mr. Miller?

Mr. MILLER. Thank you, Mr. Chairman.

And welcome, Madam Secretary.

I would like to pick up a little bit where the chairman left off. As one of the major proponents of the recompetition of Head Start—and I have got all the arrows in my back to prove that I was there at the beginning—I think this is a very important thing for us to do. And I recognize that in some areas there was nobody to compete, and my understanding is that all of the people who will be awarded Head Start will be on a 5-year timetable, not this idea that you have this program in perpetuity and——

Secretary SEBELIUS. Correct.

Mr. MILLER [continuing]. There are conditions of monitoring going forward.

I will have to say that in my own area—my district—one of our major providers was greatly diminished and a substitute provider was brought in because of the issues that were raised, and I think it was the right thing to do. I don't think—and I think that Head Start got a little of itself—that somehow it was the only premier program and they were entitled to just continue to run forever, and I think this competition will turn out to be a beneficial thing for the kids and the program and for the taxpayers.

I would like to go back a little bit to this argument that somehow Head Start doesn't make any difference. What we have known all along in the area of early childhood education and child care is that good child care, good early childhood education is good for the chil-

dren; bad child care, bad early childhood education is not good for you at all.

And then there is the question of when you leave a high-quality program that you may have in many areas where you have poor schools and you take that child and you put them into a poor school, yes, you start to lose some of the benefits of child care. We know that in even transferring between schools; we know that in the summer session.

One of the things we worry about is kids in poor schools, low-income schools, lose much of what they acquired during the year during the summer session. There is a problem of support systems. But the idea that somehow all of a sudden that this doesn't make any difference when it flies in the face of the evidence, and we are not just talking about the Ypsilanti study; we are talking about recent evidence that suggests, in fact, it makes a difference.

The other thing I always find interesting is, you know, you kind of what to know, what are the rich folks doing. Well, in conversations I have with a lot of people of good wealth and even upper middle-income people and middle-income people who struggle with this question, but others who don't struggle as much and can answer it and pay for it, they are looking for the very best early childhood education they can find.

We see almost a scandal on Wall Street: People are trading inside information to try to get into a preschool program because it is considered to be the best in the development. I don't suggest that that is the way they do it, but the fact is they know what this means in terms of the acquisition of the skills necessary to succeed in school, and studies tell us what it means in terms of the acquisition of skills to survive in the American economy and to thrive and to go forward.

And so this idea that some—it is sort of like there is now kicking around the idea that college really isn't worth it anymore. Oh, yes it is. Oh, yes it is.

And the fact of the matter is, whether it is dealing with unemployment or it is dealing with earnings over lifetime, it is worth it. And I just worry that we are building up this sort of rhetoric about somehow this really isn't worth it.

High-quality programs are clearly worth it and clearly pay a benefit, but you have to sustain them. If you are going to dump them into a school where you have ill-prepared teachers and no support systems then you are going to have a problem and you are going to fritter away your investment.

This home visitation is strongly supported by district attorneys all over the country, by law enforcement all over the country. All of these early childhood efforts are strongly supported because of what we see in terms of the outcomes.

But if you are going to cheat on quality, if you are going to cut the Title I schools that these children are going into, which we are doing under sequestration, don't look for great results in those neighborhoods or those schools. And I just want to put that point on the record because I think we are getting way off track here in terms of what benefits children.

If you would like to have a second to respond you are more than welcome to, or whatever the yellow light——

Secretary SEBELIUS. Well, Mr. Miller, I certainly agree that even though there are some indication that in some instances benefits of Head Start may fade in first grade or third grade, it is once they have left the Head Start. There is absolutely unequivocal evidence that Head Start makes a huge difference in school readiness, in catching kids up to their peers, in making sure that they are able to enter school ready to learn.

And there is a lot of evidence that over time many of the payoffs are actually at 18 and 20 and 25, that early childhood education is one of the single most positive indicators of less drug abuse, less prison time, higher graduation rates, higher job acquisition—things that don't show up in the third grade but actually follow a child through his or her life. And so I think there is a lot of evidence that these are enormously important investments, particularly for children who don't have those benefits in their home setting.

Chairman KLINE. Gentleman's time has expired.

Dr. Price?

Mr. PRICE. Thank you, Mr. Chairman.

And I want to welcome you, Madam Secretary, to the Education and Workforce Committee. As a physician I like to try to focus on patients, as you well know. I want to focus on one specific patient. Occasionally we have the opportunity to truly affect in a singular and specific way somebody's life and, Madam Secretary, I would suggest that you have that opportunity with Sarah Murnaghan.

Sarah Murnaghan, as you know, is a 10-year-old young lady in Pennsylvania who has cystic fibrosis. The physicians and scientists have all agreed that if she does not receive a lung transplant within weeks, she will die. Doctors all agree that it is indicated.

The reason she is unable to receive that right now is because of an arbitrary rule that says if you are not 12 years old you aren't eligible to receive an adolescent or an adult lung.

Madam Secretary, under Section 121.4(d) you have the opportunity. It says, "Unless the secretary directs otherwise based on possible risk to the health of patients or public safety." Madam Secretary, I would urge you this week to allow that lung transplant to move forward.

Secretary SEBELIUS. Well, Dr. Price, I appreciate your input. First, as a mother and a grandmother I can't imagine anything more agonizing than what the Murnaghans are going through, and I talked to Janet Murnaghan, the mother of Sarah, about this case. What I have also done is look very carefully at the history of the rules around lung transplant and organ transplant——

Mr. PRICE. With all due respect, Madam Secretary, it simply——

Secretary SEBELIUS. Dr. Price——

Mr. PRICE. I am going to reclaim my time. It simply takes your signature. It simply takes your signature.

A study I know you have ordered and I appreciate that, but a study will take over a year. This young lady will be dead.

I want to move on to a concern that many——

Secretary SEBELIUS. Others will——

Mr. PRICE. Madam Secretary, I want to move on to a concern that many folks across this country have about this administration and about the things that are being done outside the norm and certainly some believe outside legal limits. The Washington Post and

the New York Times reported last month that you were soliciting funds from the health industry officials to support the implementation and enrollment in the Affordable Care Act. Is that true?

Secretary SEBELIUS. No, sir. That is not true.

Mr. PRICE. So you didn't communicate—have any discussions with folks at the Robert Wood Johnson Foundation or H&R Block about donating——

Secretary SEBELIUS. You asked me if I solicited funds from anyone in the health industry and I said no, that is not true.

Mr. PRICE. Did you have any discussions or conversations with anyone about providing resources to anybody about enrollment or implementation of ACA?

Secretary SEBELIUS. Sir, I have had conversations with people all across this country including insurance companies, pharmaceutical companies, and others using the statutory authority that is clearly given to the secretary of health in the Public Health Service Act and has been used by my predecessors, Republican and Democratic, for every health innovation that has gone on. Secretary Thompson and Leavitt made public-private partnership outreach efforts to make sure Medicare Part D enrollment went well——

Mr. PRICE. So you did ask individuals to assist in providing contributions for the implementation and enrollment of the ACA?

Secretary SEBELIUS. I have made two calls involving funding with——

Mr. PRICE. To whom?

Secretary SEBELIUS. To Robert Wood Johnson and H&R Block, neither of whom are under the regulatory authority of our office. But I would suggest that the Public Health Service Act does not limit my authority to entities that are not regulated. I chose to do that——

Mr. PRICE. What did you request of Robert Wood Johnson Foundation and H&R Block?

Secretary SEBELIUS. I talked to them both about how important this outreach effort was going to be and the fact that always we anticipated having public-private partnerships on the ground, as has been done in CHIP enrollment and it Medicare Part D enrollment——

Mr. PRICE. Did you ask them to provide any resources?

Secretary SEBELIUS [continuing]. And that they consider——

Mr. PRICE. Madam Secretary?

Secretary SEBELIUS [continuing]. Making contributions to our partner in Enroll America, which is a private, not-for-profit, nonpartisan organization incorporated in 2012 under the umbrella of——

Mr. PRICE. Did you ask them to provide resources——

Secretary SEBELIUS [continuing]. Families USA.

Mr. PRICE. Did you ask them to provide resources for any other group at all?

Secretary SEBELIUS. I did not, because at that point I did not know that there were other groups soliciting funds. I talked to them specifically about Enroll America.

Mr. PRICE. Did you have any conversation with employees or representatives or designees of the pharmaceutical industry?

Secretary SEBELIUS. Pardon me?

Mr. PRICE. Have any conversations with employees or representatives or designees of the pharmaceutical industry to contribute resources to Enroll America?

Secretary SEBELIUS. Those are the only two conversations I have had about contributing resources to Enroll America. I have certainly promoted the partnership roll that Enroll America will play in an operation on the ground, much similar to—I would suggest that you look at the ABC—the coalition that was put together for Medicare Part D that Secretary Thompson and Secretary Leavitt avidly supported and traveled around with and suggested that they were very important public-private partners. It is the same kind of effort.

We are also talking to businesses and pharmaceutical companies and hospitals and insurers and faith groups about using whatever resources they have to help fulfill what I consider to be an incredible opportunity for up to 30 million Americans to have affordable, available health——

Mr. PRICE. Did you direct any of those other entities to Enroll America?

Chairman KLINE. The gentleman's time has expired.

Mr. Andrews?

Mr. ANDREWS. Secretary Sebelius, I want to talk a little bit more about the Medicare Part D enrollment process the Bush administration used.

In 2003 the Congress passed, the President signed extension of drug benefits for seniors under Medicare. It is my understanding that your predecessor, Secretary Thompson, actively solicited contributions from groups that would be used to encourage Americans to sign up in Medicare Part D. Is that correct?

Secretary SEBELIUS. That is my understanding, yes. The Access to Benefits Coalition was the major on-the-ground partner that both Secretary and——

Mr. ANDREWS. And the coalition consisted of organizations outside the federal government, private, nonprofit, and otherwise?

Secretary SEBELIUS. Absolutely. And those partnerships have been traditionally part of what public health—we have the—through the Centers for Disease Control and Prevention solicit assistance from pharmaceutical companies in——

Mr. ANDREWS. So you are doing——

Secretary SEBELIUS [continuing]. Global and national health issues. We——

Mr. ANDREWS. So you and perhaps others under your supervision are doing exactly what Secretary Thompson did for Medicare Part D, it is my understanding.

Secretary SEBELIUS. Well, that is correct, sir. And the, I think, secretary of health has very specific statutory authority that has existed since 1976 in the Public Health Service Act.

Mr. ANDREWS. I was here in 2003 when that passed and 2004 and 2005 was implemented. I can't remember one word from anyone on either side of this committee or any other committee questioning the propriety of that activity. I think your present activity is entirely proper and desirable.

I would hope that you would—the accusation would turn out to be true. I hope the accusation that you are using every legal re-

source at your disposal to get health care for Americans who need it is something you are doing. Matter of fact, if you are not doing that I would take you to task. I think you are doing the right thing.

The tragedy for the Murnaghan family is heartbreaking on every level, and I know you wanted to say more about that before you were cut off a few minutes ago. If you would like to add to your answer on that I would give you this opportunity.

Secretary SEBELIUS. Well, Congressman, what I was just going to say is I can't imagine anything more difficult. We have far too few donors and far too many desperately ill people. That is the national snapshot. That is true in the pediatric arena and it is true in the adults arena.

Unfortunately, there are about 40 very seriously ill Pennsylvanians over the age of 12 also waiting for a lung transplant, and three other children in the Philadelphia hospital at the same acuity rate as Sarah waiting for a lung transplant. The decisions of the OPTN, the transplant committee, which is not bureaucrats, it is transplant surgeons and health care providers who design the protocol, are based on their best medical judgment of the most appropriate way to decide allocation in an impossibly difficult situation.

So I have asked them to review the process, yes. That is true. I know that that may take some time because it requires public comment and it requires review. I would suggest that the rules that are in place and reviewed on a regular basis are there because the worst of all worlds in my mind is to have some individual pick and choose who lives and who dies. I think you want a process where it is guided by medical science and medical experts.

Mr. PRICE. Will the gentleman yield?

Mr. ANDREWS. I will not. I will not. You did not give the witness a chance to answer; I will not yield to you.

Mr. PRICE. Thank you, sir.

Mr. ANDREWS. Well, I think that you live by the rules that you just created here.

When the Affordable Health Care was enacted we have heard and we have heard since then there would be huge, skyrocketing health insurance premiums that would affect millions and millions of people. Last week California unveiled the initial estimates of what premiums would be under the new health insurance law. What did the result of California show us?

Secretary SEBELIUS. Well, the California preliminary results, and that is before the rates—the final rates—are negotiated, is not only will they have a very competitive market throughout the state where people will have lots of choices, but they are looking at the possibility of fairly significant rate decreases—up to 25 percent in some instances—and I think the highest rate increase that was originally filed was in the 4 to 5 percent level. So you are looking at both a competitive market and some preliminary rate reviews that look very positive.

Mr. ANDREWS. In Maryland, when they released the list of insurers bidding for the right to insure exchange enrollees, did we have more or fewer bidders than expected?

Secretary SEBELIUS. Actually, we have more bidders, which again is good news. I am a believer that markets work, but markets need to be transparent and there needs to be some competition. And

what we are seeing is that opening up these new markets for, again, individuals who were shopping in the individual market where they often had very few choices and small business owners are producing much more robust competition. New insurers are entering the market in various states across the country.

Mr. ANDREWS. Thank you.

I appreciate the time.

Chairman KLINE. Gentleman's time has expired.

Mr. Gowdy?

Mr. GOWDY. Thank you, Mr. Chairman.

Good morning, Madam Secretary. I want to pick back up where Dr. Price was.

You testified—conceded that you made at least two solicitations of donations to Enroll America. Did I hear that correctly?

Secretary SEBELIUS. Yes, sir. At their request I made two phone calls, yes.

Mr. GOWDY. All right. And was there a specific dollar amount that you solicited?

Secretary SEBELIUS. No.

Mr. GOWDY. Did you discuss these solicitations with anyone that works for Enroll America before or after you made the phone calls?

Secretary SEBELIUS. Yes.

Mr. GOWDY. Who?

Secretary SEBELIUS. I had a discussion with Anne Filipic, who is the director-President of Enroll America.

Mr. GOWDY. Was there a specific dollar amount that you solicited?

Secretary SEBELIUS. You just asked me that question and I said no.

Mr. GOWDY. Okay. I just wanted to make sure the answer was the same.

Was Enroll America the only entity you solicited funds for?

Secretary SEBELIUS. Yes, sir.

Mr. GOWDY. To the best of your knowledge, has anyone on your staff or anyone employed by HHS solicited funds on behalf of Enroll America or any other entity?

Secretary SEBELIUS. I really can't answer that question. I don't know that.

Again, there were a very small handful of calls that I made at the request and two involved actual fundraising solicitations—exactly what my predecessors have done, exactly the kind of public-private partnership that we have always anticipated would happen, driving funds not to HHS—I am not raising money——

Mr. GOWDY. Who were the other——

Secretary SEBELIUS [continuing]. For HHS; I am raising it for enrollment and outreach activities so Americans can connect with the benefits——

Mr. GOWDY. Who were the other phone calls to, Madam Secretary? You said you made——

Secretary SEBELIUS. Pardon me?

Mr. GOWDY. Who were the other phone calls to? You said you made other phone calls.

Secretary SEBELIUS. I made a total of 5 phone calls——

Mr. GOWDY. Okay.

Secretary SEBELIUS [continuing]. For Enroll America, and three of them were to discuss the organization and suggest that the entities look at the organization—to Johnson & Johnson, to Ascension health, and to Kaiser.

Mr. GOWDY. Are any of those groups regulated by your department?

Secretary SEBELIUS. Yes. All of them are.

Mr. GOWDY. So if health care officials say they felt pressured to make donations to Enroll America your response would be what, that they are just too easily pressured or that they misunderstood the conversation?

Secretary SEBELIUS. Well, I can't answer what they felt. I can tell you that I felt that the conversations that I had, as I have said in the past, I made fundraising solicitations to two groups who are not regulated; I did not discuss funding with the other three entities. I did discuss Enroll America.

And I would tell you that the statutory authority, Section 1704 in the Public Health Service Act, would not make that distinction. I could solicit—legally solicit funds from anybody regulated by our office. I chose not to do that, but promoting a public-private partnership, you bet.

Mr. GOWDY. What specific code section are you relying on?

Secretary SEBELIUS. Section 1704 of the Public Health Service Act, which has been in place since 1976.

Mr. GOWDY. Is there a legal opinion that you relied upon? Is there someone that——

Secretary SEBELIUS. Yes. My general counsel's opinion and the precedent of former secretaries. I mean, this is not something we are inventing——

Mr. GOWDY. Well, sometimes precedent is accurate and sometimes it is not. Would you be willing to make that legal opinion available to the committee?

Secretary SEBELIUS. Well, I will be able to, yes, make whatever memos are available.

Mr. GOWDY. You would make that available to us?

Secretary SEBELIUS. Yes, sir.

Mr. GOWDY. Okay.

Secretary SEBELIUS. And I will also give you the precedent that Secretary Thompson followed, that Secretary Leavitt followed, that was followed during the Clinton administration for the CHIP program. I am happy to make all of that history available to you.

Mr. GOWDY. So if there are published reports that you solicited funds from health care companies those would be inaccurate?

Secretary SEBELIUS. That is correct.

Mr. GOWDY. And if there are published reports that you solicited funds from pharmaceutical companies those would be inaccurate?

Secretary SEBELIUS. That is correct.

Mr. GOWDY. You solicited no funds from any entity that is regulated by HHS?

Secretary SEBELIUS. That is correct.

Mr. GOWDY. Whose idea was it to solicit the funds?

Secretary SEBELIUS. I would say it was a joint idea.

Mr. GOWDY. Joint among whom?

Secretary SEBELIUS. Well, in the discussions that I had with colleagues and entities interested in actually fully implementing the health care act, it was always recognized from the day the President signed the bill that there would never be enough government funding and that there would not be enough opportunity if this is only a government-run program, so we began 3 years ago——

Mr. GOWDY. I am looking for——

Secretary SEBELIUS [continuing]. To reach out for partners—business partners, health care providers——

Mr. GOWDY. I am looking for who the "we"——

Secretary SEBELIUS [continuing]. Hospitals, health insurers——

Mr. GOWDY. I am looking for a name.

Secretary SEBELIUS [continuing]. Advocacy groups, disease groups, and——

Mr. GOWDY. Can I get a name? I am looking for a name. When you said "we," who is "we"? Did you ever discuss it with anyone at the White House?

Secretary SEBELIUS. I have had discussions with people—about Enroll America, did I discuss with the White House——

Mr. GOWDY. The solicitation of funds to Enroll America?

Secretary SEBELIUS. No, sir.

Mr. GOWDY. Never discussed it with anyone at the White House?

Secretary SEBELIUS. No, sir.

Mr. GOWDY. Mr. Chairman, I am going to yield the remainder of my time to Dr. Price in case he has a follow-up question with respect to——

Chairman KLINE. Unfortunately, the gentleman's time has expired.

Mr. Holt?

Mr. HOLT. Thank you, Madam Secretary, for coming.

I would like to turn to the Older Americans Act. With 10,000 Americans reaching retirement every day and longer longevity, complexity grows in the care. And beginning in fiscal year 2012, Congress failed to fund Title IV of the Older Americans Act, what is known as the research and development arm that looks at education and training and improved access for seniors into various kinds of services, new approaches for coordinating programs and providing aging-in-place opportunities.

The community innovations for aging in place essentially was shut down. It had been funded at a few million dollars. It seems to me the need is much greater than a few million dollars. There were 14 demonstration projects across the country; there could easily have been hundreds of high-quality projects across the country, but now it is zero.

Do you see any justification for the defunding of this, and do you see any other alternative for funding these programs that would allow Americans to age in place with the services that they need?

Secretary SEBELIUS. Well, Congressman, as you know, in the last couple of years we have actually created a new administrative entity, the Administration for Community Living, which seeks to address exactly what you are talking about—not only aging in place for seniors but a fully prosperous and engaged life for those Americans with disabilities. Because often the services needed at the local level are the same: transportation, additional home health

care, supportive housing in some instances, to allow people to live to the fullest extent as independently as possible.

So one of the issues before this committee, for the first time our budget reflects the ACL structure, and what we have been trying to do is identify ways that those assets can be leveraged both from the disability programs that we are running and for the aging programs to build that robust network of services on the ground. In some cases I think some of the individual programs may have been unfunded because there was a larger stream of money running to that same service and program. I am not sure I can answer with the specificity you are——

Mr. HOLT. Well, let me just say, I hope you will work with us to——

Secretary SEBELIUS. Sure.

Mr. HOLT [continuing]. Find ways to fund these really very valuable programs that will become more and more valuable as people age.

Let me turn to the Affordable Care Act. Much has been said about the programs of the Affordable Care Act. Actually, most has been said about imaginary programs of the Affordable Care Act. There is a lot of misinformation and even disinformation.

But one thing we do know that has already taken effect are provisions of the Affordable Care Act affecting Medicare. Can you say what those provisions—what the record is now about those provisions that affect seniors on Medicare? What does it say about the long-term financial stability of the program? What did we learn about the quality of delivered care? What did we learn about the cost of that care as modified by the Affordable Care Act?

Secretary SEBELIUS. Well, in spite of the oft repeated accusations that somehow the Affordable Care Act was going to destroy Medicare, we, I think, have a very positive record of achievements in the last 3 years.

Millions of seniors are benefiting from preventive health benefits with no copays. Millions of seniors are achieving discounts in their prescription drug plans—now a 50 percent discount for the Part D brand name drugs if they fell into the so-called donut hole in the past. Millions have taken advantage of the wellness screening, which is now part of the overall Medicare beneficial program.

In addition to that, what we know is that health costs are down at the lowest level in the 51 years since Medicare has been created. In fact, the four-tenths of 1 percent increase per beneficiary this year is historically low; 3.9 percent overall growth is historically low. And that is done with additional benefits.

We were able, at the trustees meeting last week, to announce that 2 additional years had been added to the Medicare Trust Fund. The original passage of the Affordable Care Act added additional solvency years, but the trend in the last 3 years has added additional time, which is all very——

Mr. HOLT. Well, thank you.

Chairman KLINE. The gentleman's——

Mr. HOLT. Our time is expired but that is quite a notable factual——

Chairman KLINE. The gentleman's time has expired.

I have got an unwelcome administrative announcement. I am looking at the list of members who want to ask 5-minute questions. The secretary has a hard stop time at 12. I have got at least 2 hours worth of questions here, so we are going to—I am going to limit the members' time to 3 minutes. I will not be inclined to support the "ask the question at 2 minutes and 59 seconds and then give the secretary another 3 minutes."

Madam Secretary, if you could help us just a little bit by abbreviating your answers.

And with that, Mr. Wilson, you are recognized for 3 minutes?

Mr. WILSON OF SOUTH CAROLINA. Thank you, Mr. Chairman.

And, Madam Secretary, thank you for being here today.

The National Federation of Independent Business, NFIB, Research Foundation recently released a study on the impact of the new health insurance tax created by the health care law. The law created a new tax on health insurance policies that most small businesses purchase. It is structured as a fee on insurers but it is expected to be passed onto consumers.

This new tax will increase the cost of insurance for small businesses and their employees. The NFIB study indicates this tax will result in a reduction in private sector employment of 262,000 jobs. Do you believe increasing the cost of health insurance by taxing the policies that small businesses purchase make it more or less likely a small business will offer insurance to their employees?

Secretary SEBELIUS. Well, the tax helps to support setting up some new markets which will be hugely beneficial to small business owners, including the shop option, which will exist in every state in the country. Small business owners currently pay 18 to 20 percent more for their health coverage and I think that the tax to insurers who will have millions of new customers is an appropriate way to help set up these new market options.

Mr. WILSON OF SOUTH CAROLINA. But the net result will be a reduction in private sector jobs.

Secretary SEBELIUS. I haven't seen the NFIB study and I have no idea how they are—because the tax isn't even in place yet so I have no idea what they are extrapolating.

Mr. WILSON OF SOUTH CAROLINA. And as America's largest association of small businesses it has extraordinary credibility.

Secretary SEBELIUS. As you know, they also sued to strike down the law and that was not successful, so they haven't been huge fans from the outset.

Mr. WILSON OF SOUTH CAROLINA. And I am so grateful for their courage.

Next we have the costs associated with the regulatory compliance are particularly high for small businesses since they may not have a department to handle benefit issues. Are you considering any transition period or relief for employers who are acting in good faith to comply with the law but simply are unable to comply with the reporting requirements and regulations of the health care law, given the lack of instruction from the administration?

Secretary SEBELIUS. Well again, sir, we are trying to be as flexible as possible within our administrative authority. I would be happy to take a look at what specifically the complaints are. They

are not filing anything now so I am not quite sure what they are anticipating being burdensome but we will sure take a look at it.

Mr. WILSON OF SOUTH CAROLINA. Well, I think that it would be great to consider a waiver for small businesses, and I appreciate your positive response to that inquiry.

Secretary SEBELIUS. Well, I don't know what they want a waiver from; if it is a waiver from the law that is not within our administrative authority.

Mr. WILSON OF SOUTH CAROLINA. And it may not be a waiver, but it is certainly, during the transition period, a level of relief so that small businesses who do not have compliance offices can not be subject to penalty so that they can continue to conduct their business.

Chairman KLINE. The gentleman's time has expired.

Mr. Grijalva?

Mr. GRIJALVA. Thank you, Mr. Chairman.

And, Madam Secretary, thank you very much. I do appreciate the efforts to partner with community allies in promoting understanding and enrollment in the health plans, and also because all we see, at least in the community, is the private carriers promoting their specific product. I think there is a need for unbiased, general information that the public can understand, and I applaud you for that effort.

The Supreme Court decision reinforced the ability of ACA to move forward with the exception of the state Medicaid expansion; that made that optional for states. Some individuals decided the federal deficit is a reason not to accept Medicaid expansion.

Madam Secretary, can you talk to us a bit about the impact of states choosing not to expand and what would that do to the federal deficit?

Secretary SEBELIUS. Well, I think that the fear that at least has been cited was somehow that either the Congress would renege on the funding arrangement or that expanding Medicaid would add to the federal deficit, and first of all, the Medicaid expansion was contained in the funding for the Affordable Care Act, and as you know, at the end of the day the Congressional Budget Office indicated that passing the Affordable Care Act reduced the deficit by $100 billion over the first 10 years and projected an additional reduction of $1 trillion over the next 10 years. So passing the act that was fully funded actually reduced the deficit.

We do have a new RAND study that came out, I think in the last 2 days, that looked at the fiscal impact of 14 states who may choose not to expand Medicaid found that the states themselves would be bypassing about $8.4 billion of federal funding and incurring about $1 billion a year in uncompensated health care costs, so I think the return on investment analysis that has been done in states across the country indicates that Medicaid expansion is not only good for potential beneficiaries but could be very financially beneficial for states.

Mr. GRIJALVA. Thank you.

Yield back.

Chairman KLINE. Gentleman yields back.

Dr. Foxx?

Ms. FOXX. Thank you, Mr. Chairman.

Thank you, Secretary Sebelius, for being with us today.

I want to do one quick follow up on the questions that my colleagues asked earlier on Enroll America: You keep saying that the Robert Wood Johnson and H&R Block are not regulated by HHS. Are you saying they have no interest in the decisions you make as secretary?

Secretary SEBELIUS. Oh, I am sure that virtually everyone has decisions that we make as secretary. They don't have any products or entities that come under our jurisdiction.

But again, Ms. Foxx, I want to make it very clear that this is not a statutory line; this was a chosen line that I made. I have promoted and discussed outreach and education activities not only around partnership with Enroll America but with dozens of organizations for a very long time. I made two specific fundraising calls.

Ms. FOXX. Okay. H&R Block is a tax preparation company. Isn't it true the tax credits available under the law go directly from the government to the insurance company? Is that correct?

Secretary SEBELIUS. No. They would credit to the individual, not to the insurance company.

Ms. FOXX. Okay.

Secretary SEBELIUS. An individual would qualify based on his or her income for an accelerated tax credit to purchase health insurance.

Ms. FOXX. Now I would like to switch and ask this question, Madam Secretary——

Secretary SEBELIUS. Oh, I apologize. They do accrue to the individual but they go to the chosen plan. I am sorry. It goes, then, to pay for the coverage.

Ms. FOXX. In July 2012 HHS issued an information memorandum to states inviting them to apply for waivers to the work requirements under the Temporary Assistance for Needy Families, or TANF. At the time HHS claimed it was responding to requests from states that wanted more flexibility, but to my knowledge no states have applied for the waivers.

Recently it is been revealed that in late 2009, 2-1/2 years earlier, senior officials at HHS had requested a legal opinion to a series of questions they put forth on how much authority the department had in terms of waiving certain requirements even though governors didn't ask for these provisions. It seems that the department has had a plan to gut the welfare reform law from the beginning.

Considering that there seems to be little or no support from states for your memorandum, shouldn't the administration withdraw it and work with Congress to reauthorize TANF?

Secretary SEBELIUS. Well, Congresswoman, the discussions among governors—and I was one and had these discussions about the rules around TANF—have gone on for a very long time, during the Bush administration and certainly into this administration—a lot of reporting requirements that didn't seem to add jobs. What we learned during the Recovery Act was that states actually had very innovative programs that could put people to work when we could give them some flexibility around the use of their funds, so we did have conversations based on input from Republican and Democratic governors about what might be the authority that we had, not to waive work requirements, frankly, but to waive some of the

reporting requirements that directed people to spend a lot of time counting boxes and not putting people to work.

Chairman KLINE. The gentlelady's time has expired.

Mr. Courtney?

Mr. COURTNEY. Thank you, Mr. Chairman.

Madam Secretary, going back to the small business colloquy a few minutes ago, actually something that is about to also happen in January is that the small business tax credit is actually going to get bigger, isn't that correct?

Secretary SEBELIUS. That is correct.

Mr. COURTNEY. And it is for firms 25 or less and it is up to 50 percent of the——

Secretary SEBELIUS. That is correct.

Mr. COURTNEY [continuing]. Cost of the premium. And as a former small employer, I mean, that is nothing to sneeze at, and unfortunately, isn't included in some of these analyses that are getting thrown around out there.

The trustees report which just came out a few days ago, which again, was a very powerful document in my opinion in terms of the positive trend lines, and particularly in terms of the Medicare health spending rates that are out there—again, it explicitly identified the Medicare advantage program costs that are coming in lower than were projected, isn't that correct?

Secretary SEBELIUS. That is correct, and that is directly part of the structure of the Affordable Care Act.

Mr. COURTNEY. And enrollment has gone up, I mean, despite all the——

Secretary SEBELIUS. Enrollment has gone up, rates have gone down, and so beneficiaries also are—not just the Medicare program, which pays the government side of the puzzle, but beneficiaries themselves who pay a copay are paying less out of pocket.

Mr. COURTNEY. And again, it seemed like the trustees were being kind of careful not to overreach, in terms of ascribing too much to the ACA, but as you point out, I mean, between the preventive behavior that is now, I think, infusing through the system, the ACO incentives that are out there that promote collaboration, the hospital readmission incentives—I mean, the fact is is that there is real change going on out there in delivery reform.

Secretary SEBELIUS. Well, I think the first year or two people were very cautious about how to attribute that change and a lot of it was seen as potentially just a part of the recession. We have had four or 5 recent health economists—not connected with HHS in any way, but health economists—who say while a portion of the downturn in health spending—Medicare, Medicaid, and private sector health spending are all down—can be attributed to the recession, they think the large part is that there is an enormous change underway as part of the delivery system, led by the fact that for the first time Medicare is beginning to move away from the fee-for-service payment and into more of a quality outcome payment, into accountable care organizations, into preventing hospital readmissions, preventing hospital infections, and those are all having a very positive effect on health spending.

Mr. COURTNEY. And in fact, they have calculated almost $700 billion in unexpected savings if you go back in time to 2010 in terms

of—I mean, if anyone had predicted that at the time the President signed it into law they would have called you a raving lunatic, but the fact is is that it has consistently surpassed——

Secretary SEBELIUS. I have been called worse.

Mr. COURTNEY. Well, and I know you didn't—you know, you were not being that reckless to try and sort of claim that, but the fact is is that it is surpassed all the expectations, and the fact is if we can continue to, you know, nurture that sort of change in the fee-for-service there is more money on the table there for the program without butchering benefits.

Secretary SEBELIUS. Well, I think one of the big differences is to move Medicare, which has a huge—you know, 51 million beneficiaries, has contracts with every doctor, every hospital, every drug company, every medical device company, to begin to move Medicare from a fee-for-service, the more you do the more you get paid, into really a quality provider begins to really transform the market.

Chairman KLINE. The gentleman's time has expired.

Dr. Roe?

Mr. ROE. Thank the chairman.

Thank you, Madam Secretary.

A couple things that we totally agree on is the cost is the biggest issue, I think, in health care. If we could lower the cost more people would have access. I think there is no question about that, and that has been a concern of mine through my career as a physician and one of the reasons I ran for Congress.

I chair the Subcommittee on Health, Employment, Labor, and Pensions, so we look at individual markets and small group markets, and our state insurance commissioner in Tennessee—I spoke with her 2 weeks ago and then reconfirmed these numbers: The small group market in Tennessee will see an average increase of 50 to 55 percent and the individual market, depending on your age and gender, will be 45 to 70 percent increase. And I asked how many plans we had from mountains to Memphis now in our state and we have about eight plans that individuals and small groups can go to; and we will have, after the first of the year, two and maybe one plan.

So that didn't expand the number of options. And one of the reasons our governor, Governor Haslam, in Tennessee, didn't expand Medicaid in the state and didn't—and chose not to expand the exchange was because he couldn't get answers from HHS so that he felt comfortable in doing this because we have had a 20-year history of health care reform—it is called TennCare in our state—hasn't worked out all that well.

So when we held a subcommittee hearing couple of—well, I guess a month or so ago, I am going to submit some questions that I got there from the businesses, if you don't mind, so we won't take the time. But one of them was Mr. Silver, who said: I would like to challenge the secretary to make a good program, to implement changes that would not have a negative impact they have now. It is beyond belief how complex—needlessly and how complex this program has become, and that is my question.

I think what he is saying as a businessman—I will give you another example: Mr. Horn has a business over there at 350 employ-

ees. He is self-insured. He provides total preventative services. If you need a mammogram, whatever, he pays for it all.

Guess what he gets for this? He gets a $63 per person fee to—that is charged to him plus an increase in his taxes. He did everything right in his business—in the textile business, which is a tough business. So how do you answer his question? What do you say to Mr. Horn?

Secretary SEBELIUS. And his question is, "Why do I pay this"——

Mr. ROE. He is paying for everything—preventive. He has got the gold plan and yet what he gets are increased taxes and increased costs to his business.

Secretary SEBELIUS. Well I think that the way that the law is put together there are fees and taxes that pay for the program to move ahead. I think in the long run——

Mr. ROE. How do you answer him? He is a guy doing everything right.

Secretary SEBELIUS. He also is paying a hidden tax, I would say, at this point, because his hospital rates are higher——

Mr. ROE [continuing]. Isn't hidden. I can tell you that. It is out there for him; he has got to write a check for it.

Secretary SEBELIUS. I understand.

Mr. ROE. One other question I have got——

Chairman KLINE. The gentleman's time has expired.

Ms. Bonamici?

Ms. BONAMICI. Thank you very much, Mr. Chairman.

Thank you, Madam Secretary.

This is the Education and Workforce Committee where we all share the goal of student success in our nation's public schools. I frequently hear comparisons of our students with students in countries like Finland, for example, but they have a near absence of poverty in Finland. So I want to recognize the importance in the fical year 2014 budget of the anti-poverty programs and policies—not only expansion of health care but also LIHEAP and TANF, so thank you for that.

I have two questions. I will ask them together.

First, I am from Oregon, where we are ahead of the curve in implementation of the Affordable Care Act, and just last month when our proposed health premiums for plans went public on the exchange, after seeing their competitors' proposals two insurers actually requested to lower their rates. So my first question is, how can we ensure that other state exchanges and the federal exchange sufficiently foster this type of competition to make health care more affordable?

The second question is about sequestration. My district is very concerned about how sequestration is affecting medical research. Oregon Health Sciences University, for example, where they are making groundbreaking advances, is concerned because you can't put research on hold and the cuts are going to be affecting the junior researchers, which are exactly the type of workforce we need to be training.

So the second question is, how do HHS and NIH plan to continue making research progress and how will sequestration impact medical research?

Secretary SEBELIUS. Well, in terms of the competition in the market, Oregon is not only doing some great things now but has been for years, and we are trying to use your doctor governor's expertise to actually talk to a lot of colleagues across the country about what sorts of things can be done to improve the quality of care and lower costs because Oregon is proving that. And what we are seeing in these early marketplace entrants is some very positive signs about competition—new plans entering the market in states across the country and opening up what was a monopoly to competition for the first time, so I think that is going on and creating a market in many cases.

In terms of the research question and sequestration, you are absolutely right. Sequestration is a blunt instrument that slashed about $15.5 billion from the HHS budget and a big hit was taken by NIH, who is our second-biggest agency.

That will have a very significant impact on new grants going out the door. They don't have the money; they will not be able to accelerate the kind of scientific cures that are possible and have those grants, which actually return about $7 to every dollar put out is the return on investment.

So it is a program that, at the time that we should be making increased scientific investments, that took a cut through sequestration that really can't be made up.

Chairman KLINE. Gentlelady's time has expired.

Mr. Walberg?

Mr. WALBERG. Thank you, Mr. Chairman.

Madam Secretary, as you are probably aware, yesterday the IRS published a final regulation on the shared responsibility payment for not maintaining minimum essential coverage, where they estimated that $20,000 would be the cost for yearly premium for a family of four or five that want to purchase the cheapest, or the bronze, type plan. Is the IRS totally off base with that $20,000 figure as the cheapest possible plan that a family of four or five could purchase?

Secretary SEBELIUS. Sir, I haven't seen the IRS estimates, and as you know, we don't have any final rates. What I am seeing is some very positive rate information that compares favorably to what is available right now but I can't respond. I would be happy to in writing but I don't—I haven't seen the IRS report.

Mr. WALBERG. So you can't confirm to me that there would be cheaper plans available than $20,000?

Secretary SEBELIUS. Well, I know there are cheaper plans available depending on the circumstances and how high the deductible is but I can't give you exact amounts because the rates aren't set. So anyone who is telling you this is the final rates is just not accurate.

Mr. WALBERG. Well, of course the IRS may have done this after a line dance, but they certainly have some responsibility of determining what estimates at the very least these costs will be——

Secretary SEBELIUS. As I say, I would be happy to look at what they gave you and respond to it. I can't do that off the top of my head.

Mr. WALBERG. I would appreciate that——

Secretary SEBELIUS. Every state is also going to be a little different, so I have no idea what they are capturing.

Mr. WALBERG. Let me go on. And I will look forward to that response on it because definitely the IRS is intimately involved with the cost factor and what they will be assessing.

Madam Secretary, as you know, the Affordable Care Act defines full-time position as consisting of 30 hours per week. Do you know of any other federal law that defines full-time status as 30 hours?

Secretary SEBELIUS. It is my understanding, sir, that when Congress was writing the Affordable Care Act that they took a snapshot of the marketplace and 30 hours—actually it was 28 hours is what I am told—was the amount of time that business owners used as a calculation of who got benefits and who didn't get benefits.

Mr. WALBERG. Well, as I walk through my district I hear constant reports that businesses—small businesses specifically—are cutting back on hours, going away from the 40-hour and less as being a part time, and going down to 28 hours now. That is costing jobs.

Has the department considered talking with the Department of Labor to find out better information on how this is affecting jobs and the economy and growth and—as we know, the best way to have insurance is to have a job. Is there any effort from your department working with the Department of Labor to remedy this problem?

Secretary SEBELIUS. Well actually, sir, since these benefits don't kick in until January 1st we are really not at all confident that some of the speculation of what may or may not happen will actually happen.

Mr. WALBERG. They are doing it already.

Chairman KLINE. The gentleman's time has expired.

Mr. Tierney?

Mr. TIERNEY. Thank you, Mr. Chairman.

Madam Secretary, thank you for the difficult job that you have of enforcing and implementing a law that basically was passed democratically but is facing an unrelenting effort to delegitimize that law day in and day out, so I appreciate how difficult it must be.

There is a lot of cost involved with repealing the Affordable Care Act, and just some of the larger points on that would be, of course, young adults would no longer be allowed to stay on their parents' health insurance until they are 26; insurers would be able to deny coverage because of preexisting conditions; seniors wouldn't have already gotten $6 billion in savings on prescription drugs.

But also, one larger aspect on that is there is provision in this law that says insurance companies actually have to spend the larger portion of the premiums they receive on health care—on health services. And if they don't do that they have to give a rebate—so-called 80-20 rule—or have to lower their premiums going forward. How is that working out?

Secretary SEBELIUS. Well, about $2 billion was sent back to consumers at the end of 2011 based on that law—or 2012, I am sorry. The data was collected in 2011; it was sent in 2012. So consumers got checks back from their insurance companies, I would say for the first time ever. And what we have seen is a lot of rate reformu-

lation, so administrative costs are definitely coming down. More bang for their buck, more of the dollars collected are being spent on health outcomes.

Mr. TIERNEY. Well, you know, I hear from folks at home that they certainly appreciate having the money spent on health services as opposed to lobbyists or CEO bonuses and other things, so thank you for implementing that.

Thought I would switch gears a little bit to education in early childhood. I had an opportunity yesterday to be in Billerica, Massachusetts, where they are closing out 85 seats in a daycare—in a child care Head Start program; 85 seats and seven employees are going to be gone because of sequestration. And that is 85 students whose parents will now have to find a way to—either to quit their job and stay home with the child or find some other way to do it, and seven families that won't be earning money, paying taxes, and paying their bills and supporting small businesses in their district.

Can you tell us how that plays out across the country if this sequestration isn't resolved?

Secretary SEBELIUS. Well, in terms of a per unit cost, about 70,000 Head Start children could lose their slots based on sequestration, and probably 14,000 teachers, guidance counselors, others who are employed. And as you say, that has a ripple effect because if the kids don't have a place to go and some place for their parents to be confident they are safe and secure and learning, the parents have a much more difficult time going to work every day. So it has an effect on the workplace, also.

Mr. TIERNEY. Thank you very much.

I yield back.

Chairman KLINE. Gentleman's time is expired.

Mr. Guthrie?

Mr. GUTHRIE. Thank you, Madam Secretary. Nice to see you here today.

In another committee we talked about the prevention funds and the anti-lobbying restrictions——

Secretary SEBELIUS. Yes.

Mr. GUTHRIE [continuing]. And we had some questions before. Attorney General Holder sent to Lamar Smith clearly saying that state—federal funds can't be used to lobby federal, state, local. A letter from Mr. Esquea, I think your assistant secretary for legislation——

Secretary SEBELIUS. Jim Esquea.

Mr. GUTHRIE. Esquea, I am sorry—said basically the same, acknowledging you can't use federal funds for federal, state, local, and went through the different corrections or things that you put in place to deal with some of the things from last year.

There is one paragraph in that letter, though, that he sent—it is in the letter—on April 1st. He said, "When concerns about any grantee are brought to our attention CDC contacts the grantee and reviews the allegations, and we have determined through this process that specific grantee activity referenced in your letter and highlighted by Mr. Whitfield and Guthrie did not violate lobbying restrictions." And it does say that, "applicable lobbying restrictions do not prohibit awardees from all interaction with policymakers."

I know I am—because of time I am quoting, but it is accurate what I am quoting. It says, "However, it would not be permissible for awardees to use federal funds to influence a specific piece of legislation or pending legislation through the direct lobbying with legislators."

And just a couple of examples—I have several that—the ones that he referred to didn't that—what Mr. Whitfield and I highlighted, and a couple of them—and there is more, and I am reading directly from the Web site: executive office of the governor of Delaware 1 million, seeks sponsorship of bill that increases excise tax on other tobacco products; meeting with policymakers, stakeholders, and developed to introduce bill for tax equity on OTP products. This bill was tabled.

Another Nevada Department of Health, 560,000 CDC. Legislation is proposed to increase tax on all tobacco products working with Nevada state legislator on the proposed legislation.

So my question is, I know we are trying to address the lobbying and you have got things in place, but why did this not violate the lobbying restrictions? And if you say this doesn't violate the lobbying restrictions there—it appears to me there aren't really restrictions on lobbying.

Secretary SEBELIUS. Well, I can guarantee you, Congressman, that we are trying to do everything we can to enforce the law, to retrain grantees, to remind them. There are certainly instances where grantees are invited to present testimony at committees. That is not lobbying. To be involved in policy discussions, that is not lobbying. So there are specific state and local definitions of what lobbying constitutes, when you have to register as a lobbyist——

Mr. GUTHRIE. I agree. But when you are getting specific sponsorship for specific bills, I mean, that appears that that——

Secretary SEBELIUS. And again, I think that the conversation—all I can tell you is I believe that the conversation resulted in one of those other categories, so yes, the grantee was involved, but not in a lobbying activity that would have constituted registering at the local level or declaring themselves as a lobbyist.

Mr. GUTHRIE. Okay. Well thank you.

I will yield back.

Chairman KLINE. Thank the gentleman.

Mrs. Davis?

Mrs. DAVIS. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today.

I wanted to go back for a second to some of the questioning that we have heard, and having been here when Medicare Part D was passed, my understanding is that there was no paid-for for Medicare Part D. Is that correct?

Secretary SEBELIUS. That is correct.

Mrs. DAVIS. So it had some impact on our deficit, substantially.

Secretary SEBELIUS. It was definitely added to the deficit, yes.

Mrs. DAVIS. And in terms of implementation, did the secretary at that time under the Bush administration—did he have the ability to pay for implementation and the concerns and questions? I know we held a number of meetings out in our community and we

were provided with individuals that could come and explain to seniors what Medicare Part D looks like.

Secretary SEBELIUS. I can't tell you how the budget was constructed or how much additional funding was put in through Part D. I do know that there were certainly HHS resources—call center, outreach efforts, contracts. In fact, one of the public-private partnerships was with the Benefit Coalition, where HHS money paid for an entity very similar to Enroll America to have them conduct various outreach and education activities.

So there were resources. How much of that was designated by Congress and how much was within the discretion of the secretary I can't tell you.

Mrs. DAVIS. Okay. Thank you. Because I know you had suggested that things weren't so different right now and I wanted to just remind myself, as well, about how that was done because I don't remember any of this discussion at that time.

Secretary SEBELIUS. Well, at every point, I think, in recent history where there has been a significant expansion of health benefits—and the Children's Health Insurance Program during the Clinton administration, Medicare Part D during the Bush administration—there has been a very extensive outreach effort from the secretary to private groups, to business entities, to health care providers, to disease groups, to foundations, to whole insurers, drug companies, involving and engaging them in outreach efforts, knowing that the federal government could not possibly take on the entire task, that this was an all-hands-on-deck effort.

Mrs. DAVIS. Well, thank you, Madam Secretary.

I think that the issue of the NIH grants has been raised. It certainly impacts the community, the larger community of San Diego, as well. And how do you think the you can make up some of the difference, where we take away all those research dollars?

Secretary SEBELIUS. Well, I think that the President has proposed in the 2014 budget an increase in NIH funding, but if you look at that increase compared to what they lost in the sequestration, only getting rid of sequestration would indeed restore that full budget. The increase that the President has suggested would not cover the deficit that has been created by sequestration.

Mrs. DAVIS. So American research jobs could be lost.

Chairman KLINE. The gentlelady's time has expired.

Dr. Bucshon?

Mr. BUCSHON. Thank you, Mr. Chairman.

Madam Secretary, Indiana is home to over 300 medical device companies with an economic impact of over $10 billion a year, and the medical device tax in the Affordable Care Act is damaging the industry. Cook Medical has decided not to expand within the state; Orthopediatrics in Warsaw, Indiana has shelved two products for children.

The medical device tax repeal passed recently 79 to 20 in the Senate during their budget process, as you know, and last Congress it passed in the House 270 to 146 with 37 Democrats voting in the affirmative to repeal the tax. Does the administration support repealing the medical device tax?

Secretary SEBELIUS. No, sir.

Mr. BUCSHON. And if not, why would that be in the face of overwhelming support from Congress?

Secretary SEBELIUS. Well, at least Congress has not yet fully passed legislation to do that. I would say also, Congress voted to put the medical device tax in place. That was signed into law. And the medical device companies are looking for millions of new customers; as they get enrolled they will be able to purchase and have services that include medical devices.

Mr. BUCSHON. You know, Stryker up in Michigan has already laid off 1,000 in their—company-wide. Something like that. So from what we are hearing from the medical device industry is just the opposite. They don't expect more patients, so to speak, to make up the difference. And I would urge the administration and yourself to relook at the medical device tax as a way to fund the Affordable Care Act and look for other options.

Secondly, Healthy Indiana Plan, as you may know, is an HSA-based plan that—to manage the state's Medicaid dollars, which has been shown to save the state about 3 to 4 percent in a way it manages Medicaid patients. Currently covers over 40,000 Hoosiers.

Our waiver expires—this was an HHS pilot program—our waiver expires December 31st, and the enrollees have an over a 90 percent approval rating of the program. Would you expect that HHS would give us an answer soon on whether or not we will be able to use Healthy Indiana Plan as a way to manage our Medicaid dollars?

Secretary SEBELIUS. Sir, I know conversations are underway with the Indiana Medicaid department on a regular basis and I don't know the current status but I can get you an update in writing.

Mr. BUCSHON. Well, I appreciate that. And the Republican delegation members, at least, from Indiana have sent a letter to you requesting an answer, as well as, I know Governor Pence's administration. I would appreciate an answer fairly soon. Again, the waiver expires December 31st.

Secretary SEBELIUS. Yes, sir.

Mr. BUCSHON. The last question I have is, do you support a single-payer health care system?

Secretary SEBELIUS. Do I?

Mr. BUCSHON. Yes.

Secretary SEBELIUS. No, sir. I supported the concept that you build the gap in coverage based on private insurers.

Mr. BUCSHON. Okay. Thank you.

I yield back.

Chairman KLINE. Thank the gentleman.

Ms. Fudge?

Ms. FUDGE. Thank you, Mr. Chairman.

And thank you, Madam Secretary, for being here today.

Madam Secretary, I have two questions for you and I will give them both to you.

Under the Ryan fical year 2014 budget the Affordable Care Act would be eliminated. That would leave 27 million Americans out of any kind of plan, basically. The thought would be to turn Medicare into a voucher program and Medicaid into a block grant. Please discuss with us how that plan is detrimental to the very people that this budget supposedly helps.

And the second question is, many of my Republican colleagues were opposed to the ACA basically on grounds that it would significantly increase costs. Please talk with us about how the Affordable Care Act really is going to reduce costs by approximately $1 trillion over the next 20 years.

Secretary SEBELIUS. Well, Congresswoman, I think that the President put forward a plan to provide affordable health coverage for the approximately 20 percent of Americans who currently have no coverage, or are in and out of the market, or are locked out of the market or priced out of the market. And that plus the Medicaid expansion would, for the first time ever, provide an opportunity for most Americans to have affordable health coverage.

I would say that at least in the other budget proposals there is no similar plan. The high-risk pool seems to be the only alternative that was put forward during the debate around the Affordable Care Act and continues to be an alternative put forward. Just put people in a high-risk pool, allow insurance companies to continue to pick and choose who gets coverage and who doesn't, and a little unclear what happens to folks who can't afford either the high-risk pool or the health coverage.

In terms of Medicare and Medicaid, in cost stories, again, there is, I think, a very positive story to tell about how you increase benefits, how you increase quality and lower costs at the same time. It was said as we talked about that originally that that could never happen. It actually is happening. It has happened for 3 years in a row.

And the trend is much faster than the CBO ever anticipated or suggested, so that what we are seeing is a transformation in the delivery system and an opportunity in the marketplace for the first time to create competitive markets and to have people who don't have affordable employee coverage to have access to health insurance, health security for themselves and their families.

Ms. FUDGE. Thank you.

Mr. Chairman, I yield back.

Chairman KLINE. Thank the gentlelady.

Mrs. Roby?

Mrs. ROBY. Thank you, Mr. Chairman.

Thank you, Madam Secretary. In anticipation of your testimony here before us today I reached out to my constituents on Twitter and Facebook and said, "If you had an opportunity to ask the secretary a question what would you ask?"

And I just want to share with this committee and with you, Madam Secretary, how just unbelievable it was to hear from so many individuals and business owners that were afraid to give their names in light of the current IRS scandal because of the role that the IRS will play in implementing this law, that by asking you a question and revealing who they are that they may receive retribution from that agency. And of course, this is in light of everything that we are hearing in the news and that our majority is providing oversight right now. But I am going to submit their questions to you in writing since we have limited time, but I am going to redact their names, as requested.

And one constituent of mine, Mr. Jason Misseldon, of Prattville, Alabama, asked the following question that I would like to ask to

you: He says, "My employer has provided excellent insurance coverage for over 30 years. It would definitely be classified a Cadillac plan. This year we were forced to change coverage. Please tell me—Jason—how penalizing or taxing companies that provide excellent coverage has anything to do with ensuring everyone has access to affordable health care."

What would you say to Mr. Misseldon?

Secretary SEBELIUS. Well, Congresswoman, I have no idea why he would change plans this year because nothing has impacted his health plan this year. But I would just say that insurance companies who are by and large in enormously profitable condition will be paying taxes to help support a new infrastructure that in return brings them potentially 30 million new customers, and that is a part of the funding of the Affordable Care Act moving forward.

Mrs. ROBY. One other question, because I know my time is about to run out, but how are we going to count employees? For example, I have got one business that reached out to us and said, "Tell me how it is going to affect my business when we have 52 employees but three of those are owners of the business?" When it comes to the exemption, how does that work out?

Secretary SEBELIUS. Well, there are some pretty specific rules and regs how to count part-time employees, how to count full-time employees. Again, we would be happy to answer that question if we get some specifics about who exactly——

Mrs. ROBY. I am going to give you all of these questions——

Secretary SEBELIUS. That is great.

Mrs. ROBY [continuing]. In writing and we will look forward to your in-depth answers.

Thank you. I yield back.

Chairman KLINE. Thank the gentlelady.

Mr. Yarmuth?

Mr. YARMUTH. Thank you, Mr. Chairman.

Madam Secretary, it is nice to see you. We talked a little bit earlier about the effect of, or the potential effect of the expansion of Medicaid on different states, and in my state Governor Beshear recently announced that he was going to accept the expansion, and he did that after a very rigorous analysis of the costs and benefits to both the state budget and also to the state economy. And they found that over 7 years, expanding Medicaid is expected to provide a cumulative economic boost of $15.6 billion through new health spending, the addition of 17,000 jobs averaging $43,000 a year, local and state taxes generated by those workers.

The governor also found that expansion would have a positive impact of more than $800 billion on the state budget over that same 7-year period, and that is all in addition to providing coverage for more than 300,000 Kentuckians who do not have access to insurance at this point. So as you move forward and people ask questions about that I certainly would offer that evidence as proof that the Affordable Care Act, the expansion of Medicaid is going to be a positive for at least many states.

I have one question I am going to ask and that is in respect to my former colleague, Steve Kagen, from Wisconsin, who spent the entire debate about the Affordable Care Act talking about the need for transparency. And a couple months ago an incredible piece of

journalism, "The Bitter Pill," appeared in Time Magazine, Steven Brill, talking about the disparity in costs throughout the system, particularly at hospitals. Is HHS doing anything to promote transparency both at the hospital and throughout the provider network in the country?

Secretary SEBELIUS. Yes, sir. We have published, a couple months after the Steve Brill article, a snapshot of inpatient hospital costs for about 30 different procedures, comparing them hospital to hospital, and found not only enormous countrywide variation but enormous regional and some places enormous local variation. But it has been published and available.

Yesterday we released additional data, which is the publication of some outpatient services for similar procedures, again comparing side by side. We have had a process underway really from the beginning of this administration to unlock data, to make sure that the data that we are collecting actually is put in the public domain in an easy-to-read, easy-to-use way so that consumers can begin to ask important questions. Why should a hip transplant cost three times as much if I go six blocks away and have no difference in outcome? So that information is very much available.

And yesterday we had the fourth annual—third annual Datapalooza, which is a meeting of entrepreneurs and application developers and others to come in and look at the data and see what kinds of mechanisms they can put together to help drive this data for policymakers and patients. It started in a room with 46 people 3 years ago; yesterday there were 2,000 techies and entrepreneurs here from all over the country and a team from the United Kingdom who is really interested in learning what we are doing with data and how that can help inform patients and providers.

Mr. YARMUTH. Great. Thank you very much.

Chairman KLINE. Mr. Barletta?

Mr. BARLETTA. Thank you.

Ten-year-old Sarah Murnaghan is from my home state in Pennsylvania. If Sarah lives she will be 11 on August 7th coming up.

Do you think it should be legal to deny a organ transplant based on somebody's race? Do you think we should decide because of the color of your skin or——

Secretary SEBELIUS. No, sir.

Mr. BARLETTA. Think it should be legal to deny somebody an organ transplant because of their gender, because of they are a woman or a male?

Secretary SEBELIUS. Again, I have no idea what the medical evidence might be. I assume that there nay not be a difference, but there could be——

Mr. BARLETTA. But do you think it should be legal to do that? Do you think we should choose between——

Secretary SEBELIUS. If there is a medical rationale, yes, sir. But if there is not, no.

Mr. BARLETTA. Why are we going to let a little 10-year-old girl die because she is 10 and not 12? Sarah is at the top of the pediatric list—those who are 11 or younger. If Sarah were 12 she would be at the top of the adult list.

Now, transplants should be based, I believe, on the severity of the illness and not the person's age, and I know you agree with

that because you have asked OPTN to please review the policy. Sarah's parents aren't asking for special treatment for their daughter. I am the father of four girls myself. They are asking for an equitable organ transplant system.

And you are the one person who has the authority to suspend the current policy until we are confident that children have equal access to lifesaving treatment and aren't discriminated against because of their age. We wouldn't do it for any other reason.

I am begging you. Sarah has 3 to 5 weeks to live. Time is running out. Please, suspend the rules until we look at this policy, which we all believe is flawed.

Secretary SEBELIUS. Well, I would suggest, sir, that, again, this is an incredibly agonizing situation where someone lives and someone dies.

Mr. BARLETTA. Based on their age.

Secretary SEBELIUS. Sir.

Mr. BARLETTA. Based on their age.

Secretary SEBELIUS. What I have been told by the transplant experts—and I don't profess to have any expertise in this area—is that the medical evidence and the transplant doctors who are making the rule and have had the rule in place since 2005, making a delineation between pediatric and adult lungs, it is—lungs, because lungs are different than other organs——

Mr. BARLETTA. But in Sarah's case——

Secretary SEBELIUS [continuing]. That it is based on the survivability——

Mr. BARLETTA. But this is different. This is different. Sarah's case is different. Doctors have said that she could survive with an adult lung. It can be modified to save her life. Why wouldn't we do it? Why, we do so much bull crap around this place and we have the chance to save someone's life, and because of some kind of—there is no logic to this.

Secretary SEBELIUS. Forty people in your home state——

Mr. BARLETTA. But she would be first if she was 12.

Secretary SEBELIUS [continuing]. Are waiting on——

Mr. BARLETTA. But she would be first——

Secretary SEBELIUS. Sir, there are 40 people in the highest acuity list waiting for a lung in Pennsylvania.

Mr. BARLETTA. Sarah would be at the top of that list.

Chairman KLINE. The gentleman's time has expired.

Mr. Hinojosa?

Mr. HINOJOSA. Thank you, Chairman Kline.

Madam Secretary, I am concerned that despite past bipartisan support for the Head Start programs, the sequester threatens more than 70,000 children's access to Head Start. Please share your thoughts on why federal investments in early learning are needed now more than ever. And the second part to this question: How does the President's early learning proposal affect Head Start programs, including migrant and seasonal Head Start families as well as our Native American children?

Secretary SEBELIUS. Well, I think there is a lot of evidence, Congressman, that has been developed over decades that early childhood education that is a quality program makes a lifetime of difference in a young person, not just in school readiness and school

success and parental involvement, but in less drugs, less alcohol, higher graduation rates, more likelihood to get a job. So it is an investment early that pays off over a lifetime.

Certainly the—in this very competitive global world we want all of our children to be able to live up to their potential to be a prosperous nation, to have the full advantage of the opportunities that America can have in the 21st century, so the President has proposed in his 2014 budget a significant expansion of early learning opportunities aimed at lower-income kids, but really aimed at all kids, so that you would have more home visiting programs, which have proven to be enormously successful in families, Early Head Start child care partnerships, which would bring some of the parental skills and early learning from Head Start into child care settings, raising the quality for 100,000 more children; universal pre-K in a partnership with states, so that more 4-year-olds would have access to high-quality early kindergarten, and then hopefully a successful transition into school, which would, I think, not only improve the fate of those individual children, but when you look at the amount of money schools now spend on remedial work even at the very earliest age, at the dropout rates, at the lack of success of some kids, making a dent in that dismal outcome could save money, make more prosperous workers, make for a more prosperous nation.

So I think the President understands this very well and has proposed that one of the biggest investments we should make for a 21st century economy is in early childhood education.

Mr. HINOJOSA. Madam Secretary, what you have answered is exactly what we hear from other countries that are leading——

Secretary SEBELIUS. Yes, sir.

Mr. HINOJOSA [continuing]. The competition in interscholastic competition, and so the rule of early reading plus writing equals success in school is exactly what you have——

Chairman KLINE. The gentleman's time has now expired.

Mr. HINOJOSA. I yield back.

Chairman KLINE. Mr. Salmon?

Mr. SALMON. Thank you.

Madam Secretary, we are just about 6 months away from the implementation of the Affordable Health Care Act and several of the groups that have been very, very supportive of the act when it initially passed are now raising red flags and some are actually calling for its repeal. In fact, most recently the United Union of Roofers, Waterproofers, and Allied Workers—they came out and asked for its repeal. Several other unions have expressed concerns about losing their Taft Hartley coverage.

And so my question would be to you, given the fact that you were integrally involved in the negotiating and putting this act together, if you had it to do all over again would there be any things that you would do differently? And if so, what?

And then also, why do you believe some of these groups that were so supportive in the past are now opposed to it and are having problems with it?

Secretary SEBELIUS. I would tell you, I was very involved from April of 2009 when I got sworn in to March of 2010 when the bill was passed, and probably every day along the way there was some

decision or some discussion that could have gone one way or the other.

I think overall this is a law that has been long overdue in this country. For seven decades Republican and Democratic Presidents have been trying to pass some kind of comprehensive reform. I think the President chose not to blow up the private insurance market but, in fact, to build on the private insurance market, close the gap that way, not go to a single-payer system, which a lot of his supporters would have preferred but felt this was far less disruptive and a way to fill the gap.

So I think that as we go through time, after full implementation, after we see how things are shaking out, there are likely to be fixes along the way. But it is impossible right now to deal with speculation and that is really what we have: this will happen, or this won't happen, or this could happen. Medicare doesn't look the same today as it did when my father was here and voted for it in 1965. I am sure the Affordable Care Act in 50 years will look very different and there will be changes along the way based on real experience in the marketplace.

But I think our success so far in the 3 years with implementation of pieces of this, with the cost control issues underway, with what has happened and not happened to Medicare is very, very positive. And I just—I am very excited about the next step and fully implementing this law.

Mr. SALMON. [Off mike.]

Secretary SEBELIUS. Sir, I really don't know and I would be happy to—I wasn't aware that the union you cited is now saying they are opposed, and I don't really know why, if they have a particular issue that they were hoping to get a tax credit and be part of an exchange at the same time, which I know has been the case in some instances. I don't know why they are saying that.

Mr. SALMON. [Off mike.]

Chairman KLINE. The gentleman's time has expired.

Mr. Polis?

Mr. POLIS. Thank you, Madam Secretary.

A lot of Coloradans in my district and across my state still don't know how Obamacare can help them. It is a particular concern among our many residents who don't speak English.

In Colorado our state officials, the health exchange, the nonprofit organizations advocacy groups are all channeling their efforts into public awareness campaigns focusing on one-on-one conversations with non-English speakers. We are also doing outreach to English and non-English speakers in the Latino community through media personalities, nurses, doctors, friends and family, and running TV, radio, and print ads in Spanish.

My question is, is a similar effort underway at the federal level and what actions have you and the department taken to ensure that non-English speakers in Colorado and across the country are aware of and can access the new services available to them?

Secretary SEBELIUS. Well, that is a great question and it isn't, as you know, just Spanish language, but there are multiple languages spoken across this great, diverse country. So we are taking that very seriously. We have put together an operation where a call cen-

ter will open I think later this month, and questions will be able to be answered in 150 languages out of that call center.

Materials on our Web site are automatically available in both English and Spanish because Spanish is the most frequently spoken other language here in the United States, so everything that we are doing will always be available in English and Spanish but we are trying also to be very sensitive to the diversity of languages and have—I am hopeful that when we get the proposals back for navigators who will be on-the-ground helpers in communities, that many of those will come out of community groups with cultural sensitivity and language skills to reach into some of our more vulnerable populations.

We are also putting in-person assistance in the community health centers across this country, many of whom have personnel who speak multiple languages and come out of the neighborhood. So we are looking at all the kind of levers that we have.

Mr. POLIS. Thank you. We will look forward to our state coordinating with your efforts and helping to publicize your multilingual call center and I applaud you for those efforts.

We don't have much more time. I just want to applaud your efforts on early childhood education. I recently introduced the Continuum of Learning Act to align early childhood education and elementary school standards and I would encourage you to continue to work in early childhood with the areas under your jurisdiction with the areas under the jurisdiction of Secretary Duncan and school districts and states to make sure we have a coordinated approach to early childhood education.

And with that, I will be happy to yield back.

Chairman KLINE. Thank the gentleman.

Mr. Thompson?

Mr. THOMPSON. Thank you, Chairman.

Madam Secretary, thank you for joining us here today. I need to address an issue that is very near and dear to my heart as a—actually a couple in Pennsylvania. I just want to just briefly weigh in and say that in terms of that little girl that is—would reach the age of 11 by August, you are probably the one person certainly in this chamber and maybe in this country that has the ability to waive a rule to keep her from dying, and I really encourage you to do that.

My remarks really is—the other side is I want to talk about the concept behind the State Children's Health Insurance Program. As you know, it was born in Pennsylvania. This is a one-of-a-kind program to provide coverage to children whose families earn too much to qualify for medical assistance but not enough to purchase private insurance.

The federal CHIP program was signed into law in 1997, authorized in 2009—one of the first votes I made as a new member of Congress. Now, I voted in favor of that reauthorization because I saw how Pennsylvania was able to provide—excuse me—children private health insurance coverage using a market-based approach, not Medicaid. However, I am worried that the vote that I cast may have been in vain now that Pennsylvania's CHIP program is under threat by the Affordable Care Act.

Madam Secretary, in April 2013—I apologize for this cough; I am hoping to get over it before the full implementation of the Affordable Care Act——

Secretary SEBELIUS. We can find you a good doctor.

Mr. THOMPSON. I have got a good doctor.

April 2013 Pennsylvania's governor, Tom Corbett, met with you to ask that you work with the commonwealth to ensure that the children will not be affected by the implementation of the ACA, and particularly those children enrolled in CHIP. On May 30th Governor Corbett reiterated his request, writing you and expressing serious concern that upwards of 70,000 children will be transferred to Medicaid off of CHIP.

Now, Mr. Chairman, I ask unanimous consent to enter that correspondence from Governor Corbett to the secretary into the record.

[The information follows:]

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF THE GOVERNOR
HARRISBURG

THE GOVERNOR

May 30, 2013

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue SW
Washington, D.C. 20201

Re: Request to Maintain Pennsylvania's CHIP Program

Dear Secretary Sebelius:

I am renewing my request made to you in April when we met to not force children from Pennsylvania's Children's Health Insurance Program (PA CHIP) into the Medicaid system. I am asking you to work with me to prevent possible confusion and disruption for children and their families and potentially avoid some children from losing access to their health care provider.

PA CHIP is a highly effective Title XXI CHIP program that provides health care to 187,034 Pennsylvania children. PA CHIP was established in 1992 and has long been acknowledged as a national model. When the federal CHIP program was created by the Federal Balanced Budget Act of 1997, PA CHIP received specific recognition as one of only three child health insurance programs nationwide that met Congressional specifications. CHIP continues to have broad bipartisan support at the federal and state levels.

Unlike most states, Pennsylvania's CHIP program is based on a commercial product platform, not Medicaid, and provides not only a robust array of health insurance benefits but also access to more doctors and hospitals than traditional Medicaid. I am concerned that a child in PA CHIP may not, in some instances, be able to stay with their current health care provider and will not have as broad of a choice of health care provider if moved to Medicaid. As policymakers, let's not force a parent to change their child's health care provider needlessly.

One program that is touted universally as working well in health care is PA CHIP. As one parent said: "Because our kids are able to be enrolled in CHIP, I have been able to provide for my family. There is not a product out there that is as good as CHIP, low-cost CHIP. Nothing."[1] In a survey of our PA CHIP parents, nine out of ten reported satisfaction with their

[1] Pennsylvania provides CHIP for free to children below 200% of the federal poverty level (FPL), and at subsidized rates between 201% and 300% FPL. Families over 300% FPL may purchase PA CHIP at cost.

The Honorable Kathleen Sebelius
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child's PA CHIP health plan, and an even greater number reported they were able to access urgent care services for their child as soon as necessary, and were able to obtain an appointment for their sick child within twenty-four hours. These are successes that should be continued.

As I highlighted for you in my February 5, 2013 letter, it is these successes, and many others, of PA CHIP that serve as examples of an innovative state program that is working and that should continue to be allowed to work in tandem with the insurance coverage reforms of the Affordable Care Act (ACA). Additionally, in the April 2 meeting with you and your staff, I along with Insurance Commissioner Consedine repeated our request that HHS give Pennsylvania the flexibility to continue PA CHIP and to exempt Pennsylvania from having to transfer a significant portion of its enrollees into the Medicaid system.

Implementation of the ACA may mean the de facto end to PA CHIP. Based on our initial analysis, prior to any formal guidance from HHS, of the 187,034 current enrollees in PA CHIP, we anticipated having to involuntarily transfer approximately 70,000 enrollees, representing children between 100-138% FPL, onto our Medicaid rolls. Recently my administration received from CMS the application of the new method for determining eligibility and income required by the ACA that may escalate the required transfer number to possibly 144,000 children. The Commonwealth has asked CMS to re-visit the issue, and I believe our respective staffs are working to resolve what appears to be an inadvertent error in how the new method was developed.

Although I do not believe adversely impacting PA CHIP was either the ACA's or HHS's intent, implementation of certain ACA requirements, if not done conscientiously and with forethought, will result in the reduction of PA CHIP enrollment by no less than 70,000 children. Let's work together to preserve a program that works for Pennsylvania's children.

In closing, I respectfully ask that you allow Pennsylvania to preserve our PA CHIP program for the children and families that currently enjoy its benefits, and for those families that may avail themselves of it in the years to come. My administration looks forward to working with you to save PA CHIP and work for the benefit of young Pennsylvanians so that they may continue to enjoy the coverage afforded them through this nationally recognized program.

Sincerely,

TOM CORBETT
Governor

Chairman KLINE. Without objection.

Mr. THOMPSON. Madam Secretary, my question is pretty straightforward: Are you going to work with Governor Corbett to see that kids enrolled in CHIP are not put into a position where they can no longer use the doctor of their choice, not dumped into Medicaid, they will continue to have viable access to health providers?

Secretary SEBELIUS. Well, Congressman, what I can tell you is I have had a number of conversations with Governor Corbett and I will certainly continue to work with him to make sure that the children in Pennsylvania are not disadvantaged, certainly, by this next transition. CHIP remains an independent program. Again, off

the top of my head I can't tell you what all the issues are around the Pennsylvania program but I will go back and look them up.

But we have frequent conversations and I am——

Mr. THOMPSON. Well, Madam Secretary, the issue is 170,000 kids, 70,000 of them right now are going to move out of CHIP, which is a program that works——

Secretary SEBELIUS. Right.

Mr. THOMPSON [continuing]. It is market-based—and be put into Medicaid. And I would say the majority of folks on Medicaid cannot find physicians, let alone specialists such as pediatricians.

Thank you, Mr. Chairman.

Chairman KLINE. The gentleman's time has expired.

Mr. Scott?

Mr. SCOTT. Thank you, Mr. Chairman.

Madam Secretary, we heard about the Cadillac plan being taxed. Isn't it true that the taxes really affect that you only get a deduction on the cost of a basic plan and if you spend more than that that is just taxable income, that you pay tax like everybody else?

Secretary SEBELIUS. That is correct. It is a cap on how much you can deduct——

Mr. SCOTT. Okay. And——

Secretary SEBELIUS [continuing]. And how—the level of the insurance deduction. And again, Congressman, as you know, it is not to kick in until 2018 and it was an attempt to put on the horizon the need for health plans to actually deliver some lower-cost services.

Mr. SCOTT. Well, and so they are blaming something on the Affordable Care Act. It could not have had any effect—the Affordable Care Act couldn't have had any effect on that because it hadn't—the tax hadn't even gone into effect. Is that right?

Secretary SEBELIUS. That is correct.

Mr. SCOTT. You mentioned the reason that 20 percent of the people have no insurance and would benefit with the Affordable Care Act. Isn't it true that the 80 percent that have insurance, for them we are closing the donut hole, we are—those with preexisting conditions can get and keep insurance and can switch insurances, that they get free prevention, that is lower cost to individuals in the individual market, those—we are eliminating insurance abuses like rescission for those with insurance, the no limits annual or lifetime on what the insurance company has to pay, and we extended the cost of Medicare for 8 years—aren't those benefits that the 80 percent will get?

Secretary SEBELIUS. Well, I think you are absolutely right. You have just outlined some of the market advantages for the 80 percent. But I would say there are some additional ones.

First of all, the 80 percent right now are paying for the cost of care for a lot of the people who don't have coverage——

Mr. SCOTT. And how much——

Secretary SEBELIUS [continuing]. Because their hospital bills are higher, their doctor bills are higher——

Mr. SCOTT. How much is that for the average policy?

Secretary SEBELIUS. It is estimated by some economists that it is about $1,000 per family on their policies extra that they are paying for uncompensated care.

Mr. SCOTT. The gentleman from South Carolina raised questions about the administration of the program. Can you say a word about what the budget cuts and sequester has done to your ability to properly and effectively administer the program?

Secretary SEBELIUS. All of our programs?

Mr. SCOTT. Putting the Affordable Care Act into effect?

Secretary SEBELIUS. Well, I think that we certainly have had a challenge the last couple of years in terms of resources specifically to effectively implement the Affordable Care Act. We did not have a budget in 2013 and then we had sequester on top of that so that it has made, I think, it very difficult, but we are doing a job to make sure the resources go, that the programs are built, and that we are ready to implement on October 1st.

Chairman KLINE. The gentleman's time has expired.

Dr. DesJarlais?

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Madam Secretary, what, in your opinion, was the biggest reason or need for Obamacare or this health care law?

Secretary SEBELIUS. The biggest reason was that way too many of our population had no coverage at all or coverage that was unaffordable in and out of the market.

Mr. DESJARLAIS. How many people?

Secretary SEBELIUS. It is estimated that it is about a sixth of our population.

Mr. DESJARLAIS. Can you put a number on that? How many people were uninsured?

Secretary SEBELIUS. I can go back to 2010 and get you the exact number. I don't——

Mr. DESJARLAIS. Can you give me a guess?

Secretary SEBELIUS. Well, a sixth of the—about 20 percent of the population, we have about 300 million people.

Mr. DESJARLAIS. Okay. The President said when he implemented the law that there was roughly 31 million uninsured Americans. Is that right?

Secretary SEBELIUS. He may have said that. That is probably a little low.

Mr. DESJARLAIS. Okay. According to the CBO's recent report, 44 million people will be uninsured next year and still 31 million people will be uninsured in 2023. This is despite the federal government spending almost $2 trillion to implement this law.

Now, would you say if the CBO—the Congressional Budget Office's numbers are correct, that the President's signature legislation at—to achieve universal coverage is a success or is it looking to be maybe not so much?

Secretary SEBELIUS. Well, what we know right now—and I think it is safer to deal in fact——

Mr. DESJARLAIS. Well, let's look at the numbers—you can address the numbers that CBO——

Secretary SEBELIUS [continuing]. Is that we have got 3 million young adults who were not covered in 2010 who now have coverage. We know that. We know that small business owners are staying in the marketplace differently than they were in the decade before the Affordable Care Act when they were dropping coverage. So we start with a baseline that has added 3 million——

Mr. DESJARLAIS. Well, Madam Secretary, I know what you are saying here, but what about all the concerns of the people who have insurance that are going to lose it? Because these numbers that CBO aren't projecting aren't the ones that you were talking about; these are new people.

These are a bunch of people around the country—the fifth—sixth—60 percent of Americans that didn't want this health care law that are going to lose their insurance and have to pay taxes. What do you say to those people? I mean, the CBO says it. Do you agree with the CBO's numbers?

Secretary SEBELIUS. I don't have any idea what numbers you are quoting but I would rather deal with what is happening on the ground and I will be glad to come back next year, sir, and——

Mr. DESJARLAIS [continuing]. 30 million to 40 million people are not going to have insurance with this new signature Obamacare and you have to——

Secretary SEBELIUS. I have no idea where those numbers come from and where the CBO has got them. No idea.

Mr. DESJARLAIS. Well, we will get you the numbers. Thank you.

Secretary SEBELIUS. Yes.

Chairman KLINE. Gentleman yields back.

Dr. Heck?

Mr. HECK. Thank you, Mr. Chairman.

Thank you, Madam Secretary.

You know, there has obviously, as expected, been a lot of discussion about the Affordable Care Act today and how it is supposed to increase access to health care. And I think it is a bit of a mischaracterization because the bill really attempts to increase access to health insurance, and increased access to health insurance doesn't necessarily increase access to health care.

With that in mind, I would like to ask you a question about a bipartisan concern, and that is the looming physician shortage. The Association of American Medical Colleges projects that by 2020 the U.S. will be facing a 91,500-physician shortage that is evenly split between specialists and primary care physicians.

And so I am concerned that at a time when we need to grow the physician workforce the administration continues to propose cutting Medicare support for physician training and the critical services provided by teaching hospitals. It is estimated that the President's proposal to cut Medicare IME by 10 percent could cost America's teaching hospitals over $700 million annually, including about $1.6 million in my home state of Nevada, and would severely impact their ability to train the next generation of physicians.

As you know, IME is not an overhead payment. In fact, teaching hospitals receive IME funding to help compensate them for the higher costs because they take care of sicker, more complex patients and provide services that other hospitals cannot, such as trauma centers, burn units, and standby capacity.

Can you tell me, has the administration even considered the impact of this cut on teaching hospitals' ability to maintain these critical services and thus actually increase access to quality health care?

Secretary SEBELIUS. Yes, sir. I know that the reduction in medical education is potentially difficult for a number of teaching hos-

pitals. The cost reduction is estimated based on how much it costs to actually provide the residency slots and how much is administrative costs, and the administrative costs are reduced and the costs to provide the residential slots are in the President's budget—were in the President's budget last year.

In addition, there are a whole variety of additional workforce initiatives that have been underway since the beginning of this administration to provide more health care providers, I mean, more—tripling the size—or doubling the size, I am sorry, of the national health service corps, which not only is doctors but nurses, mental health practitioners, dentists, and others—increasing nurse and nurse training programs, looking at moving medical slots from specialty care to primary and geriatric care, knowing that is where the providers are going to be needed.

So there is a constant and, I think, continued look at workforce issues, which really have nothing to do with the Affordable Care Act but have to do with our aging population and the demographics of what we are going to need in terms of health care providers.

Mr. HECK. Well, I would agree but I would be concerned when the Association of Medical Colleges is saying there is not enough training slots and we are trying to look at cutting dollars to training slots, that we are going to continue to compound this shortage. And I have always said that the greatest single threat to Medicare, in my opinion, is SGR——

Secretary SEBELIUS. I would agree.

Mr. HECK [continuing]. And the second-greatest threat is GME. And we can have a great program but if there is nobody to take care of the seniors then the program really doesn't do much good.

Thank you, Mr. Chair. I yield back.

Chairman KLINE. Gentleman's time has expired.

My apologies to those members of the committee who didn't get a chance to answer questions. We have hit the hard stop of 12 o'clock.

I would like to yield briefly to my colleague for his closing comments?

Mr. MILLER. I won't take time because there are members who didn't get questions because of the secretary's schedule.

And I just want to thank you, Madam Secretary, for your presentation here today. I think that, you know this list of successes that mount every day, the studies that are done every day that point to the positive impacts of the Affordable Care Act is very exciting, and I thank you again for the tremendous work you have done in implementation of this act.

Chairman KLINE. I thank the gentleman.

Of course, I have a different view. It seems to me we are seeing an awful lot of bad news that is coming out of the impending implementation of the Affordable Health Care Act and so the debate will continue.

I ask unanimous consent that an article from the Wall Street Journal called "Obamacare Bait and Switch" be included in the record. Again, I thank the secretary——

[The information follows:]

[From the *Wall Street Journal,* June 3, 2013]

ObamaCare Bait and Switch

The truth about those rate increases in Oregon and California

Liberals have spent years claiming that "rate shock" under the Affordable Care Act—the 20% to 30% average spike in insurance premiums that every independent analyst projects—is merely the political imagination of Republicans and the insurance industry. So they immediately claimed victory when California reported last month that the plans that will be available on the state's new insurance exchange next year would be cheaper than they are today.

Except now it emerges that California goosed the data to make it appear as if ObamaCare won't send costs aloft as the law's regulations and mandates kick in. It will, by a lot. And now liberals have suddenly switched to arguing that, sure, insurance will be more expensive but the new costs are justified. Needless to say that was not how Democrats sold health-care reform.

California reported that the rates would range from 2% above to 29% below the current market. "This is a home run for consumers in every region of California," said Peter Lee, the director of the state exchange. "These rates are way below the worst-case gloom-and-doom scenarios we have heard."

But Mr. Lee and his fellow regulators were making a false comparison. They weren't looking at California's lightly regulated individual insurance market that functions surprisingly well. They were comparing ObamaCare insurance to the state's current small-business market where regulations similar to ObamaCare have already been imposed.

In other words, California wasn't comparing apples to apples. It wasn't even comparing apples to oranges. It was comparing apples to ostriches. The conservative analyst Avik Roy consulted current rates on the eHealthInsurance website and discovered that the cheapest ObamaCare plan for a typical 25-year-old man is roughly 64% to 117% more expensive than the five cheapest policies sold today. For a 40 year old, it's 73% to 146%. Stanford economist Dan Kessler adds his observations nearby.

We wouldn't be shocked if California deliberately abused statistics in the hopes that no one would notice that in some cases premiums would more than double. In any case, the turn among the liberals who touted the fake results has been educational.

They now concede that individual costs will rise but claim that it is unfair to compare today's market to ObamaCare because ObamaCare mandates much richer benefits. Another liberal rationalization is that the cost-increasing regulations are meant to help people with pre-existing conditions, so they're worth it.

So they're finally admitting what some of us predicted from the start, but that's also the policy point. Americans are being forced to buy more expensive coverage than what they willingly buy today. Liberals also argue that some of the new costs will be offset by subsidies, which is great news unless you happen to be a taxpayer or aren't eligible for ObamaCare dollars and wake up to find your current coverage is illegal.

The Affordable Care Act was sold as a tool to lower health costs. In case you missed it, the claim is right there in the law's title. The new Democratic position is that the entitlement will do the opposite but never mind, which is at least more honest.

But we wonder how long this new candor will last. If the public reacts badly to these higher premiums, the authors of ObamaCare will soon be back to blaming insurance companies and Republicans.

Mr. MILLER. I ask unanimous consent that an article from the New York Times talking about the rise of entrepreneurship and——

[The information follows:]

[From the *New York Times,* May 31, 2013]

Affordable Care Act Could Be Good for Entrepreneurship

By CATHERINE RAMPELL

The Affordable Care Act is expected to produce a sharp increase in entrepreneurship next year, according to a new report from the Robert Wood Johnson Foundation, the Urban Institute and Georgetown University's Health Policy Institute. The number of self-employed people is expected to rise by 1.5 million—a relative increase of more than 11 percent—as a direct result of the health care overhaul.

One major barrier to entrepreneurship in the United States—beside the usual risks involved with starting a company—is that it has been difficult to get health insurance on the individual market. Those who do end up founding or joining a start-up are often able to do so because they have a spouse with employer-sponsored insurance, or because they are keeping a day job with a bigger company. (This was the case, for example, for most of the people involved with Leap2, a Kansas City start-up that I profiled last fall.)

Economists have looked at whether this insurance-related job lock is deterring self-employment and the formation of new businesses, and the data suggest it is. A Journal of Health Economics paper, for example, found that business ownership rates jumped sharply from just under age 65 to just over age 65, when people become newly eligible for Medicare. Using Current Population Survey data, the same paper also found that wage and salary workers are more likely to start businesses from one year to the next if they have a spouse with employer-based insurance.

A working paper from the Upjohn Institute looked at a change in the law in New Jersey that expanded access to individual health insurance. It found that the law seemed to increase self-employment, particularly among "unmarried, older, and observably less-healthy individuals."

The report released Friday applies those findings to a model of what will happen in 2014, based on the Affordable Care Act's provisions for "universal availability of non-group coverage, the financial assistance available for it, and other related market reforms." The authors also adjusted their numbers depending on the access that residents of various states already have to individual health insurance. (Vermont, for example, already has a statute that allows the self-employed to obtain small group coverage.) Over all, they found, the ranks of the self-employed are likely to rise 11.5 percent, from about 13.1 million to 14.6 million. A table with their state-by-state estimates is below.

By the way, the paper does not mention this, but the same forces that will make it easier for workers to become self-employed may also make it easier for workers to retire early. I have heard anecdotally about people in their late 50s or early 60s who would like to retire but can't do so because they're basically uninsurable (for now) on the individual market; I wonder if we'll notice a wave of retirements in this age group come 2014.

State	Self-employment absent A.C.A.	Self-employment post-A.C.A. changes	Increase due to A.C.A.	% Increase due to A.C.A.
Alabama	118,000	134,000	16,000	13.60%
Alaska	31,000	35,000	4,000	12.90%
Arizona	301,000	340,000	39,000	13.00%
Arkansas	99,000	112,000	13,000	13.10%
California	1,901,000	2,149,000	248,000	13.00%
Colorado	304,000	331,000	27,000	8.90%
Connecticut	185,000	202,000	17,000	9.20%
Delaware	31,000	33,000	2,000	6.50%
District of Columbia	21,000	24,000	3,000	14.30%
Florida	819,000	891,000	72,000	8.80%
Georgia	432,000	488,000	56,000	13.00%
Hawaii	58,000	63,000	5,000	8.60%
Idaho	83,000	94,000	11,000	13.30%
Illinois	475,000	537,000	62,000	13.10%
Indiana	224,000	253,000	29,000	12.90%
Iowa	148,000	167,000	19,000	12.80%
Kansas	116,000	131,000	15,000	12.90%
Kentucky	150,000	170,000	20,000	13.30%
Louisiana	179,000	203,000	24,000	13.40%
Maine	73,000	79,000	6,000	8.20%
Maryland	231,000	261,000	30,000	13.00%
Massachusetts	281,000	281,000	0	0.00%
Michigan	317,000	344,000	27,000	8.50%
Minnesota	258,000	292,000	34,000	13.20%
Mississippi	102,000	110,000	8,000	7.80%
Missouri	242,000	273,000	31,000	12.80%
Montana	72,000	81,000	9,000	12.50%
Nebraska	104,000	117,000	13,000	12.50%
Nevada	104,000	117,000	13,000	12.50%
New Hampshire	74,000	81,000	7,000	9.50%
New Jersey	304,000	330,000	26,000	8.60%

State	Self-employment absent A.C.A.	Self-employment post-A.C.A. changes	Increase due to A.C.A.	% Increase due to A.C.A.
New Mexico	94,000	106,000	12,000	12.80%
New York	743,000	808,000	65,000	8.70%
North Carolina	378,000	411,000	33,000	8.70%
North Dakota	52,000	58,000	6,000	11.50%
Ohio	514,000	581,000	67,000	13.00%
Oklahoma	173,000	196,000	23,000	13.30%
Oregon	212,000	240,000	28,000	13.20%
Pennsylvania	464,000	524,000	60,000	12.90%
Rhode Island	43,000	46,000	3,000	7.00%
South Carolina	155,000	176,000	21,000	13.50%
South Dakota	57,000	65,000	8,000	14.00%
Tennessee	258,000	292,000	34,000	13.20%
Texas	955,000	1,079,000	124,000	13.00%
Utah	99,000	112,000	13,000	13.10%
Vermont	41,000	41,000	0	0.00%
Virgina	333,000	376,000	43,000	12.90%
Washington	346,000	376,000	30,000	8.70%
West Virginia	46,000	52,000	6,000	13.00%
Wisconsin	256,000	290,000	34,000	13.30%
Wyoming	32,000	36,000	4,000	12.50%

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Chairman KLINE. Without objection, they will both be included in the record.

I thank the secretary for your testimony, for your answering questions, and for your presence here today.

And with that, we are adjourned.

[Questions submitted for the record follows:]

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COMMITTEE ON EDUCATION
AND THE WORKFORCE
U.S. HOUSE OF REPRESENTATIVES
2181 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6100

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August 2, 2013

The Honorable Kathleen G. Sebelius
Secretary of Health and Human Services
United States Department of Health and Human Services
200 Independence Avenue, Southwest
Washington, DC 20201

Dear Secretary Sebelius:

Thank you for testifying at the Committee on Education and the Workforce's June 4, 2013, hearing on "Reviewing the President's Fiscal Year 2014 Budget Proposal for the U.S. Department of Health and Human Services." I appreciate your participation.

Enclosed are additional questions submitted by Committee members following the hearing. Please provide written responses that answer the questions posed no later than August 16, 2013, for inclusion in the official hearing record. Responses should be sent to Benjamin Hoog of the Committee staff, who can be contacted at (202) 225-4527.

Thank you again for your contribution to the work of the Committee.

Sincerely,

John Kline
Chairman

Enclosures

CHAIRMAN KLINE

Head Start

The president's proposed Preschool for All program would be housed at the Department of Education while HHS plans to continue to operate Head Start and the Child Care and Development Block Grant, programs that provide education and care services primarily targeted to children ages zero to five. In fact, a 2012 Government Accountability Office (GAO) report found 45 such programs scattered across multiple agencies (including yours) costing taxpayers at least $13.3 billion annually. Why is the administration proposing to further fragment the federal government's early childhood education and care system?

Child abuse

How many HHS programs exist to help states protect children from abuse and neglect? How is HHS coordinating these efforts to ensure the best investment of taxpayer funds?

Now that HHS has completed all four reports as required by the CAPTA Reauthorization Act of 2010 on important aspects of state and local child abuse prevention systems, how do you plan to address some of your findings?

Older Americans

1. How is the Administration for Community Living meeting the needs of both the disability and aging communities? How have the constituencies of both groups responded to the consolidation of the Administration on Aging, the Office of Disability, and the Administration on Intellectual and Developmental Disabilities?

2. How is the Assistant Secretary on Aging managing the new responsibilities related to the disability community, as well as the existing responsibilities to the aging community?

3. In the president's 2014 budget request, HHS calls for funding new programs and projects at the expense of its current obligations, specifically in nutrition programs for seniors. The budget requests $816 million for Older Americans Act nutrition programs, a reduction from 2013 levels, which is estimated to support meals for 2.3 million seniors. These cuts come on top of: (1) state and local budget cuts; (2) rising costs for food and transportation; (3) smaller or fewer donations due to a slow economy; (4) increased demand for services, as Baby Boomers turn 65 at a rate of 10,000 a day (about 12,000 individuals turn 60 everyday); and (5) increased need for services. How do you justify the call for funding new programs when current obligations are not being met?

4. While the committee continues to gather information to inform the reauthorization of the Older Americans Act, when can we expect to see your recommendations, if any, for the reauthorization?

CONGRESSMAN THOMAS PETRI (WI)

1. I have been contacted by several Wisconsin Medicaid-dependent home care providers with over 1,000 employees each. As you know, the ACA requires that these entities provide insurance to their employees or pay a fine. While most normal businesses would raise their prices in the face of rising costs, unfortunately these providers are in the unique position of only having one customer—the Medicaid program. As has been well documented, the Medicaid program significantly underpays providers relative to their costs, leaving these operators with very little margin. Therefore, the ACA puts them in an impossible position as they cannot afford to provide the required insurance or pay the fine, but also cannot raise their rates.

It is my understanding that they have sought relief from your department as well as from the Department of the Treasury. While sympathy is expressed, no solution has been offered. These personal care providers are vital to our nation's health care infrastructure as they allow individuals to receive care in their homes, rather than an institution. What alternative can you offer to these providers besides bankruptcy?

CONGRESSMAN PHIL ROE (TN)

1. Several hospitals in East Tennessee recently brought to my attention the wide disparity in Medicare payments among different regions of the country as a result of the wage index. The low payments that hospitals in my state are receiving as a result of the wage index are threatening their viability and could lead to diminished access to care. Does your department have any recommendations on how Congress could address this inequity and provide adequate payment to hospitals in states like Tennessee?

2. At a recent committee field hearing in North Carolina, Mr. Chuck Horne, the president of a textile company with 350 employees, testified as to the impact that the Affordable Care Act will have on his business. Mr. Horne currently offers outstanding insurance benefits—at great cost to the company—because he believes it is the right thing to do. Mr. Horne, however, will be punished by the transitional reinsurance fee of $63 per covered life even though his company will not benefit from it. What would you say to Mr. Horne, who will pay $32,000 to provide a backstop to large insurance companies instead of having that money to reinvest in his business? Do you believe this is fair?

CONGRESSMAN TODD ROKITA (IN)

1. Over 5 million people in the United States have Alzheimer's disease. Getting a timely and accurate diagnosis is an important part of addressing this disease. Leading experts & even the Health and Human Services own web site stress the value of early diagnosis.

Early diagnosis allows families to better plan for the course of this disease and it allows patients and medical experts to explore various treatments available that can help possibly delay or mitigate symptoms common with this disease.

Far too many people with Alzheimer's are not diagnosed until their symptoms have become severe, making it much more difficult and complex for them and their loved ones to plan for the future. What is HHS doing to ensure timely access and coverage to new technologies for Alzheimer's disease as they become available, particularly diagnostic tools that can help individuals to get the care they need before it's too late?

2. CMS currently reimburses for countless medications and procedures to treat patients with Alzheimer's disease or other forms of cognitive impairment. Given that 1 in 5 patients who are diagnosed with Alzheimer's actually have something else, can you comment on why the agency is considering not covering a diagnostic agent for this disease state that was approved by the FDA over a year ago?

CONGRESSMAN LARRY BUCSHON (IN)

1. Secretary Sebelius, the Association of American Medical Colleges and the US Health Resources and Services Administration—an agency within HHS—project that by 2020 the US will be facing a large physician shortage that is evenly split between specialists and primary care physicians. I'm very concerned that at a time when there is general agreement that we need to grow the physician workforce because of the aging of the baby boomers, the Administration is actually proposing cutting Medicare's support for teaching hospitals and the critical services they provide.

The President's proposal to cut Medicare indirect medical education payments by 10 percent would cost America's teaching hospitals millions annually as they try to train physicians and would jeopardize these hospitals' ability to provide care for the sickest in their communities, especially seniors and the underserved. Make no mistake, in addition to hindering the training of doctors, cuts to providers will wind up leading to cuts to patient services.

Can you help me understand the rationale behind this cut?

CONGRESSMAN TREY GOWDY (SC)

1. What section of the Public Health Service Act do you derive your authority to solicit funds from private groups in order to fund the implementation of the Patient Protection and Affordable Care Act?

CONGRESSMAN LOU BARLETTA (PA)

As you know, Pennsylvania recently requested that HHS provide flexibility to the state to continue the Pennsylvania Children's Health Insurance Program (CHIP) and to exempt the state from having to transfer a significant portion of its enrollees into the Medicaid system. Under Obamacare, PA's CHIP kids would have to be added to that population. Because of the law, the state has calculated that of the 187,000 current enrollees in PA CHIP, they will have to involuntarily transfer approximately 70,000 enrollees onto the Medicaid rolls.

1. Do you think it is better for those kids to remain in a program that has better provider capacity?

2. How are you going to explain that they can no longer get prompt service because they have been moved to a program that reimburses providers so poorly that there aren't enough providers to take care of everyone in the program?

CONGRESSWOMAN MARTHA ROBY (AL)

1. Prior to the House Committee on Education and the Workforce hearing on June 4, 2013, I reached out to my constituents on Twitter and Facebook to see what questions they might ask you if they had the opportunity to do so. I compiled their questions and would like responses to share with each individual. Per their request, personal information has been redacted.

a. My employer has provided excellent insurance coverage for over 30 years. It would definitely be classified as a 'Cadillac Plan.' This year we were forced to change coverage. Please tell me how penalizing or taxing companies that provide excellent coverage has anything to do with ensuring everyone has access to affordable healthcare.

b. The President said if we liked our current plan we could keep it. This has turned out to be false. What changes to Obama Care is the administration doing to ensure that this statement does not turn out to be a lie?

c. The plan [PPACA] was touted as a cost saver, but as the details become available we're seeing the opposite. My question is: if the plan is evolving into something it was never intended to be, what is the Secretary intended to do to impose cost controls?

d. Now that we see so many companies reducing work hours of employees to preclude having to pay the higher cost /coverage of insurance for people working over 30 hrs, what are you going to do to help those people make up the difference in lost pay and lost benefits?

e. Why is the IRS involved in anything having to do with healthcare?

f. Why are healthcare costs already rising when the whole goal was to reduce costs?

2. As you know, beginning in 2014, businesses with 50 or more full-time equivalent employees will be required to provide health insurance coverage to full-time employees or face new tax penalties.

Many of the businesses Alabama are family owned and operated businesses, passed down generation after generation. One specific heating and plumbing company in Montgomery, AL is extremely confused with the current mandate set to go into effect in 2014.

Their business currently has a count of 52 employees; however, three of these individuals are considered businesses owners. Per the law's mandates, is this business required by law to provide coverage to their employees?

Has the Department issued any specific, in-depth guidance as to how to count each employee—including business owners and family members as employees? For example, the State of Alabama's workers compensation regulations do not take into account business owners as employees. Does the health care law?

3. On a similar note, there is much ambiguity regarding coverage for young adults who remain on their parent's insurance plans until they are 26.

If a young adult is employed part-time at a local grocery store, around 25-30 hours a week, they are technically be classified as a "full-time employee" per the Department's definition. In this instance, who is primarily responsible to provide health care to the young adult—the parent or the business?

If there is a lack of compliance from such business and they do not provide the health insurance mandated by law, what is the penalty associated to this business?

CONGRESSWOMAN SUSAN BROOKS (IN)

1. Alzheimer's disease is estimated to cost the nation $200 billion this year alone, and about 70 percent of that—$140 billion—is shouldered by taxpayers in Medicare and Medicaid costs. If the current trajectory holds, this number will exceed $1 trillion annually in the coming decades.

Experts as well as our government have stressed the value of an early and accurate diagnosis in treating Alzheimer's to prevent costly and time-consuming misdiagnoses, as well as begin proper care planning earlier. At the same time, companies have been working to create diagnostic tests that could lead to an earlier finding of Alzheimer's.

As diagnostic technologies for Alzheimer's and other diseases continue to be developed and gain approval by the FDA, what measures be taken to prioritize coverage of diagnostic tools, particularly when early diagnosis of diseases like Alzheimer's and others can lead to dramatically lower costs?

2. One of the selling points of the health care law to small businesses was the ability to offer their employees a range of choices in the new insurance exchanges. However, last Friday HHS announced a delay in the implementation of the employee choice component of SHOP in the 33 states where the federal government will run the exchange. This delay once again shows the administration is falling behind in implementation of this flawed law. The result is fewer choices and higher premiums for small businesses and their employees. Are you at all concerned this delay will push more employers to simply drop insurance?

3. It has been three years since enactment of the health care law, yet the administration has not issued many of the critical rules needed for 2014. When will these much-needed rules be released? Open enrollment is expected to begin in October 2013. Won't states, employers, and insurers need to know the final rules before they can invest the hundreds of millions of dollars required to implement the law?

CONGRESSMAN RICHARD HUDSON (NC)

1. Madam Secretary, the Congressional Budget Office estimates that job creators will pay $140 billion in new taxes because of the employer mandate in the health care law

Last December, Chairman Kline and Dr. Roe, sent you and Sectaries Geithner and Solis a letter asking for information about how the employer mandate and its penalties will impact employment, specifically part-time workers. Treasury responded on behalf of the three agencies, stating, quote: "We have not conducted any specific analysis of the effects on employment".

In April, our health subcommittee held a hearing in my district in North Carolina where we heard from employers struggling to figure out how the law will affect their businesses, employees, and customers. Ed Tubel, owner of Sonny's BBQ, testified that his company's compliance costs may reach $200,000. Tina Hayes, Chief Human Resources Officer at a local community college testified they will have to reduce the number of courses they offer because of the new employer mandate.

Madam Secretary, an employer with 49 workers that cannot afford to buy government approved insurance will face a fine of $40,000 for hiring just one new worker. We need job growth and small businesses to lead the way. What would you say to the small business owners that testified in North Carolina about the crushing new taxes they face for not providing government approved insurance? Or, to the workers who are seeing their hours and take home pay reduced because their employer simply cannot afford government-approved insurance?

Madam Secretary, to confirm for the record, your agency has not conducted any specific economic analysis to determine how the new employer mandate will impact employment?

CONGRESSMAN LUKE MESSER (IN)

1. I have been contacted by several superintendents and part-time school employees in my congressional district about the harmful impact the Affordable Care Act may have on educational organizations and their employees.

A. Are you concerned the quality of education provided to students will suffer because schools are reducing the hours of some employees below 30 per week due to the harsh tax penalties imposed by the Affordable Care Act?

B. Do you believe a 30 hour work week is an appropriate amount to be considered a full-time employee?

C. Has the Department analyzed the potential impact on school employees that the Affordable Care Act's employer responsibility provisions may have, particularly given Internal Revenue Service guidance regarding the manner in which schools are required to calculate their number of full-time employees?

2. The Administration has made early detection and clinical diagnosis of Alzheimer's disease a priority under its National Alzheimer's awareness campaign. What specific steps is the Administration undertaking to further this principle?

A. For example, will you make a diagnostic test that can assess whether a Medicare beneficiary with cognitive impairment actually has Alzheimer's disease accessible to all the appropriate patients for such a test?

3. Currently, a significant number of patients with cognitive impairment, possibly Alzheimer's disease, do not receive the right diagnosis. I appreciate that an accurate and early diagnosis is one of the continuing goals of the National Plan to Address Alzheimer's Disease.

Do you agree that ensuring access to accurate diagnosis through FDA approved technologies for patients with cognitive impairment would help achieve a major goal of the National Plan to Address Alzheimer's Disease?

CONGRESSMAN BOBBY SCOTT (VA)

1. Is there currently data available that shows the effects of preventive care without co-pays or deductibles? For example, due to increased access for tests such as mammograms, are cancers being detected at an earlier stage than before?

2. Should Members of Congress or Congressional influence affect the policies governing organ transplants?

CONGRESSMAN RUBEN HINOJOSA (TX)

1. As you know the rollout of the Affordable Care Act exchanges in January of next year is a critical time. In the coming months, my constituents and small business need to be educated as to what they can expect, what is expected of them, and they will look to our offices to help guide them through the process.

With the Republican budget cuts, including the arbitrary sequestration cuts they championed and passed into law, what resources are available for HHS employees to travel to congressional districts for rollout events, informational town hall meetings and constituent outreach in the months ahead?

2. As you know in the state of Texas, Governor Parry has put politics above the health of Texans and refused to participate in the Medicaid expansion program which would have provided health care to over 1.5 million Texans as well as create more than three million jobs, according to a report generated by the Perryman Group. This is all despite the fact that a recent poll by the Texas Hospital Association shows a majority of Texans are in favor of Medicaid expansion.

My concern is that because of the Governors short sighted decision hospitals will get stuck in the middle. As you know, the Affordable Care Act calls for a reduction in Disproportionate Share Hospital (DSH) payments based on an assumption that states are expanding Medicaid. Since this expansion is not happening in Texas, how will you work with hospitals in Texas to make sure they do not get financially harmed by a DSH reduction?

CONGRESSMAN JARED POLIS (CO)

1. In addition to expanding access to high quality early education programs, it is crucial that early education programs such as Head Start work with elementary schools to ensure a strong transition. That's why I introduced a bipartisan, no-cost bill, the Continuum of Learning Act, which would align early childhood education and early elementary school standards and professional development activities through strong child development practices and policies. How would the administration's preschool proposal strengthen connections between existing early learning programs and the elementary grades?

[Secretary Sebelius' response to questions submitted for the record follows:]

OFFICE OF THE SECRETARY,
DEPARTMENT OF HEALTH & HUMAN SERVICES,
Washington, DC, February 7, 2014.

Hon. JOHN KLINE, *Chairman,*
Committee on Education and the Workforce, House of Representatives, Washington, DC 20515.

DEAR MR. CHAIRMAN: Thank you for the opportunity to complete the record for the June 4, 2013 hearing at which Secretary Sebelius testified on the FY 2014 Budget for the Department of Health and Human Services. Enclosed you will find the answers to your questions.

I hope this information is helpful. If I may be of further assistance, please do not hesitate to contact me at 202-690-7627.

Sincerely,

JIM R. ESQUEA,
Assistant Secretary for Legislation.

Enclosure.

CHAIRMAN JOHN KLINE (MN)

1. The president's proposed Preschool for All program would be housed at the Department of Education, but HHS plans to continue to operate Head Start and the Child Care and Development Block Grant, programs that provide education and care services primarily targeted to children ages zero to five. A 2012 Government Accountability Office (GAO) report found 45 such programs scattered across multiple agencies (including yours) costing taxpayers at least $13.3 billion annually. Why is the administration proposing to further fragment the federal government's early childhood education and care system?

Answer: The Administration's proposal represents a coordinated and comprehensive approach to strengthen and expand early childhood education services for our nation's most vulnerable children. The President's plan will maintain and build on current Head Start investments to support a greater share of infants, toddlers and three year olds in Head Start centers, while state preschool settings will serve a greater share of four year olds using Department of Education preschool funding. The net result will be more five year old children entering kindergarten ready to succeed. The Preschool for All program focuses on 3 and 4 year olds. Head Start (and Early Head Start) will now focus on infants and toddlers. Currently, fewer than 5% of infants and toddlers living below the poverty line receive Early Head Start Services.

As part of the President's Early Education Plan, we would also expand high quality early learning services to over 100,000 infants and toddlers through Early Head Start—Child Care Partnerships. These partnerships will build on the strengths of Early Head Start and child care investments. Instead of duplicating efforts, HHS will purposefully use the existing infrastructure of child care centers and homes in partnership with Early Head Start to improve access and quality so that more of our nation's most vulnerable infants and toddlers will receive the high quality, comprehensive full day full year services they need. Additionally, this proposal was de-

veloped in partnership with the U.S. Department of Education and the U.S. Department of Health and Human Services, to ensure that children and families experience successful transitions and continuous high-quality early learning services from birth through age five and into the early grades of elementary school.

2. How many HHS programs help states protect children from abuse and neglect? How is HHS coordinating these efforts to ensure the best investment of taxpayer funds?

Answer: Child abuse and neglect is a complex, multidimensional problem. Research confirms that childhood trauma and maltreatment can lead to a range of negative effects on physical and mental health that extend into adulthood. Addressing child maltreatment cuts across many disciplines and therefore collaborative efforts are essential to preventing child maltreatment, promoting well-being, and improving the lives of children and families across the United States. There are several programs, both across HHS and other agencies that in some way touch on the issue through prevention, intervention, treatment, and law enforcement activities.

Within HHS, the grant programs authorized by the Child Abuse Prevention and Treatment Act (CAPTA) and the programs authorized under titles IV-B of the Social Security Act specifically focus on the prevention and treatment of child abuse and neglect and the provision of public child welfare services as part of their core mission. CAPTA programs include the Community-Based Child Abuse Prevention Program, Children's Justice Act, Basic State Grant, and CAPTA research and demonstration grants.

CAPTA programs focus on collaboration and coordination for upfront prevention and improving the investigation and response to child maltreatment. The title IV-B programs provide funding for a wide range of child welfare related activities, including child abuse and neglect prevention and family preservation. Under the Title IV-B program, states are required to develop a Child and Family Services Plan (CFSP), a five-year strategic plan that sets forth the vision and the goals to be accomplished to strengthen the states' overall child welfare system. A primary purpose of the CFSP is to facilitate states' integration of programs that serve children and families into a continuum of services for children and their families. Programs addressed through the CFSP include title IV-B, subparts 1 and 2 of the Social Security Act (the Stephanie Tubbs Jones Child Welfare Services Program and the Promoting Safe and Stables Families Program, respectively), and the Chafee Foster Care Independence Program and Education and Training Vouchers Program for older and/or former foster care youth. States also report on their use of the CAPTA State grant in conjunction with their plan submission. The CFSP consolidates plans for these programs to help states comprehensively integrate the full array of child welfare services, from prevention and protection through permanency.

In addition to promoting coordinating planning across several key programs, the Obama Administration has focused significant attention on bringing together the resources of the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, and the Centers for Medicare & Medicaid Services to address trauma and promote well-being.[1] Our Department has been proactive in reaching out to states to let them know about federal authority and funding streams, strategies for coordinating cross-system efforts, and good practices for integrating evidence-based screening, assessment, and interventions related to complex trauma, including the trauma associated with child abuse and neglect.

Additionally, it is important to note that HHS chairs the Federal Interagency Workgroup on Child Abuse and Neglect, which is a longstanding group that includes federal staff from over 40 different agencies across the government and provides an ongoing forum for information sharing and facilitating stronger collaboration and coordination across various child maltreatment related programs.[2]

3. Now that HHS has completed all four reports required by the CAPTA Reauthorization Act of 2010 on important aspects of state and local child abuse prevention systems, how do you plan to address some of your findings?

Answer: HHS will continue to foster partnerships with other federal agencies and other partners to address child maltreatment, trauma and other adverse childhood experiences. HHS will continue to use the findings from the four CAPTA Reports to Congress to support ongoing research, training, technical assistance, and service delivery across all our programs. The findings from the reports emphasize the need to increase states' and grantees' capacity to collect and use data for assessing program performance and continuous quality improvement. HHS is also committed to

[1] See: *http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-004.pdf*

[2] See: Report on Efforts to Coordinate Programs and Activities Related to Child Abuse and Neglect, June 2013

investing more resources towards evidence-based and evidence-informed programs across various funding streams. We plan to continue developing opportunities for shared learning, knowledge development and dissemination at the federal level. We also plan to encourage grantees and community service providers to make similar efforts at the state and local level. We believe that interagency coordinated efforts throughout HHS and with other federal and non-federal partners are critical for preventing child maltreatment and promoting the well-being of children and families.

Given the unique demographics and cultures of all states, it was challenging to generalize findings of states' use of the CAPTA State grant that might be implemented across all states or to draw conclusions about the effectiveness of states' use of the CAPTA State Grant since the state CAPTA plans focus on state spending plans, rather than outcomes. Through the report, we did learn that 37 percent of states selected a CAPTA program area because it aligned with the CFSP, and 47 percent of states selected a CAPTA program area because it aligned with the state's Program Improvement Plan developed to address findings from the federal Child and Family Services Review (CFSR). This confirms that most states are already working to integrate planning for the title IV-B and CAPTA programs to make broader program improvements to better support the state's comprehensive child and family services programs, including child abuse and neglect programs. It also confirms that the CFSP is the best vehicle to ensure coordination and integration of state child protective services with overall child welfare services in the state.

In regard to the report on citizen review panels, we understand the panels may play a role in improving child protective systems across the states. The report is inconclusive on the effectiveness of citizen review panels in examining how agencies are fulfilling their child protective services responsibilities because of the parameters of the study. The report was an exploratory, descriptive report based on the analysis of annual reports submitted by citizen review panels and the state child protection system responses to those reports. We generally learned about citizen review panel recommendations and state responses to those recommendations and that practices vary from state to state. As such, states will continue to need the flexibility afforded by the CAPTA provision that mandates the responsibilities of the citizen review panels. We would need to conduct a future study with appropriate funding if we are to better understand how citizen review panels might be useful as a systems improvement in state and local child welfare agencies. Although such a study may be informative, the study would not directly meet the critical informational need for child protective service agencies, and is therefore a lower priority than other agency activities. We concluded, however, that the public may not be able to easily access all of the citizen review panel reports as required by CAPTA. Therefore, we plan to address this with states that do not have their reports available on their websites.

The report on efforts to coordinate the objectives and activities of agencies and organizations which are responsible for programs related to child abuse and neglect demonstrates that the Administration for Children and Families' (ACF) Children's Bureau, Office on Child Abuse and Neglect (OCAN) has been consistently engaged in significant efforts to meet its coordination responsibility. Through collaborative work with federal, state and local agencies, and a network of non-federal partners, OCAN manages efforts to share and disseminate information, promote awareness, and implement various activities to address child abuse and neglect. We will continue these coordination activities by working with our federal partners on issues of child abuse prevention through the Federal Interagency Workgroup on Child Abuse and Neglect; interagency agreements and initiatives; conferences, workshops and other projects. Very specifically, we will continue our longstanding interagency agreements between ACF and other federal agencies to co—fund child abuse and neglect prevention and treatment activities.

In the report on immunity protections for professionals who consult or assist on cases involving child abuse and maltreatment, we concluded all states have universally extended civil immunity to all good faith reporters in law in compliance with the requirements in CAPTA. Professionals who consult or assist on child maltreatment cases may have less fear of liability for their actions and potentially cooperate more readily if they had immunity for their actions. Although not required by CAPTA, states may want to consider whether to enact laws to extend immunity for professionals who consult, cooperate, or assist on child maltreatment cases.

4. How is the Administration for Community Living meeting the needs of the disability and aging communities? How have the constituencies of both groups responded to the consolidation of the Administration on Aging, the Office of Disability, and the Administration on Intellectual and Developmental Disabilities?

Answer: The Administration for Community Living (ACL) is meeting the needs of the disability and aging communities primarily through continued implementation of the Older Americans Act and the Developmental Disabilities Assistance and Bill of Rights Act at state and local levels. ACL is conducting ongoing assessments of the needs of these communities and evaluating and continuously improving our performance and seeking efficiencies. Additionally, ACL is working closely with a number of partners within HHS, such as the Centers for Medicare & Medicaid Services, the Substance Abuse and Mental Health Services Administration, and others, with regard to policies that can better coordinate the provision of long-term services and supports for persons with intellectual and developmental disabilities and older Americans.

The communities' response has been very positive. Since the creation of ACL, both communities have seen the benefits of collaboration, alignment of goals, and cooperation in order to achieve greater results.

5. How is the Assistant Secretary on Aging managing the new responsibilities related to the disability community, as well as the existing responsibilities to the aging community?

Answer: The Assistant Secretary for Aging has found that the two constituencies have so many similarities that her joint role as Administrator for Community Living has allowed her to become a stronger advocate for enhanced Long Term Service and Support Systems that are critical to the communities that ACL represents.

6. The president's 2014 budget request calls for funding new programs and projects at the expense of its current obligations, specifically related to nutrition programs for seniors. The budget requests $816 million for Older Americans Act nutrition programs, a reduction from 2013 levels, which is estimated to support meals for 2.3 million seniors. These cuts come on top of: (1) state and local budget cuts; (2) rising costs for food and transportation; (3) smaller or fewer donations due to a slow economy; and (4) increased demand for services, as Baby Boomers turn 65 at a rate of 10,000 a day (about 12,000 individuals turn 60 everyday). How do you justify the call for funding new programs when current obligations are not being met?

Answer: ACL recognizes the critical need for funding for senior nutrition programs. To this end, the President's FY 2014 budget requests to restore funding for these programs to the FY 2012 level of $816 million from the FY 2013 enacted level of $768 million after sequestration. In addition to this restoration of funding for senior nutrition and other core services programs, the FY 2014 budget request continues to propose the transfer of three programs for greater alignment and efficiency, continues the focus on prevention through the Alzheimer's initiative, and continues to support Aging and Disability Resource Centers. The President's budget also contains a modest investment of $8 million in discretionary grant funding to test innovative approaches to reducing and addressing elder abuse in states and tribal settings through Adult Protective Service systems, a need which was documented through two recent reports of the General Accountability Office.

7. While the committee continues to gather information to inform the reauthorization of the Older Americans Act, when can we expect to see your recommendations, if any, for the reauthorization?

Answer: ACL continues to support the reauthorization of the Older Americans Act, as noted in our previously-submitted statement of principles for reauthorization. These principles were based on listening sessions from the field as to how to best serve our communities. ACL has no plans for specific recommendations in the form of bill language. However, we are pleased to work with Congress to provide technical assistance regarding any specific program area, principle, or proposal. Our principles for reauthorization are posted on the ACL website at: *http://www.aoa.gov/AoARoot/AoA_Programs/OAA/Reauthorization/Target_Change.aspx.*

CONGRESSMAN THOMAS PETRI (WI)

1. I have been contacted by several Wisconsin Medicaid-dependent home care providers with over 1,000 employees each. As you know, the Patient Protection and Affordable Care Act (PPACA) requires that these entities provide insurance to their employees or pay a fine. While most normal businesses would raise their prices in the face of rising costs, unfortunately these providers are in the unique position of only having one customer—the Medicaid program. As has been well documented, the Medicaid program significantly underpays providers relative to their costs, leaving these operators with very little margin. Therefore, the PPACA puts them in an impossible position as they cannot afford to provide the required insurance or pay the fine, but also cannot raise their rates.

It is my understanding that they have sought relief from your department as well as from the Department of the Treasury. While sympathy is expressed, no solution has been offered. These personal care providers are vital to our nation's health care infrastructure as they allow individuals to receive care in their homes, rather than an institution. What alternative can you offer to these providers besides bankruptcy?

Answer: Thank you for your question regarding payment rates to Medicaid providers. I recognize the critical importance of Medicaid home care providers to enable Medicaid beneficiaries to remain in the community.

States set payment rates with approval from the Centers for Medicare & Medicaid Services (CMS), and CMS works with states as they set their payment rates with beneficiary access in mind. States have a considerable amount of flexibility when it comes to setting rates and can consider as part of that rate setting process any relevant factor, including the cost of overhead components such as employee group health coverage. CMS reviews state provider payment rates to ensure that such rates are in keeping with federal statutory and regulatory guidelines, but states have the flexibility to adjust payment rates within those guidelines. To the extent that a state wishes to increase payment rates to certain providers, CMS is available to work with the state to ensure that such increase meets federal requirements. Furthermore, to the extent that the payment increase meets CMS approval, the federal government would provide financial participation (FFP) for the increased payment at the appropriate matching rate.

Additionally, as you may know, the Administration has announced that it will provide an additional year before the Affordable Care Acts mandatory employer reporting requirements begin, which will provide affected businesses with additional time as they move towards making health coverage available to their employees.

CONGRESSMAN PHIL ROE (TN)

1. Several hospitals in East Tennessee recently brought to my attention the wide disparity in Medicare payments among different regions of the country as a result of the wage index. The low payments that hospitals in my state are receiving as a result of the wage index are threatening their viability and could lead to diminished access to care. Does your department have any recommendations on how Congress could address this inequity and provide adequate payment to hospitals in states like Tennessee?

Answer: Under the current hospital wage index system, hospitals are classified into geographically similar labor market areas. The labor market areas are based on the Office of Management and Budget delineations of metropolitan statistical areas.

In April of 2012, CMS submitted a Report to Congress entitled, "Plan to Reform the Medicare Wage Index." In that report, CMS discussed a different approach to calculating the wage index that we believe would more accurately reflect the labor costs incurred by each hospital based on the hospital employees' commuting patterns. This "commuting-based wage index" would allow for the wage index to be calculated at a more granular level, down to the individual hospital. It could also potentially obviate the need for hospital reclassifications to other labor market areas. In the report, we indicated that more data on hospital employee commuting patterns may be necessary before adopting a commuting-based wage index. Additionally, we stated that certain special adjustments to the wage index under current law may no longer be applicable and should be reviewed in order to determine if they would still be relevant under the new system. Current law is rather prescriptive with respect to the wage index; nonetheless, we continue to evaluate whether improvements could be made under existing authority.

2. At a recent committee field hearing in North Carolina, Mr. Chuck Horne, the president of a textile company with 350 employees, testified as to the impact that the Patient Protection and Affordable Care Act will have on his business. Mr. Horne currently offers outstanding insurance benefits—at great cost to the company—because he believes it is the right thing to do. Mr. Horne, however, will be punished by the transitional reinsurance fee of $63 per covered life even though his company will not benefit from it. What would you say to Mr. Horne, who will pay $32,000 to provide a backstop to large insurance companies instead of having that money to reinvest in his business? Do you believe this is fair?

Answer: The Affordable Care Act has many components that help contain costs, hold health insurers accountable to consumers and ensure that American families receive value for their health insurance premium dollars. One such mechanism is the 80/20 rule, or Medical Loss Ratio (MLR) rule. The 80/20 rule brings consumers value, increases transparency and accountability, and promotes better business

practices and competition among insurance companies. MLR generally requires insurance companies in the individual and small group markets to spend at least 80 percent of the premium dollars they collect on medical care and quality improvement activities or pay a rebate. Issuers in the large group market also have to comply with MLR requirements by spending 85 percent of premium dollars on medical care and quality improvement activities, or else they must pay a rebate.

The Congressional Budget Office analyzed the net impact of the Affordable Care Act reforms on premiums in the individual, small group, and large group markets.[3] CBO calculated that premiums in the large group market (50 or more employees) will be zero to a 3 percent lower than they would have been without the Affordable Care Act. Employers (and their premium paying employees) will benefit from factors such as a decrease in uncompensated care, a reduction in fees—such as state high-risk pool assessments—associated with assisting the uninsured, and population improvements in health.

By combining insurance market reforms, new efficiencies created by the Marketplaces, and programs such as reinsurance that will help stabilize premiums in the new Marketplaces, the Affordable Care Act increases competition between health insurance issuers and reduces uncompensated care.

CONGRESSMAN TODD ROKITA (IN)

1. Over 5 million people in the United States have Alzheimer's disease. Getting a timely and accurate diagnosis is an important part of addressing this disease. Leading experts and even the Department of Health and Human Services' (HHS) own web site stress the value of early diagnosis.

Early diagnosis allows families to better plan for the course of this disease and it allows patients and medical experts to explore various treatments available that can help possibly delay or mitigate symptoms common with this disease.

Far too many people with Alzheimer's are not diagnosed until their symptoms have become severe, making it much more difficult and complex for them and their loved ones to plan for the future. What is HHS doing to ensure timely access and coverage to new technologies for Alzheimer's disease as they become available, particularly diagnostic tools that can help individuals to get the care they need before it's too late?

Answer: We are actively engaged in reviewing new technology to ensure timely access to innovation for our beneficiaries. For example, in October 2012, the Centers for Medicare & Medicaid Services (CMS) opened a National Coverage Analysis (the first step in the National Coverage Determination (NCD) process) to reconsider a prior NCD on the use of Positron Emission Tomography (PET) scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by a stakeholder who advocated coverage of PET using a radiopharmaceutical approved by the FDA in 2012 to image beta-amyloid plaques in adult patients with cognitive impairment who are being evaluated for Alzheimer's disease and other causes of cognitive decline.

To help inform this evidence review, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) in January 2013. A proposed coverage decision is expected by July 2013, with a final decision (including consideration of public comments) expected by October 2013. Information on the status of this coverage review is available on the CMS website at *http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId = 265&NcaName = Beta + Amyloid + Positron + Emission + Tomography + in + Dementia + and + Neurodegenerative + Disease&bc = AgBAAAAAAAAAAA%3d%3d&.*

2. CMS currently reimburses for countless medications and procedures to treat patients with Alzheimer's disease or other forms of cognitive impairment. Given that one in five patients who are diagnosed with Alzheimer's actually have something else, can you comment on why the agency is considering not covering a diagnostic agent for this disease state that was approved by the Food and Drug Administration over a year ago?

Answer: As noted above, a National Coverage Analysis on beta-amyloid PET scans is underway to reconsider a prior National Coverage Determination on Medicare coverage of PET scans. CMS' evidence-based coverage decision-making process is separate and distinct from the Food and Drug Administration's processes for determining a product's safety and effectiveness; CMS' coverage decision-making process is designed to meet CMS' statutory obligation to ensure that Medicare covers only

[3] *http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf*

items and services determined to be "reasonable and necessary" for our beneficiaries.

CONGRESSMAN LARRY BUCSHON (IN)

1. The Association of American Medical Colleges and the U.S. Health Resources and Services Administration—an agency within your department—project that by 2020 the United States will be facing a large physician shortage, evenly split between specialists and primary care physicians. I'm very concerned that at a time when there is general agreement that we need to grow the physician workforce because of the aging of the baby boomers, the administration is actually proposing to cut Medicare's support for teaching hospitals and the critical services they provide.

The president's proposal to cut Medicare indirect medical education payments by 10 percent would cost America's teaching hospitals millions annually as they try to train physicians, jeopardizing hospitals' ability to provide care for the sickest in their communities, especially seniors and the underserved. In addition to hindering the training of physicians, cuts to providers will lead to a reduction in patient services. Please explain the rationale behind the president's proposal.

Answer: MedPAC has repeatedly found that IME payments are more than twice as high as what is empirically justified by teaching hospitals' actual teaching costs. The 10% reduction in IME would reduce (though not eliminate) this disparity. We recognize the critical importance of graduate medical education. Nonetheless, like any other category of Medicare spending, payments to teaching hospitals must be well-justified. We believe this proposal brings these payments closer to the empirically justified level. By supporting the training of more and higher quality primary care providers, this proposal also helps fill a key long-term need of the health care system.

CONGRESSMAN TREY GOWDY (SC)

1. From what section of the Public Health Service Act do you derive your authority to solicit funds from private groups in order to promote the Patient Protection and Affordable Care Act?

Answer: Within HHS, we are working everyday so that uninsured Americans will be able to sign up for healthcare coverage starting October 1. This important mission to extend health insurance coverage to millions of Americans for the first time can't be accomplished by government alone. It takes the support of the business sector, non-profits, community organizations, and others who share this vision. Many private organizations share our mission and they are pursuing their own efforts to get Americans covered. Because of sections of the Public Health Service Act (42 U.S.C. §§ 300u-2 to -3) HHS Secretaries since 1976 have had the authority to encourage others to support important health initiatives. For example, previous Secretaries from both parties marshalled private-sector support efforts to enroll eligible beneficiaries in two important programs that expand the availability of health insurance: the Medicare prescription drug benefit (Medicare Part D) and the Children's Health Insurance Program.

CONGRESSMAN LOU BARLETTA (PA)

1. As you know, Pennsylvania recently requested that the Department of Health and Human Services provide flexibility to the state to continue the Pennsylvania Children's Health Insurance Program (CHIP) and to exempt the state from having to transfer a significant portion of its enrollees into the Medicaid system. Under the Patient Protection and Affordable Care Act, Pennsylvania's CHIP children would have to be added to the Medicaid population. Because of the law, the state has calculated that of the 187,000 current enrollees in Pennsylvania CHIP, approximately 70,000 enrollees will involuntarily be transferred onto the Medicaid rolls. Do you think it is better for those kids to remain in a program that has better provider capacity? How are you going to explain that these children can no longer get prompt service because they have been moved to a program that reimburses providers so poorly that there aren't enough providers to take care of everyone in the program?

Answer: Thank you for your question related to the Affordable Care Act's provision raising the minimum income eligibility level for children in Medicaid.

Section 2001(a)(5)(B) of the Affordable Care Act increased the minimum eligibility level for children from ages 6 through 18 in the Medicaid program from 100 percent to 133 percent of the Federal poverty level (FPL). This reform simplifies coverage by eliminating age-based eligibility rules that have resulted in children in the same family being eligible for two different programs (Medicaid and CHIP) and that requires children to switch programs, from Medicaid to CHIP, and potentially doctors,

when they turn 6. Many states had previously extended Medicaid coverage for these older children. The Affordable Care Act codifies this successful approach nationwide January 1, 2014.

For some states, including Pennsylvania, this will mean that some children will need to transfer from CHIP to Medicaid. Pennsylvania may continue its coverage of children from 133 through 300 percent of the FPL under CHIP. It is also important to note that there is no change in the federal support that will be available for the children that transfer to Medicaid—the enhanced CHIP matching rate will continue to be available for these children even though they will be enrolled in Medicaid.

I appreciate your concern that this transition could potentially cause families to have to change providers. While it is my understanding that most of the plans in Pennsylvania serve both Medicaid and CHIP populations, thus reducing the risk of disruptions in care, we recognize that transitions will be necessary for some families. States can ease this transition by giving families time to choose their new health plans and we will work directly with states to develop transition plans that protect patient access to care.

CONGRESSWOMAN MARTHA ROBY (AL)

1. Prior to the House Committee on Education and the Workforce hearing on June 4, 2013, I reached out to my constituents on Twitter and Facebook to see what questions they might ask you if they had the opportunity to do so. I compiled their questions and would like responses to share with each individual. Per their request, personal information has been redacted.

a. My employer has provided excellent insurance coverage for over 30 years. It would definitely be classified as a 'Cadillac Plan.' This year we were forced to change coverage. Please tell me how penalizing or taxing companies that provide excellent coverage has anything to do with ensuring everyone has access to affordable healthcare.

Answer: Section 4980I of the Internal Revenue Code is not effective until 2018, five years from now, so that does not explain why your coverage changed this year.

The costs for large employers directly associated with the implementation of the Affordable Care Act are far outweighed by the systemic savings of the law. These savings are due to greater market transparency and competition and a more stable marketplace with more covered Americans. For example, premiums for employer-sponsored insurance increased by only 3 percent from 2011 to 2012, the lowest rate of increase since the data series began in 1996.

b. The president said if we liked our current plan we could keep it. This has turned out to be false. What changes to Obama Care is the administration doing to ensure that this statement does not turn out to be a lie?

Answer: The Affordable Care Act allows health plans that existed on March 23, 2010, when the law was enacted, to be "grandfathered" and thus be exempt from many of the new law's provisions. It allows insurers and employers to make some routine changes without losing grandfather status. Plans relinquish their "grandfathered" status if they choose to significantly cut benefits or increase out-of-pocket spending for consumers. Consumers in plans that make such changes and lose their "grandfathered" status will gain new consumer protections.

If you are among the 80 percent of Americans who already have health insurance through your employer, or through government programs such as Medicare and Medicaid, the Affordable Care Act provisions that apply to you are providing you with better consumer protections and ensure that you get more value for each dollar you spend on your health insurance. However for people ineligible for coverage under a government program who do not receive their insurance from their employer, or who are unemployed, the Affordable Care Act is making changes to ensure that they can now find, afford, and keep a plan that they like. Soon, the Marketplaces will provide a new way to shop for coverage for all Americans, that will particularly benefit the uninsured, those with pre-existing conditions, and individuals who currently buy coverage on their own. On October 1, Americans will begin shopping in the Marketplaces, and they'll be able to fill out one application to purchase private insurance, qualify for premium tax credits and reduced cost sharing, or obtain Medicaid or CHIP coverage.

c. The plan [PPACA] was touted as a cost saver, but as the details become available we're seeing the opposite. My question is: if the plan is evolving into something it was never intended to be, what does the secretary intend to do to impose cost controls?

Answer: I disagree. We are already seeing reductions in the growth of healthcare spending. From 2010 to 2012, Medicare spending per beneficiary grew at 1.2 percent annually, more slowly than the average rate of growth in the Consumer Price Index, and substantially more slowly than the per capita rate of growth in the economy. This is in sharp contrast to the 7.6% annual growth rate in per beneficiary spending from 2000-2010, and health economists recognize that the Affordable Care Act has contributed to the slowdown in spending growth. From 2011 to 2012, total spending per Medicaid beneficiary actually declined by 1.9%, resulting in substantial savings for federal and state taxpayers.

New elements are reducing costs and saving taxpayer money in the Medicare program. New anti-fraud programs, like the fraud prevention system that uses predictive modeling technology, are helping deter bad actors and saving billions for the Medicare program. We are using market-driven solutions, like the competitive bidding program for durable medical equipment, to save tens of billions for taxpayers and seniors. Also, in Medicare we're promoting better coordination of care by hospitals through penalties for excess readmissions and payment tied to value for the first time. In 2012, readmissions for Medicare patients dropped significantly, with an estimated 70,000 readmissions avoided due to a variety of new incentives for hospitals to keep patients well and avoid these costly events.

The rate of cost growth is decreasing for private insurance as well. Premiums for employer sponsored insurance increased by only 3% from 2011 to 2012, the lowest rate of increase since the data series began in 1996. In addition, early evidence shows that prices for Marketplace products are lower than expected, and, for small businesses, lower on average than current small business rates in the handful of states that have released data. In part, this appears to be a result of greater transparency and competition.

d. Now that we see so many companies reducing work hours of employees to preclude having to pay the higher cost /coverage of insurance for people working over 30 hours, what are you going to do to help those people make up the difference in lost pay and lost benefits?

Answer: The employer responsibility provision, which applies only to employers with 50 or more full-time equivalent employees, will not be enforced until 2015. Furthermore, if you look at the economic data, the suggestion that the Affordable Care Act is reducing full-time employment is not supported by the facts. Plus, a Minneapolis Federal Reserve Bank study shows that the vast majority of employers are not considering cutting hours. The Affordable Care Act should not cause a leap in part-time jobs, since less than 1 percent of employees work 30 to 34 hours, are uninsured, and are employed by businesses affected by the employer responsibility provision.

In fact, employers are benefitting from the Affordable Care Act, which includes a range of cost-saving, quality-improving measures that are contributing to a slowdown in health care cost growth, which should help employers save money. For example, in 2012, premium growth for employer-sponsored insurance was at its lowest rate (3 percent) since the Medical Expenditure Panel Survey started in 1996. Additionally, starting in October, small employers in every state will be able to offer coverage to their employees beginning in 2014 from among a variety of plans within the Small Business Health Options Program (SHOP) Marketplace in their state.

SHOP Marketplaces will provide side-by-side comparisons of Qualified Health Plans, their benefits, premiums, and quality—expanding options and increasing competition. SHOP Marketplaces also can save businesses money by spreading insurers' administrative costs across more employers. In some states in 2014, and in all states in 2015, billing will be consolidated as well; employers can go to the SHOP Marketplace as "one stop shopping" in order to offer multiple insurer's options to employees without having to deal with each insurer separately.

Businesses might be eligible for small business tax credits when they offer health coverage to their employees through a SHOP Marketplace. From 2014 to 2016, a tax credit of up to 50 percent of the employer-paid premium cost of health insurance coverage will be available, if the employer otherwise qualifies for the credit.

e. Why is the IRS involved in anything having to do with health care?

Answer: The IRS is the U.S. government agency responsible for tax collection and tax law enforcement. It is involved in implementing the portions of the Affordable Care Act that contain tax provisions. For a full list of the Affordable Care Act's tax provisions, please see: *http://www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions.*

f. Why are healthcare costs already rising when the whole goal was to reduce costs?

Answer: I disagree that health care costs are rising due to the Affordable Care Act. In fact, we are already seeing reductions in projected healthcare spending

growth. From 2010 to 2012, Medicare spending per beneficiary grew at 1.2 percent annually, more slowly than the average rate of growth in the Consumer Price Index, and substantially more slowly than the per capita rate of growth in the economy. This is in sharp contrast to the 7.6% annual growth rate in per beneficiary spending from 2000-2010, and health economists recognize that the Affordable Care Act has contributed to the slowdown in spending growth. From 2011 to 2012, total spending per Medicaid beneficiary actually declined by 1.9%.

New elements are reducing costs and saving taxpayer money in the Medicare program. New anti-fraud programs, like the fraud prevention system that uses predictive modeling technology, are helping deter bad actors and saving billions for the Medicare program. We are using market-driven solutions, like the competitive bidding program for durable medical equipment, to save tens of billions for taxpayers and seniors. Also, in Medicare we're promoting better coordination of care by hospitals through penalties for excess readmissions and payment tied to value for the first time. In 2012, readmissions for Medicare patients dropped significantly, with an estimated 70,000 readmissions avoided due to a variety of new incentives for hospitals to keep patients well and avoid these costly events.

The rate of cost growth is decreasing for private insurance as well. Premiums for employer sponsored insurance increased by only 3% from 2011 to 2012, the lowest rate of increase since the data started in 1996. In addition, early evidence shows that prices for Marketplace products are lower than expected, and, for small businesses, lower on average than current small business rates in the handful of states that have released data. While further work is needed to better understand 2014 rates, the results strongly suggest that greater competition and transparency are leading to substantial benefits for both consumers and employers in these markets.

2. As you know, beginning in 2015, businesses with 50 or more full-time equivalent employees will be required to provide health insurance coverage to full-time employees or face new tax penalties. Many of the businesses in Alabama are family owned and operated businesses, passed down generation after generation. One specific heating and plumbing company in Montgomery, AL is extremely confused with the current mandate set to go into effect in 2015. Their business currently has a count of 52 employees; however, three of these individuals are considered businesses owners. Per the law's mandates, is this business required by law to provide coverage to their employees?

Has the department issued any specific, in-depth guidance as to how to count each employee—including business owners and family members as employees? For example, the State of Alabama's workers compensation regulations do not take into account business owners as employees. Does the health care law?

Answer: In December of 2012, the Department of Treasury released a proposed rule Shared Responsibility for Employers Regarding Health Coverage, which can be found here: *http://www.irs.gov/pub/newsroom/reg-138006-12.pdf. The regulation discusses, among other things, methods of calculating what is considered a large employer under the law and the definition of an "employer" versus an "employee." For further clarification, please refer to the Department of the Treasury.*

3. On a similar note, there is much ambiguity regarding coverage for young adults who remain on their parent's insurance plans until they are 26. If a young adult is employed part-time at a local grocery store, around 25-30 hours a week, they are technically being classified as a "full-time employee" per the department's definition. In this instance, who is primarily responsible to provide health care to the young adult—the parent or the business? If there is a lack of compliance from such business and they do not provide the health insurance mandated by law, what is the penalty associated to this business?

Answer: The definition of full-time employee is prescribed by statute in section 4980H(c) (4) of the Internal Revenue Code (the Code) of 1986. The Department of Treasury is responsible for regulations implementing Code provisions. In December of 2012, the Department of Treasury released a proposed rule Shared Responsibility for Employers Regarding Health Coverage, which can be found here: *http://www.irs.gov/pub/newsroom/reg-138006-12.pdf. The regulation discusses, among other things, methods of calculating the 30 hours of services per week for large employers. For further information, please contact to the Department of the Treasury.*

CONGRESSWOMAN SUSAN BROOKS (IN)

1. Alzheimer's disease is estimated to cost the nation $200 billion this year alone, and about 70 percent of that—$140 billion—is shouldered by taxpayers in Medicare and Medicaid costs. If the current trajectory holds, this number will exceed $1 trillion annually in the coming decades.

Experts as well as our government have stressed the value of an early and accurate diagnosis in treating Alzheimer's to prevent costly and time-consuming misdiagnoses, as well as begin proper care planning earlier. At the same time, companies have been working to create diagnostic tests that could lead to an earlier finding of Alzheimer's.

As diagnostic technologies for Alzheimer's and other diseases continue to be developed and gain approval by the Food and Drug Administration, what measures are being taken to prioritize coverage of diagnostic tools, particularly when early diagnosis of diseases like Alzheimer's and others can lead to dramatically lower costs?

Answer: We are actively engaged in reviewing new technology to ensure timely access to innovation for our beneficiaries. For example, in October 2012, the Centers for Medicare & Medicaid Services (CMS) opened a National Coverage Analysis (the first step in the National Coverage Determination (NCD) process) to reconsider a prior NCD on the use of Positron Emission Tomography (PET) scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by a stakeholder who advocated coverage of PET using a radiopharmaceutical approved by the FDA in 2012 to image beta-amyloid plaques in adult patients with cognitive impairment who are being evaluated for Alzheimer's disease and other causes of cognitive decline. To help inform this evidence review, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) in January 2013. A proposed coverage decision is expected by July 2013, with a final decision (including consideration of public comments) expected by October 2013. Information on the status of this coverage review is available on the CMS website at *http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId = 265&NcaName = Beta + Amyloid + Positron + Emission + Tomography + in + De mentia + and + Neurodegenerative + Disease&bc = AgBAAAAAAAAAAA%3d%3d&.*

2. One of the selling points of the health care law to small businesses was the ability to offer their employees a range of choices in the new insurance exchanges. However, last Friday HHS announced a delay in the implementation of the employee choice component of the SHOP Marketplace in the 33 states where the federal government will run the exchange. This delay once again shows the administration is falling behind in implementation of this flawed law. The result is fewer choices and higher premiums for small businesses and their employees. Are you at all concerned this delay will push more employers to simply drop insurance?

Answer: In 2014, a SHOP Marketplace will be operational in every state. As you know, the SHOP Marketplaces will be competitive private health insurance marketplaces through which small businesses and their employees will have access to affordable coverage. In the current small group market, the smallest businesses nationwide pay about 20 percent more than large companies.[4]

Through the SHOP Marketplaces, small employers will benefit from leveraging the buying power of a larger purchasing pool. They will also have access to a transparent marketplace with online tools to help them make meaningful comparisons among qualified health plans (QHPs). Beginning in 2014, if they meet other eligibility requirements, small employers who purchase coverage for their employees through a SHOP Marketplace will also receive tax credits of up to 50 percent of the employer-paid premium cost of coverage to offset the cost of providing health insurance.

As we've seen in Massachusetts, employer-sponsored insurance increased post-reform, and it makes sense to expect a similar outcome for the rest of the United States. We expect the robust employer-sponsored health insurance market to continue. The SHOP Marketplaces will help more employers to offer coverage to their employers, and help provide more American workers insurance. Additionally, the SHOP Marketplaces will improve information for small employers and employees and enable certain eligible employers to access small business health insurance tax credits.

3. It has been three years since enactment of the health care law, yet the administration has not issued many of the critical rules needed for 2014. When will these much-needed rules be released? Open enrollment is expected to begin in October 2013. Won't states, employers, and insurers need to know the final rules before they can invest the hundreds of millions of dollars required to implement the law?

Answer: The Affordable Care Act fixes the broken insurance market by helping consumers and employers shop for and compare affordable health insurance plans, while knowing they won't be denied or priced out of insurance because of their pre-

[4] J. R. Gabel et al. "Generosity and Adjusted Premiums in Job-Based Insurance: Hawaii is Up, Wyoming is Down." Health Affairs, 2006, 25(3): 832-843.

existing condition, occupation, or gender. HHS and CMS have worked diligently to release rules and guidance for states, employers, and insurers in timely manner. States, employers, and insurers will have the information they need to ensure that the Marketplaces are open for business on October 1.

CONGRESSMAN RICHARD HUDSON (NC)

1. Madam Secretary, the Congressional Budget Office estimates that job creators will pay $140 billion in new taxes because of the employer mandate in the health care law. Last December, Chairman John Kline (R-MN) and Chairman Phil Roe (R-TN), sent you and Sectaries Geithner and Solis a letter asking for information about how the employer mandate and its penalties will impact employment, specifically part-time workers. The Department of the Treasury responded on behalf of the three agencies, stating, "We have not conducted any specific analysis of the effects on employment."

In April, our Health, Employment, Labor, and Pensions subcommittee held a hearing in my district in North Carolina where we heard from employers struggling to figure out how the law will affect their businesses, employees, and customers. Ed Tubel, owner of Sonny's BBQ, testified that his company's compliance costs may reach $200,000.

Tina Hayes, Chief Human Resources Officer at a local community college testified they will have to reduce the number of courses they offer because of the new employer mandate.

Madam Secretary, an employer with 49 workers who cannot afford to buy government approved insurance will face a fine of $40,000 for hiring just one new worker. We need job growth and small businesses to lead the way. What would you say to the small business owners that testified in North Carolina about the crushing new taxes they face for not providing government approved insurance? What would you say to the workers who are seeing their hours and take home pay reduced because their employer simply cannot afford government-approved insurance?

Answer: As you know, small firms (less than 50 full time equivalents) are exempt from employer responsibility provisions in the Affordable Care Act. Instead, small firms will gain access to the SHOP Marketplace that provides the purchasing power of large businesses.

Additionally, businesses might be eligible for small business tax credits when they offer health coverage to their employees through a SHOP Marketplace. For tax years beginning in 2014 or later, a tax credit of up to 50 percent of the employer-paid premium cost of health insurance coverage will be available, if the employer otherwise qualifies for the credit.

The Affordable Care Act fixes the broken insurance market of the past by giving small businesses the tools and opportunities to control costs and increase value. We believe that most employers want to provide quality health insurance to their employees, because it's the right thing to do and because it helps them attract and retain the workers they need. A healthy workforce is a more productive workforce, with fewer absences. We know that when people have health insurance they are more likely to get preventive care and get better care, earlier. A Minneapolis Federal Reserve Bank[5] study shows that the vast majority of employers aren't even considering cutting hours.

Prior the Affordable Care Act, many insurers had been able to charge more for people who are sick, one person with a serious illness can make it impossible for small employers to afford to provide coverage. Starting in 2014, premiums for most small employers will no longer be based on the employees' medical history.

The lack of competition and transparency in the current small group market, has allowed some small businesses to be locked into insurance plans that continually provide worse benefits at higher premiums. With the availability of the SHOP Marketplaces, small businesses will be able to choose from many plans in a provide side-by-side comparisons of health plans—their benefits, premiums, and quality—expanding options and increasing competition.

2. Madam Secretary, to confirm for the record, has your agency not conducted, or participated in, any specific economic analysis to determine how the new employer mandate will impact employment?

Answer: While HHS has not conducted any economic analysis of its own on the impact on employment, it is analyzing several studies of respected independent or-

[5] *http://minneapolisfed.typepad.com/roundup/2013/03/like-it-or-not-the-affordable-care-act-will-offer-an-interesting-economic-experiment-on-incentives-or-punishments-dependin.html*

ganizations that confirm that employers will continue to offer coverage. These include:

• The Rand Corporation:[6] "The percentage of employees offered insurance will not change substantially, but a small number of employees in small firms (defined as those with under 100 employees in 2016) will obtain employer-sponsored insurance through the state insurance exchanges."

• Mercer:[7] "In a survey released today by consulting firm Mercer, employers were asked how likely they are to get out of the business of providing health care once state-run insurance exchanges become operational in 2014 and make it easier for individuals to buy coverage. For the great majority, the answer was 'not likely.'"

• International Foundation of Employee Benefit Plans Survey:[8] A total one percent of businesses said they are not going to continue coverage.

CONGRESSMAN LUKE MESSER (IN)

1. I have been contacted by several superintendents and part-time school employees in my congressional district about the harmful impact the Patient Protection and Affordable Care Act (PPACA) may have on educational organizations and their employees. Below is a series of questions regarding these concerns:

a. Are you concerned the quality of education provided to students will suffer because schools are reducing the hours of some employees below 30 per week due to the harsh tax penalties imposed by PPACA?

Answer: The employer responsibility provision, which applies only to employers with 50 or more full-time equivalent employees, will not be enforced until 2015. Furthermore, if you look at the economic data, the suggestion that the Affordable Care Act is reducing full-time employment is not supported by the facts. Minneapolis Federal Reserve Bank study shows that the vast majority of employers are not considering cutting hours. The Affordable Care Act should not cause a leap in part-time jobs, since less than 1 percent of employees who work 30 to 34 hours are both uninsured and employed by businesses affected by the employer responsibility provisions. State governments and workers are being hit by reduced budgets and the effects of the sequester. Furloughs, reduced hours, and reduced benefits for government employees are in response to these budget problems—not the Affordable Care Act.

In fact, employers are benefitting from the Affordable Care Act, which includes a range of cost-saving, quality-improving measures that are contributing to a slowdown in health care cost growth, which should help employers save money. For example, in 2012, premium growth for employer-sponsored insurance was at its lowest rate (3 percent) since the Medical Expenditure Panel Survey started in 1996. Additionally, starting in October, small employers will be able to offer coverage to their employees beginning in 2014 from among a variety of plans within the SHOP Marketplace in their state. SHOP Marketplaces will provide side-by-side comparisons of Qualified Health Plans, their benefits, premiums, and quality—expanding options and increasing competition. SHOP Marketplaces also can save businesses money by spreading insurers' administrative costs across more employers. In some states in 2014, and in all states in 2015, billing will be consolidated as well; employers can go to the SHOP Marketplace as "one stop shopping" in order to offer multiple insurer's options to employees without having to deal with each insurer separately. Businesses might be eligible for small business tax credits when they offer health coverage to their employees through a SHOP Marketplace. From 2014 to 2016, a tax credit of up to 50 percent of the employer-paid premium cost of health insurance coverage will be available, if the employer otherwise qualifies for the credit.

b. Do you believe a 30 hour work week is an appropriate amount to be considered a full-time employee?

Answer: The definition of full-time employee is prescribed by statute in section 4980H(c) (4) of the Internal Revenue Code (the Code) of 1986. The Department of Treasury is responsible for regulations implementing Code provisions. In December of 2012, the Department of Treasury released a proposed rule Shared Responsibility for Employers Regarding Health Coverage, which can be found here: *http://www.irs.gov/pub/newsroom/reg-138006-12.pdf. The regulation discusses, among other things, methods of calculating the 30 hours of services per week for large employers. For further information, please contact to the Department of the Treasury.*

[6] *http://www.rand.org/pubs/research—briefs/RB9589/index1.html*

[7] *http://www.mercer.com/press-releases/survey-find-few-employers-to-drop-health-plans-after-health-care-reform-in-place*

[8] *http://www.businessinsurance.com/article/20130410/NEWS03/130419983?template = mobileart*

c. Has the Department of Health and Human Services analyzed the potential impact on school employees that PPACA employer responsibility provisions may have, particularly given Internal Revenue Service guidance regarding the manner in which schools are required to calculate their number of full-time employees?

Answer: The definition of full-time employee is prescribed by statute in section 4980H(c) (4) of the Internal Revenue Code (the Code) of 1986. The Department of Treasury is responsible for regulations implementing Code provisions. In December of 2012, the Department of Treasury released a proposed rule Shared Responsibility for Employers Regarding Health Coverage, which can be found here: *http://www.irs.gov/pub/newsroom/reg-138006-12.pdf. The regulation discusses, among other things, methods of calculating the 30 hours of services per week for large employers. For further information, please contact to the Department of the Treasury.*

2. The administration has made early detection and clinical diagnosis of Alzheimer's disease a priority under its National Alzheimer's awareness campaign. What specific steps is the administration undertaking to further this principle? For example, will you make a diagnostic test that can assess whether a Medicare beneficiary with cognitive impairment actually has Alzheimer's disease accessible to all the appropriate patients for such a test?

Answer: We are not aware of an FDA approved product to establish a diagnosis of Alzheimer's disease. However, we are actively engaged in reviewing available new technology to ensure timely access to innovation for our beneficiaries. For example, in October 2012, the Centers for Medicare & Medicaid Services (CMS) opened a National Coverage Analysis (the first step in the National Coverage Determination (NCD) process) to reconsider a prior NCD on the use of Positron Emission Tomography (PET) scans that allowed Medicare coverage of PET using only specified radioisotopes for certain indications. Reconsideration of this NCD was requested by a stakeholder who advocated coverage of PET using a radiopharmaceutical approved by the FDA in 2012 to image beta-amyloid plaques in adult patients with cognitive impairment who are being evaluated for Alzheimer's disease and other causes of cognitive decline. To help inform this evidence review, CMS convened a meeting of the Medicare Evidence Development and Coverage Advisory Committee (MEDCAC) in January 2013. A proposed coverage decision is expected by July 2013, with a final decision (including consideration of public comments) expected by October 2013. Information on the status of this coverage review is available on the CMS website at *http://www.cms.gov/medicare-coverage-database/details/nca-details.aspx?NCAId = 265&NcaName = Beta + Amyloid + Positron + Emission + Tomography + in + De mentia + and + Neurodegenerative + Disease&bc = AgBAAAAAAAAAAA%3d%3d&.*

3. Currently, a significant number of patients with cognitive impairment, possibly Alzheimer's disease, do not receive the right diagnosis. I appreciate that an accurate and early diagnosis is one of the continuing goals of the National Plan to Address Alzheimer's Disease. Do you agree that ensuring access to accurate diagnosis through the Food and Drug Administration approved technologies for patients with cognitive impairment would help achieve a major goal of the National Plan to Address Alzheimer's Disease?

Answer: While there is value for patients and families in early diagnosis, the evidence continues to develop. We do not currently have a cure or definitive therapeutic treatment for Alzheimer's disease, but individualized care planning and care coordination are essential to maximizing the functioning of the person with the disease and to putting family members at ease.

We are not aware of an FDA approved product to establish a diagnosis of Alzheimer's disease (AD). For example, the label for the imaging agent florbetapir F 18 injection ("florbetapir") states that although a negative florbetapir scan reduces the likelihood that a patient's cognitive impairment is due to AD, a positive florbetapir scan does not establish a diagnosis of AD or other cognitive disorder. The FDA-approved label for florbetapir indicates that it was not evaluated by the FDA as a screening tool to predict the development of dementia or other neurologic conditions, nor to monitor the therapeutic response to treatment of these neurological conditions.

When making coverage determinations under Medicare parts A and B, CMS seeks evidence that the item or service is reasonable and necessary to diagnose or treat an illness or injury or to improve the functioning of a malformed body member. In this case we would look for evidence to conclude that the diagnostic technology improves health outcomes for beneficiaries by providing useful information that will be used by the treating physician in the management of the patient's medical condition. Such evidence is customarily sought in the results of published reports of randomized clinical trials that compare the impact of different management on patients' clinical outcomes. We recognize that improvements in health outcomes may be

brought about by changes in patient management if physicians can employ effective treatments or avoid ineffective, burdensome treatment attempts.

CMS and FDA work closely to support patient access to innovative healthcare technologies that are supported by evidence of benefit. For example, the agencies have implemented an FDA-CMS parallel review pilot, which operationalizes collaboration and efficiency across the two agencies. In addition, CMS permits Medicare payment for Category B devices undergoing clinical investigation under an Investigational Device Exemption (IDE) as well as Medicare payment for routine care in FDA-approved IDE trials while collecting safety and effectiveness data. In situations when there is not yet enough evidence for a technology or treatment to be otherwise covered by Medicare, CMS may allow coverage with evidence development (CED).

CONGRESSMAN BOBBY SCOTT (VA)

1. Is there currently data available that shows the effects of preventive care without co-pays or deductibles? For example, due to increased access for tests such as mammograms, are cancers being detected at an earlier stage than before?

Answer: Under the Affordable Care Act (ACA), Section 2713 of the Public Health Service Act requires non-grandfathered health plans to cover certain recommended preventive services without cost sharing. Preventive services to which this requirement applies must be covered, without cost sharing, effective with the first plan or policy year that begins on or after the date that is one year after the recommendation is issued; section 2713 and its implementing regulations have required that many recommended preventive services be covered, without cost sharing, for plan or policy years beginning on or after September 23, 2010. HHS has begun efforts to monitor the trends in use of preventive services, such as influenza immunizations, mammograms, Pap smear tests, colonoscopy screenings, and well child checkups. However, the lag time for processing survey data, including the National Health Interview Survey (NHIS) and the National Ambulatory Medical Care Survey (NAMCS), limits the ability to accurately measure the magnitude of the impact of coverage requirements that went into effect as recently as 2011. At this time, available data allow analyses to assess underlying trends in the use of certain preventive services prior to the enactment of the Affordable Care Act. HHS agencies will be monitoring rates in utilization of recommended preventive services as new data become available for analysis. As we continue to implement the Affordable Care Act, HHS will also explore the availability of other non-federal data sources that could provide information to help monitor the use of preventive care and screenings on an ongoing basis.

2. Should Members of Congress or Congressional influence affect the policies governing organ transplants?

Answer: The process of organ donation and allocation of deceased donor organs to those in need of life-saving transplants is fundamentally based in public trust and, to maintain that public trust, the process for developing organ allocation policies must remain free of political influence. The Organ Procurement and Transplantation Network's (OPTN) organ allocation policies are, and should continue to be, based on current medical and scientific evidence and developed by experts in the field through an open and transparent process with input from the general public and those directly affected by donation and transplantation (e.g., transplant patients, living organ donors, and deceased donor family members).

As stated in the preamble to the final regulations governing the operation of the OPTN, "decisions about who should receive a particular organ in a particular situation involve levels of detail, subtlety and urgency that must be judged by transplant professionals." 64 Fed. Reg. 56650, 56652 (Oct. 20, 1999). Congress' intent was clear with the passage of the National Organ Transplant Act of 1984, as amended, (42 U.S.C. § 273, et seq.) (NOTA) that the OPTN was created to "establish membership criteria and medical criteria for allocating organs and provide to members of the public an opportunity to comment with respect to such criteria," through its Board of Directors, which includes representatives of organ procurement organizations, transplant centers, voluntary health associations, and the general public. 42 U.S.C. § 274(b).

Consistent with statute, HHS oversees the OPTN by contract with a non-profit entity with expertise in organ procurement and transplantation. HHS has also further clarified the requirements of the OPTN's policy making process and organ allocation policies in the OPTN final rule (42 CFR part 121). HHS is tasked with ensuring that OPTN's policies are consistent with the NOTA and our regulations.

CONGRESSMAN RUBEN HINOJOSA (TX)

1. As you know the rollout of the Affordable Care Act exchanges in January of next year is a critical time. In the coming months, my constituents and small business need to be educated as to what they can expect, what is expected of them, and they will look to our offices to help guide them through the process.

With the Republican budget cuts, including the arbitrary sequestration cuts they championed and passed into law, what resources are available for HHS employees to travel to congressional districts for rollout events, informational town hall meetings and constituent outreach in the months ahead?

Answer: Implementing the Affordable Care Act is a top priority of the Department. Outreach is a vital component to the law's success—to ensure that Americans in need of healthcare understand how to access it. CMS is engaging a variety of different types of outreach and managing its available funding resources in the best manner possible.

2. As you know in the state of Texas, Governor Perry has put politics above the health of Texans and refused to participate in the Medicaid expansion program which would have provided health care to over 1.5 million Texans as well as create more than three million jobs, according to a report generated by the Perryman Group. This is all despite the fact that a recent poll by the Texas Hospital Association shows a majority of Texans are in favor of Medicaid expansion.

My concern is that because of the Governors short sighted decision hospitals will get stuck in the middle. As you know, the Affordable Care Act calls for a reduction in Disproportionate Share Hospital (DSH) payments based on an assumption that states are expanding Medicaid. Since this expansion is not happening in Texas, how will you work with hospitals in Texas to make sure they do not get financially harmed by a DSH reduction?

Answer: We continue to believe that the Medicaid coverage expansion is a good deal for states and will ensure that millions of Americans have access to affordable, quality health coverage.

The Medicaid expansion will also help lessen the burden of uncompensated care on hospitals throughout the nation.

As you know, the Affordable Care Act requires aggregate reductions in Medicaid disproportionate share hospital (DSH) payments beginning in Fiscal Year (FY) 2014. In May 2013, the Centers for Medicare & Medicaid Services (CMS) proposed a rule to implement the statutorily required Medicaid DSH reductions for FYs 2014 and 2015 using statutorily required factors to allocate the reductions among states. CMS is currently reviewing comments received during the proposed rule's comment period and will finalize the rule in the coming months. The proposed rule includes a reduction methodology only for FY 2014 and FY 2015. CMS plans to use state data obtained in FYs 2014 and 2015 to inform how the reductions should be made in FY 2016 and beyond. CMS will revisit the methodology and promulgate new rules to govern DSH reductions in FYs 2016 and beyond.

Additionally, the President's FY 2014 Budget includes a proposal to delay the reductions by one year, with the reductions taking effect in FY 2015, rather than FY 2014. Should Congress not act to move the President's proposal forward, the reductions will take effect in FY 2014 as statutorily required.

CONGRESSMAN JARED POLIS (CO)

1. In addition to expanding access to high quality early education programs, it is crucial that early education programs such as Head Start work with elementary schools to ensure a strong transition. That's why I introduced a bipartisan, no-cost bill, the Continuum of Learning Act, which would align early childhood education and early elementary school standards and professional development activities through strong child development practices and policies. How would the administration's preschool proposal strengthen connections between existing early learning programs and the elementary grades?

Answer: The President's Early Learning Initiative will develop a continuum of high-quality early learning for children—from birth to age 5. The Initiative will align standards across early learning programs and preschool, raising the standards throughout the continuum of early learning. The President's Initiative expands high-quality early learning opportunities in the years before preschool, helping children move from Home Visiting, Early Head Start-Child Care Partnerships, and Head Start into Pre-kindergarten while maintaining high quality care and education at each step. Congress has provided $1.5 billion to expand home visitation to hundreds of thousands of America's most vulnerable children and families across all 50 states, and President Obama has called for a significant investment in a new

Early Head Start-Child Care partnership. This investment, combined with an expansion of publicly funded preschool education for four-year olds, will ensure a cohesive and well-aligned system of early learning for children from birth to age five.

ACF is already working with State Advisory Councils to develop and enhance high-quality, comprehensive systems that optimize childhood services so children arrive at school ready to learn and prepared to excel. For example, a number of states used grant funds to align their Early Learning Standards with the Common Core, K-12 standards, so that what children are expected to know is seamless across the age spectrum. Additionally, states with Race to the

Top-Early Learning Challenge (RTT-ELC) funding are working to connect and build on existing early learning systems statewide. RTT-ELC states are measuring outcomes and progress to inform early learning services whether children are entering kindergarten ready to succeed in elementary school.

[Whereupon, at 12:01 p.m., the committee was adjourned.]