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A FINANCIAL REVIEW OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND ITS FISCAL YEAR 2014 BUDGET

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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A FINANCIAL REVIEW OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND ITS FISCAL YEAR 2014 BUDGET

THURSDAY, APRIL 18, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Burgess, Murphy, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Barton, Upton (ex officio), Pallone, Dingell, Engel, Capps, Schakowsky, Matheson, Green, Butterfield, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Staff present: Clay Alspach, Chief Counsel, Health; Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Brenda Destro, Professional Staff Member, Health; Paul Edattel, Professional Staff Member, Health; Steve Ferrara, Health Fellow; Julie Goon, Health Policy Advisor; Debbee Hancock, Press Secretary; Sydne Harwick, Legislative Clerk; Sean Hayes, Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Carly McWilliams, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; John O'Shea, Professional Staff Member, Health; Monica Popp, Professional Staff Member, Health; Andrew Powaleny, Deputy Press Secretary; Krista Rosenthall, Counsel to Chairman Emeritus; Heidi Stirrup, Health Policy Coordinator; Lyn Walker, Coordinator, Admin/Human Resources; Alli Corr, Democratic Policy Analyst; Amy Hall, Democratic Senior Professional Staff Member; Elizabeth Letter, Democratic Assistant Press Secretary; Karen Nelson, Democratic Deputy Committee Staff Director for Health; Anne Morris Reid, Democratic Professional Staff Member; and Matt Siegler, Democratic Counsel.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. The time of 10 o'clock having arrived, the subcommittee will come to order. The chair will recognize himself for an opening statement.

First, I would like to thank Secretary Sebelius for appearing before the subcommittee to discuss the Administration's fiscal year 2014 budget request for the Department of Health and Human Services.

While the budget request is 65 days late, and both the House and Senate have already passed their respective budget resolutions, it is still important that the country know what the Administration's priorities are for the upcoming fiscal year.

As implementation of the Affordable Care Act is now a major item in the President's request, this hearing will allow members to ask the Secretary questions about the law on behalf of our constituents.

The law is simply not working as advertised. It was sold to the American people as a job creator. The Administration put forward an estimate that 4 million jobs would be created. Instead, red tape and a new employer mandate are discouraging companies from creating new full-time jobs. In many instances, workers are seeing their hours cut to part-time or only finding part-time jobs available. Even the Federal Reserve has noted that the uncertainty being created by the law is holding back hiring. I have personally heard from constituents who have been harmed by the mandate.

When the government makes it more expensive and more complex to hire workers, companies will hold back on hiring. That is just a simple economic principle. However, that doesn't seem to matter with many government regulators. The law was sold as saving the American people money. Yet today, wherever I go I hear from individuals and businesses facing insurance premiums that are growing by double digits.

Now, you may say that this is because everyone is going to have gold standard, government-approved insurance. Let me remind you that the American people were told by the President that each family would save $2,500 a year. Now, that wasn't a promise that came with a caveat. In fact, that promise was made with a deadline that it would happen in the first term. That first term is over, and the nonpartisan PolitiFact rates that as a broken promise.

Businesses and individuals are seeing their premiums rise as a direct result of the law. I know that some may shake their heads and wonder why Republicans don't just move along and learn to tolerate the ACA. Well, we should not tolerate a government law that makes it harder for our constituents to find and keep a full-time job. Congress should not tolerate regulations that drive up costs for struggling businesses. Finally, we should not stand by and watch Americans with preexisting conditions be left out of the plan that was intended to give them coverage.

I will continue to look for ways to make health care more affordable, more accessible and simpler for the American people. While it might be best if we could start by repealing the ACA, that law will not stop me and my colleagues from proposing constructive health care reforms.

Madam Secretary, we hope that you will stay in order to answer all of our questions, and, with only 5 minutes of questions per member, we ask that you try to keep your answers concise and to the point.

The constituents we hear from every day, including those who are able to be here in the audience today, deserve answers.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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- Congress should not tolerate regulations that drive up costs for struggling businesses.
- Finally, we should not stand by and watch Americans with pre-existing conditions be left out of the plan that was intended to give them coverage.

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The constituents we hear from every day, including those who are able to be here in the audience today, deserve answers.

Thank you, and I yield back. The Chair now recognizes the Ranking Member, Mr. Pallone, for five minutes for his opening statement.

Thank you. The Chair now recognizes the Chairman of the full Committee, the gentleman from Michigan, Chairman Upton for five minutes for his opening statement.

Thank you. The Chair now recognizes the Ranking Member of the full Committee, Mr. Waxman for five minutes for his opening statement.

Mr. PITTS. Thank you, and I yield back and the chair now recognizes the ranking member, Mr. Pallone, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. FRANK PALLONE JR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Chairman Pitts, and I want to welcome Secretary Sebelius here this morning.

Before I address the Secretary, though, I do have to say that I do not appreciate the comments about the ACA. I know you are saying that you want constructive reforms but I think that if the mantra of the Republican leadership is going to continue to be that we have to repeal the ACA, it is going to be very difficult in that poisoned atmosphere to talk about constructive reforms, and the fact of the matter is that even after the last November election, we continued to hear the Republican leadership both on the committee as well as in the full House speak out and say that their priority is repealing the ACA, and of course, we see that in the Ryan budget that passed the House, and too would like to move towards constructive reforms in the health care system but this constant notion that the priority is to repeal the ACA and that that has to go and that is the most important thing that we have to do for constructive reform. It really does poison the atmosphere and makes it very difficult for us to sit down on a bipartisan level and look at things that we could do together. So I will just say that.

Today we are going to hear about the President's fiscal year 2014 Health and Human Services budget proposal. I want to commend Secretary Sebelius for your agency's hard work this past year to implement the Affordable Care Act. Because of these efforts, Americans are enjoying greater access to health benefits, and I recognize the challenge your agency faces in implementing this law with limited resources.

When the Affordable Care Act passed, we did not anticipate that States would give up the opportunity to tailor programs directly to their individual State's needs and opt for federal exchanges, and I regret that my State, New Jersey, is one of the 26 States that will rely on federal exchanges rather than run its own. Again, I think this is pure politics on the part of our Republican Governor, but despite this, I urge the Administration to remain committed to fully implementing the Affordable Care Act.

I was pleased to see the inclusion of increased funding for access to mental health services to protect children and communities in the fiscal year 2014 proposal. I said before, it is time to focus more attention on improving mental health services to make sure troubled kids don't fall through the cracks, that the fiscal year 2014 budget proposal is an important step towards making mental health issues a national priority and adequately funding these efforts.

I also support the FDA's Food Facility Registration Inspection fee and the Food Importer fee included in the Administration's proposal. These fees will help ensure that the FDA has the resources needed to fully implement the FDA Food Safety Modernization Act, which of course originated in this committee.

Along the same lines, I was pleased to see that the budget proposal includes new user fees to support FDA's Cosmetic Products program. Cosmetics are used extensively throughout the United States by all types of people, and last Congress I joined with my colleague, Mr. Dingell, to introduce the Cosmetic Safety Enhancement Act of 2012 to help address the lack of authority at FDA to regulate cosmetics. Like the President's budget proposal, our bill included facility registration fees to defray the costs of cosmetic safety activities. So I hope we can work together on modernizing the cosmetic regulations.

Before I conclude, I would like to note some concerns. First, I am disappointed that the funding proposal for the Children's Hospital Graduate Medical Education program is only $88 million, a two-thirds cut from the fiscal year 2012 level. Reducing the federal investment in pediatric will only threaten the pediatric workforce and threaten access to primary care. The small class of hospitals that receive this funding, which includes the Children's Specialized Hospital in my district, represents about 1 percent of hospitals nationwide that trains approximately 40 percent of all pediatricians. Underfunding this program would have a major negative impact on access to primary care and a devastating impact on access to specialty care for children.

And finally, I have long advocated for strengthening Medicare and Social Security, and I am concerned that this budget makes some hurtful cuts to the programs, and I really would urge the Administration to do what they can to strengthen Medicare and Social Security and move away from some of the cuts that the President has proposed.

I know we are going to have more questions about the ACA and some of the funding for implementing your outreach, and I want to bring that up during my questions, but thank you, Madam Secretary.

Mr. PITTS. The chair thanks the gentleman and now recognizes the chairman of the full committee, the gentleman from Michigan, Chairman Upton, for 5 minutes for his opening statement.

Mr. UPTON. Well, thank you, Mr. Chairman, and knowing that we have votes on the floor in about an hour, I am going to yield back my time and submit my statement.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Mr. Chairman, thank you for holding this important hearing. I want to welcome Secretary Sebelius back to the committee.

This morning, we will review the president's proposed fiscal year 2014 budget for the Department of Health and Human Services, which calls for nearly $1 trillion in spending—a budget larger than the estimated 2012 federal expenditures of the country of Brazil. With such massive spending levels, and a debt topping $16.5 trillion, we owe it to American taxpayers to diligently review the administration's proposals.

Today's hearing will not just be an opportunity to review the president's budget proposal, but it will also serve as an opportunity to bring the questions and concerns of our constituents about the resident's health care law directly to the secretary, with the hope of getting answers.

Even though the majority of Americans oppose Obamacare and do not want it implemented, they still need to know what they need to do to comply with the law. The administration has had three years to provide guidance, but many important questions remain unanswered. The lack of answers has caused confusion and con-

cern across this country on issues that are central to Americans' lives, like whether small business owners can continue to provide health care to their employees.

Take the case of a business in my district. They are a family-owned business with a history of good stewardship in the community. They treat their employees like family and have been proudly protecting them against injury or illness for many years. But they are worried about how the health care law creates a perverse incentive for employers to stop offering health care coverage. In a recent meeting with them back in Michigan, they told me that their long history of providing health coverage might end if one of their competitors decides save money by forcing workers into the exchanges and paying a small penalty. If other companies like the one in my district do not follow suit, they will not be able to remain competitive and their entire business could go under.

Americans are now faced with many hard choices because of this law. With less than nine months until the new health care law is fully implemented, Americans are watching closely and becoming increasingly concerned about the law's impact on their health care, their jobs, and their well-being.

There is also cause for alarm when those with intimate knowledge of the law, its own authors, are predicting a "huge train wreck coming down" as Senate Finance Chairman Max Baucus said just yesterday.

My hope is that this hearing will be an informed discussion on the department's intentions for this budget and the implementation of the president's health care law. The American people deserve answers, and I hope they get them today.

# # #

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for his opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman. Despite the fact that we are going to have votes in an hour, I want to make some comments welcoming Secretary Sebelius to our committee. It has been a year since you have been here, and it has been a productive and busy year, and I want to commend you and your team for your tireless efforts on implementing the Affordable Care Act.

It is difficult for most Americans to realize the enormity of the task you and others at HHS are undertaking to this law, but for the millions of uninsured in our country and those for whom insurance fails to provide the security and guarantees that they are looking for, there is certainly appreciation for the difference this law will bring to their lives as they now gain access to health care.

The President's budget, which is the topic of today's hearing, includes key proposals to continue the journey forward: additional funding for CMS to support health insurance marketplaces, building the infrastructure needed to ensure consumer protections and engagement, continuing improvements in Medicare, and further investment in the successful Health Care Fraud and Abuse Control program.

The President's budget also expedites the timeline for closing the Medicare Part D donut hole, a provision that has already brought critical relief, providing $2.7 billion in savings to beneficiaries in 2012 alone. The budget proposal also recaptures rebates for dually eligible seniors, a proposal that I have long supported, enabling us to capture over $120 billion in savings through better drug prices

over 10 years. Those are the things that are major pluses, and I support all of those effort in the President's budget.

I am concerned about some of the proposals in the President's budget such as raising costs on Medicare beneficiaries. I know that this is put in the context to be part of a broader balanced package that includes both spending cuts and increased revenues. However, Medicare beneficiaries have lower incomes than younger Americans, more chronic conditions and health care needs, and pay significantly more out of pocket already. It makes little sense to shift more burden on to their backs. Such policies may inadvertently create barriers to appropriate care for vulnerable seniors, and I hope we can continue a dialogue on this issue.

I also have a number of concerns, and have heard from a number of constituents, both providers and beneficiaries, regarding the dual-eligible pilot programs, especially in California. I hope I have your commitment to closely monitor and evaluate these dual demonstrations to assure these demonstrations for dual-eligibles, to assure protection of our vulnerable seniors and people with disabilities.

I appreciate the Administration's continuing commitment to public health. Specifically, I applaud the inclusion of the proposal for food safety registration and inspection fees, which will provide much-needed resources to support the Food and Drug Administration's implementation of the Food Safety Modernization Act of 2011. I hope we can work together to get those critical fees enacted into law.

I am also pleased to see a strong investment in biomedical and behavioral research at the NIH of and continued support for the National HIV/AIDS Strategy, including through prevention, surveillance and treatment activities at the Centers for Disease Control and Prevention and Health Resources and Services Administration.

The proposals that continue our commitment to community-based primary care, providing additional funding for Community Health Centers and the Title X Family Planning program, are also important.

And finally, as a Nation, we are appropriately focusing more of our attention on the impact of gun violence in our communities and the critical importance of promoting mental health and the early detection and treatment of mental illness. I appreciate the President's leadership on this and am pleased that his budget reflects these priorities, by expanding support for gun violence surveillance and research at the CDC and proposing funding for both mental health training in our communities and for additional mental health professionals.

I would be remiss, though, if I didn't mention the need to fully implement mental health parity. We are anxiously awaiting the final rule on this important legislation, and I appreciate your assistance in securing this.

I certainly do appreciate your being here and look forward to your testimony, and I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman. That concludes the opening statements of the members. Thank you.

We have one panel today. Our distinguished witness is the Honorable Kathleen Sebelius, Secretary, Department of Health and Human Services. Madam Secretary, welcome again. Thank you for coming today. You will have 5 minutes to summarize your testimony, and your written testimony will be placed in the record. Please make sure your microphone is on. Please speak clearly into it. You may proceed.

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

Secretary SEBELIUS. Well, thank you, Chairman Pitts and Ranking Member Pallone and Ranking Member Waxman and Chairman Upton for having me here this morning 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 job growth. It ensures that the American people will continue to benefit from the Affordable Care Act, and it provides much-needed support for mental health services.

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 addresses another issue that has been on our minds recently: mental health services and the ongoing epidemic of gun violence. While 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. That is why our 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 mental health professionals to join our behavioral health workforce.

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 childcare partnerships, and it provides additional support to raise the quality of childcare programs and promote evidence-based home visiting for new parents. Together, these investments will create long-lasting positive outcomes for families and provide huge returns for children and society at large.

Our budget also ensures that America remains a world leader in health innovation. The significant new investments in NIH will lead to new cures and treatments and help create good jobs.

Our budget will further provide support for the development and use of compatible electronic health records systems that have huge potential for improving care coordination and public health.

Even as the budget invests in the future, it also helps reduce the long-term deficit by making sure that programs like Medicare are put on a more stable fiscal trajectory. Medicare spending per beneficiary grew at just 4/10ths of 1 percent in 2012, thanks in part to the $800 billion in savings already captured 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 the lower Medicaid rates, resulting in savings of more than $120 billion over the next 10 years. In total, this budget will 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 our department. We are proposing an increase in mandatory funding for our health care fraud and abuse control program, an initiative that saved taxpayers nearly $8 for every $1 we 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.

This all adds up to a budget guided by this Administration's north star of a thriving middle class that will promote job growth and keep our economy strong in years to come while also helping to reduce the long-term deficit.

Now, I know, Mr. Chairman, that many of you have questions and I am happy to take those now. Thank you very much.

[The prepared statement of Secretary Sebelius follows:]

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

THE PRESIDENT'S FISCAL YEAR 2014 BUDGET

BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE

UNITED STATES HOUSE OF REPRESENTATIVES

APRIL 18, 2013

Testimony of
Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
before the
United States House of Representatives
Committee on Energy and Commerce
April 18, 2013

Chairman Upton, Ranking Member Waxman, 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 more than 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.

Improving Patient Safety. HHS is committed to improving patient safety and reducing harm to patients, as reflected in the $63 million in this budget for patient safety research at the Agency for Healthcare Research and Quality (AHRQ). This research focuses on the risks and harm inherent in the delivery of health care, which helps us to understand the factors that can contribute to adverse events and how to prevent them. In FY 2014, AHRQ will fund projects on improving team performance, provider training, and coordination, as well as establishing cultures conducive to patient safety in health care organizations. This research can help the medical community reduce errors and improve patient safety. This research focuses on the elements critical to making care safer and more effective.

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:

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.

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.

Child Care Quality Fund. The request 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. In addition to this funding, 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.

Child Support and Fatherhood Initiatives. Additionally, the Budget includes a set of proposals to encourage states to provide 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.

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 Lifespan Respite Care program, as an example, focuses on providing a test bed for needed infrastructure changes and on filling gaps in service by putting in place coordinated systems of accessible, community-based respite care services for family caregivers of children and adults with special needs.

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 Alzheimer'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.

Ryan White. The Budget includes $2.4 billion for the Ryan White HIV/AIDS CARE Act to continue its critical role in support of patients across the HIV/AIDS continuum, which links patients to care; prescribes, and improves adherence to antiretroviral medicine; and achieves viral suppression. Included in this total is $943 million for the AIDS Drug Assistance Program, an increase of $10 million to provide life saving and extending medications to 218,900 individuals, an additional 1,600 people living with HIV/AIDS.

Protecting the Nation's Public Health and National Security

Project BioShield and Advanced Development. In FY 2014, HHS will continue to support the development and procurement of medical countermeasures (MCMs) against chemical, biological, radiological, and nuclear (CBRN) threats. This funding includes $415 million to support advanced research and development of MCMs through the Biomedical Advanced

Research and Development Authority. Additionally, the Budget includes $250 million as the first installment of a multi-year commitment to support Project BioShield, aimed to facilitate the procurement of these MCMs for the Strategic National Stockpile. Together, these efforts will enhance the Nation's ability to acquire MCMs that will be vital to mitigating or preventing the effects of CBRN threats.

Strengthening the Nation's Food Supply. Ensuring the safety of the Nation's food supply remains one of the Administration's top priorities. The Budget includes $1.5 billion, an increase of $312 million over FY 2012, to support the Food and Drug Administration (FDA) and CDC activities that will develop and strengthen an integrated and prevention-based food safety system. The Budget supports FDA's efforts to invest in system-wide domestic and foreign enhancements, such as improving import safety, risk analysis, and putting in place preventive controls to implement the FDA Food Safety and Modernization Act. The Budget proposes the food facility registration and inspection user fee and an importer user fee to support FDA's activities in FY 2014. The Budget also increases funding for CDC to enhance surveillance systems and continue support of Integrated Food Safety Centers of Excellence.

Medical Products. The Budget includes $2.6 billion, an increase of $456 million over FY 2012, for FDA to ensure the safety, effectiveness, and timely availability of medical products including prescription drugs, generic drugs, biologics, and devices. The FDA Safety and Innovation Act provided for the continuation of the prescription drug and medical device user fees. In addition, FDA may now collect from industry fees for two recently authorized programs to support generic drugs and biosimilar biological products. These resources are critical to strengthen the medical product review process. The Budget includes resources from these user fees and also proposes a medical product reinspection fee.

Infectious Disease Surveillance Modernization. The Budget invests $40 million to modernize CDC's surveillance technology and methods to better detect and track infectious disease. This investment will allow CDC to retool its national surveillance systems and detect and respond to emerging health threats in a timely manner. CDC's infectious disease surveillance technologies are becoming increasingly outdated and threaten the basic public health mission of the agency. In an effort to keep up with advances, CDC is making substantial investments in bioinformatics, database development, data warehousing, and analytics. This initiative requires strategic and sustained investment in the following areas: pathogen identification and detection using genomics, adaptation of new diagnostics, state assistance and coordination, enhanced and integrated sustainable laboratory systems, and tool development to support prediction and modeling for early disease detection.

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.

The Medicare and Medicaid legislative proposals in the Budget seek to reduce the deficit while encouraging economic growth and maintaining the administration's commitment to HHS programs upon which tens of millions of Americans depend. Medicare savings would total $371.0 billion over 10 years by encouraging beneficiaries to seek value in their health care choices; strengthening provider payment incentives to promote high-value, efficient care; and increasing the availability of generic drugs and biologics. The Budget also includes $22.1 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the FY 2014 discretionary budget request and these legislative proposals allow HHS to support the Administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

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.

Performance, Evaluations and Effectiveness

Assessing the Impact of Health Insurance Coverage Expansions on Public Health Service Delivery Programs. The Budget includes $3 million to the Assistant Secretary for Planning and Evaluation to evaluate the impact of health insurance coverage and benefit expansions among beneficiaries of HHS direct service programs. These programs include Health Centers; Ryan White Program; Title X Family Planning Program; Substance Abuse Prevention and Treatment Block Grant; Breast and Cervical Cancer Early Detection Program; and Immunization, Section 317 Grant Program, among others. This request supports the continuation of research and evaluation studies, collection of data, and assessments of the costs, benefits and impacts of policies and programs under consideration by HHS or the Congress. This data will inform decisions about how to tailor policies and programs to align with new coverage options and support available starting in 2014.

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

Mr. PITTS. The chair thanks the gentlelady for her opening statement and will now begin questions from the members, and I will begin the questioning and recognize myself 5 minutes for that purpose.

Madam Secretary, the President promised that the ACA would help to make health insurance cheaper for the American people, but unfortunately, exactly the opposite is happening. That is why one of the law's early supporters, the Roofers Union, announced this week that they are now calling for the law's repeals. I have a couple of guests here with us today. Sam and Elaine Stoltzfus are constituents of mine. They are owners of Keystone Wood Specialties in Lancaster, Pennsylvania, and their company makes kitchen cabinets and similar wood products, so Sam and Elaine, welcome. You can identify yourself.

Sam recently wrote to me to say "We are faced with a 25 percent increase in health care insurance for our employees and have no idea of where the additional $95,000 is coming from. Help."

Madam Secretary, can you tell us this morning what help does the President's budget either through its implementation of the ACA or other programs offer to Americans like Sam, and tell us what changes you are proposing in the budget to help Sam.

Secretary SEBELIUS. Well, Chairman Pitts, we intend to complete the implementation of the Affordable Care Act with the resources requested in this budget, and one of the things that happens is the full implementation includes marketplaces in every State in the country, so small business owners, individuals who purchase health insurance in the individual market will have competitive insurance for the first time. Americans with preexisting health conditions will not be locked out or priced out of the marketplace, and there will be larger risk pools established in every State in the country. As you know, insurance regulation remains under State regulation. We are seeing nationally a trend that has the lowest level of rate increases in the private market that we have seen in over a decade, but the insurance marketplaces are not fully implemented until January of 2014.

Mr. PITTS. Madam Secretary, the law passed with a provision designed to help small businesses like Sam's, and I am talking about the SHOP Act, but there is no funding, there are no funding allocations for it in the President's budget. Will that provision be able to help them come January 1, 2014?

Secretary SEBELIUS. Yes, sir. I have no idea your constituent's size or what kind of employer market he may be in, but the SHOP Act will be open in every State in—I mean the SHOP market—excuse me—will be open in every State in January of 2014. Employers will have an opinion to choose among competitive plans in every State in 2014.

Mr. PITTS. Madam Secretary, did you not recently announce a delay for implementation of exchanges for small business until 2015?

Secretary SEBELIUS. No, sir. We——

Mr. PITTS. What did you do?

Secretary SEBELIUS. In the federal marketplaces in the States where we will be running the market, the portions of the SHOP market that will be delayed one year are employers being able to

offer their employees multiple plans to choose from. Every employer will be able to choose from a variety of plans and offer the plan of his or her choice to those employees, and the employers who qualify for the tax credit because of the size of their workforce and the level of the employee's income will also get a tax credit in the SHOP market but it won't be until year two that that wider employee choice will be available only in the federally facilitated marketplaces. States may offer it starting in 2014.

Mr. PITTS. Madam Secretary, I also hear from constituents who are being hurt by the ACA two or three times a week. Mostly I hear from constituents who had their work hours cut as companies try to avoid skyrocketing costs imposed by the law. Just yesterday, it was reported that a national movie chain with theaters in my district has cut some employees' hours as they struggle to provide insurance for full-time employees, and right now there are fewer Americans working than at any time since 1979.

My constituents are looking for full-time jobs but the ACA is making those jobs harder to come by. I have had another constituent from Lancaster County who wrote recently saying he retired last year after 26 years as a police officer but still needs to work, and his hours have been cut. He can only now work 3 ½ days a week. Basically he is saying, and this is his quote, "Obamacare limits me to working 29 hours a week." Tell us what help the President's fiscal year 2014 provides this man.

Secretary SEBELIUS. Well, Mr. Chairman, I don't have any idea why the employers have restricted hours. There is absolutely nothing in place in the Affordable Care Act in the year 2013 that would impose any burden on an employer or have him cut work hours. What we know is in 2014, there will be new markets set up and an employer responsibility. Employers who have 50 or more full-time workers or the equivalent of 50 or more full-time workers will be responsible for offering health insurance to those employees, and what we know, Mr. Chairman, is that 94 percent of employers in that market right now offer health insurance but often pay 18 to 20 percent more than their large competitors because they are in a very volatile and very expensive market. Creating competitive options and choices for those employers is part of what the Affordable Care Act is all about.

Mr. PITTS. Thank you, Madam Secretary. My time is expired. The chair recognizes the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman, but with all respect, the Republican leadership on the committee as well as in the House just rabidly attacks the ACA every day. It has been going on for 3 years, actively trying to defund or undermine its implementation. The chairman is asking questions about no funding for small businesses and the health exchange, but is the Republican leadership willing to fund any of these things? I mean, I would be glad to provide more funding in the budget or through the appropriations process for implementation but I don't believe for one minute I would get any support from the GOP. So, you know, it is a little crazy to come here and say we should repeal the ACA, we should defund the ACA, we should defund the ACA, we should get rid of this and get rid of that and then at the same time say oh,

you know, you are not implementing because you are not providing enough funding.

I mean, the same thing with jobs. The GOP is saying oh, you know, there aren't any jobs. Well, the sequester, which the President keeps putting out proposals every day to try to eliminate and have some sort of sensible budget proposals here is furloughing people left and right. I mean, in my district, I don't care where it is, it is not just public jobs, it is having an impact on the private sector as well. So you can't come in here and say oh, you know, people are working part time, meanwhile you support a sequester that furloughs people all across the country, tens or hundreds of thousands of people. Whatever.

You know, some Republicans, now of course they are talking about the marketplaces and the exchanges won't be ready in time and so I wanted you to talk, if you could, about the status of implementation of the exchanges, which is on everybody's mind and, you know, give you a chance to update what progress you are making toward setting up the exchanges and implementing them. But again, if you would like to comment on the fact that Congress is not providing enough funding for outreach, States like New Jersey that rely on federal exchanges may get even less funding. So please don't hesitate to say that if you are going to do outreach and implement these things that you need money that we are not giving you because we are not. I mean, that is the reality, but whatever. I am obviously very frustrated. Go ahead.

Secretary SEBELIUS. Well, Congressman, the budget before you has a request for an additional $1.5 billion in implementation funding to fully set up marketplaces throughout the country. We are definitely going to be open for open enrollment in every State in the country starting October 1, 2013, and we will be beginning plan years and benefit years for individuals who currently either don't have insurance or have expensive insurance or locked out or priced out of the marketplace because of preexisting conditions starting in January 2014.

We are very pleased that 31 States and the District of Columbia are running all or part of their partnership programs, marketplaces either in partnership with HHS or doing it on their own. In the other States where the States had opted not to be engaged or involved, we will be running the marketplaces. We are setting up as we speak the federal hub with the call center and outreach. The resources that we had hoped to get in the Continuing Resolution deal with outreach and education, a huge issue of or people to actually understand what the reality is of the law, what benefits are coming their way, what kind of choices they will have, but we have reallocated some resources within the Department and fully intend to give people the information and the facts about the law as we move forward.

Mr. PALLONE. Well, look, I think it is highly unlikely that the House Republicans are going to give you this money for outreach that you are asking for, but again, they can't come back here and criticize if the outreach doesn't occur if they are not funding it.

Let me ask a question about the GME, the Children's Hospital Graduate Medical Education program. I see that the White House is proposing $88 million, which is one-third of current funding. I

don't think that is a good idea given the struggles these hospitals have in training of pediatricians. Wouldn't scaling back that program take us back to the same flawed system we had in the past, and why would the Administration seek to reverse the success we have had in this area? You know, I always ask you about this, and you don't have a lot of time here.

Secretary SEBELIUS. Congressman, the funding level recognizes the direct costs of training pediatricians, an incredibly important task that a lot of children's hospitals engage in. What we don't have is the overhead and administrative costs as part of that proposal, and in a better budget time, we would have included both, but all of the direct costs of the residency programs are included in that budget recommendation.

Mr. PALLONE. I am hoping that we on a bipartisan basis, Mr. Chairman, can address that because I do think that is one thing where Democrats and Republicans can come together to avoid that cut.

Thank you, Madam Secretary.

Mr. PITTS. The chair thanks the gentleman and now recognizes the chairman emeritus of the committee, Mr. Barton, 5 minutes for questions.

Mr. BARTON. I thank the chairman. I want to apologize to the chairman and the ranking member and our esteemed witness for not being here to hear the opening treatment. We are always honored to have you, Madam Secretary, and we look forward to dialog.

My staff and the committee staff encouraged me to tweet and ask the American people for a question or two to ask you. I guess they decided that I wasn't up to it. I am not sure. But in any event, we did it and these are two questions from real people who I don't know. We had in the neighborhood of 100 tweet questions come back in. In the interests of transparency, we thought we would give the American people an opportunity to ask you a direct question or two. The first one is a tweeter named @JoshMertz, and his question is—I assume it is a he—"How is the typical small business going to be able to comply with the thousands of pages of new regulations that Obamacare requires? Where are these business owners going to find the money to pay for the compliance? Many of them expressed how they will have to hire new administrative personnel and spend countless hours with their attorneys figuring out just what they have to do." This is from @JoshMertz.

Secretary SEBELIUS. Do you want me to take that and then ask the second one?

Mr. BARTON. Well, let us give you a chance to answer that one and then we will hold the second one in reserve.

Secretary SEBELIUS. Well, Congressman, the small business owner tweeter, welcome to Twitter land. I am a new tweeter myself. Depending on the size of this small business, the law may or may not impact the business at all. So if this employer has fewer than 50 full-time or the equivalent of 50 full-time employees, there is absolutely no impact except for the fact that in the SHOP exchange, in the SHOP market, if he wants to provide health insurance for his employees, he will have an opportunity to have some competitive plans and one-stop shop and go forward.

Mr. BARTON. Let us assume they are just over that limit.

Secretary SEBELIUS. And if he falls into the over 50 full-time equivalent, there will be for the first time ever again a one-stop shop coming in through a Web site. He will not have to hire administrative personnel. He will be able to determine from a choice of plans what plan is best suited to his employees, offer that to his employees, and if he indeed qualifies for a tax credit, depending on the wages of that employees, that will automatically be part of the package moving forward.

Mr. BARTON. Your basic answer is, he is not going to have any compliance costs?

Secretary SEBELIUS. Well, depending on—I mean, there are no additional forms and things to fill out. The goal is really to make this as seamless as possible for small business owners and for individuals so that their experience is relatively simple as they come into the market.

Mr. BARTON. Well, let me go to the second one, and you will know that I don't know this person when I give the name. It is EricTheBanker@YankeesFanatic6, and I am a Ranger and Astro fan so there is no way I know this guy. "How does the Obama Administration justify the rising cost of health care including rising premiums and a reduction in work hours even before Obamacare is fully in effect, even though President Obama and your Department specifically promised that premiums would not rise and health care costs would go down?" So his basic question is, how do you justify, in spite of what was said before the fact, that rising costs of health care including rising premiums are going up?

Secretary SEBELIUS. Well, as I said to the chairman a few minutes ago, first of all, the increases in private health insurance are at a slower pace than we have seen in well over a decade over the last 3 years, and that has been documented. The other kind of good news is that there finally is some stability in the small employer marketplace who were shedding policies prior to the passage of the ACA for well over a decade, so that has stabilized, and there is nothing in place right now in the legislation that would require any employer to change work hours, and we don't think there is going to be—so whatever is happening to work hours, I think, is impossible to tie to the Affordable Care Act because there is no connection here in 2013.

Mr. BARTON. Well, Mr. Chairman, my time is expired. I hope the two tweeters that we use will tweet some more questions. I think it is good to give the public a chance. And I do want to compliment you, Madam Secretary, for coming before the committee. I know it is difficult, and your time is limited, but we do appreciate you coming.

With that, Mr. Chairman, I yield back.

Mr. BARTON. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Well, thank you, Mr. Chairman, and Madam Secretary, it is a tweet to have you here.

Secretary SEBELIUS. That is so bad.

Mr. WAXMAN. That is terrible. Wait until you hear my question. That was the high point of my 5 minutes.

The Republicans fought against the Affordable Care Act. In fact, Republicans fought against Medicare, but they certainly hated the Affordable Care Act. I never could understand that because it is based on a lot of Republican principles, proposals that Senator Dole and others had put forward, and they would love to repeal it. They would have liked the Supreme Court to throw it out. They would have liked for the election to go otherwise. And so they are making life as difficult as possible for you moving forward to implement the law.

But I would just like to ask you, what would the world be like for health insurance if we let the insurance companies be in charge? Because that is what the Republicans would have if they repealed the Affordable Care Act. Insurance companies are businesses, and for them, it is better to get healthier insured patients than the sickest. So they try to exclude people who are sick. If you have got a preexisting condition, they don't want you. They can discriminate against you. They can charge you a lot more. In fact, if you a woman, they think just being a woman is a preexisting condition.

Secretary SEBELIUS. And I am.

Mr. WAXMAN. That is almost as bad as my comment. So they would allow insurance companies to discriminate against people they look at as maybe costing them money, and then not only that, they could raise the rates if you got sick, they could drop you, they have these rescissions they were doing. They have all sorts of way of making it difficult for people who are not just healthier enough to cover. So tell us, what would happen to American families, consumers, seniors, particularly those with preexisting conditions, if Republicans repeal health reform and put the insurance companies back in charge?

Secretary SEBELIUS. Well, Congressman, as you know, I served for 8 years as the elected insurance commissioner in Kansas and have worked on the insurance side of this puzzle for a long time, and what I saw and what we continued to see, frankly, until 2010 was from the industry point of view, a death spiral. That is terminology used by insurers, which means they had fewer and fewer customers and the prices continued to rise because the people who stayed in the marketplace were older and sicker and needed the coverage. The people who dropped out were younger and healthier.

Mr. WAXMAN. Well, you really can't blame the insurance companies. They are in business to make a profit.

Secretary SEBELIUS. Well, and they were experiencing, or consumers were experiencing double-digit rate increases year in and year out in that market, and being locked out and priced out if you had a preexisting condition——

Mr. WAXMAN. I want to move forward because there are some other questions and I am looking at the clock tick by. There is a Prevention and Public Health Fund that we set up in the Affordable Care Act. This fund is there to help fund a lot of important efforts to keep people well and yet there has been an ongoing attack on its since its creation. The Republicans have sought to repeal, rob and otherwise destroy this fund. Just yesterday in this committee, Republicans argued that the fund is merely a slush fund, its resources are being used inappropriately to pay for public

lobbying efforts, for example, that the Obama Administration itself is guilty of stealing from the fund to support activities related to the implementation of the Affordable Care Act, and in brief, they contend that the fund is not being used as intended and therefore should be available to support other worthy health-related initiatives such as an extension of the PCIP program. I would like you to take this opportunity to set the record straight on exactly how the Prevention Fund is and isn't being used and why we need it even though you had to borrow money from it because the Republicans wouldn't give the Administration the funds to go forward and fully implement the Affordable Care Act.

Secretary SEBELIUS. Well, Congressman, I think there is a great track record so far with the Prevention Fund, the first time ever in the United States that we have focused serious dollars on preventing people from getting sick in the first place, a great track record on our anti-tobacco efforts, quit lines around the country, smoking-cessation efforts and those are beginning to show up in the drop in smokers. Work on chronic disease in communities continues, and you are right, we did this year appropriate about $340 million from the Prevention Fund for 2013 to outreach and education around the Affordable Care Act. In the long run, that will ensure that lots of Americans who currently have no primary health home, who have no insurance coverage, who have no ability to get preventive care will indeed be connected with the benefits of the Affordable Care Act.

Mr. WAXMAN. Well, nothing is more important than preventing disease and promoting good public health, and I hope this fund can be used for the purpose for which it was intended.

Mr. PITTS. The gentleman's time is expired. The chair thanks the gentleman and now recognizes the vice chairman of subcommittee, Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. I thank the chairman for the recognition. Let me just start off, it has been a tough morning. We all acknowledge that our friends and neighbors down in the town of West, Texas, just 100 miles north of Waco are suffering this morning as they dig out from under that rather horrific explosion that occurred last night, so we continue to pray for the people in Boston. We also need to pray for the citizens of West.

Now, Madam Secretary, I also appreciate you being here because it has been almost a year since we have had an opportunity to talk. It has been too long. Please come back to our committee frequently. In fact, I would recommend to the chairman that we do have frequent visits because, as you know, October 1st becomes a very important day in the history of our country where your exchanges are going to go live online by statute. They are to go live online on October 1st. And I guess the question on everyone's mind this morning is, will you be ready?

Secretary SEBELIUS. Yes, sir, and the exchanges——

Mr. BURGESS. I will take that as a yes.

Secretary SEBELIUS [continuing]. Won't be October 1st. Open enrollment will start October 1st. The exchanges will be up and running on January 1st.

Mr. BURGESS. Open enrollment?

Secretary SEBELIUS. Yes.

Mr. BURGESS. Now, I do have to ask you a question about the Prevention Fund. I had difficulty finding that in your budget in the expected outlays for the Prevention Fund, but it is written in statute. It is in the so-called Affordable Care Act, section 4002, and it lays out the monies that will be available for successive fiscal years up to fiscal year 2014 where it is $1.5 billion and then for 2015 and every year thereafter it is $2 billion, so it is a significant amount of money even in Washington, D.C. Is that not correct?

Secretary SEBELIUS. Yes, sir.

Mr. BURGESS. And you have pretty broad transfer authority within that fund. Is that not correct?

Secretary SEBELIUS. Transfer authority within the fund?

Mr. BURGESS. That is what it says, subsection D, transfer authority, that the transfer of funds in the fund to be for eligible activities under this section subject to subsection C, which delineated the activities you could fund and one of those activities——

Secretary SEBELIUS. You can expend funds within the fund, if that is what you are asking, yes, sir.

Mr. BURGESS. Yes, you can transfer funds to spend for education and outreach, for example. Education and outreach is going to be a big part of what happens with the Affordable Care Act this summer, is it not?

Secretary SEBELIUS. Yes.

Mr. BURGESS. So in other words, to implement the Affordable Care Act, you are going to take funds from the Prevention Fund for advertising for the benefits of the elysian fields of Obamacare that start this fall. Is that not correct?

Secretary SEBELIUS. We are going to reach out to people who currently have no health insurance and who are underinsured or uninsured and inform them about the benefits of the Act and connect them with the Act.

Mr. BURGESS. And how much money are you going to spend on that informing activity?

Secretary SEBELIUS. Sir, we transferred about $332 million from the Prevention Fund to be used for outreach activities.

Mr. BURGESS. This is an important point, and I want people who are watching to understand this. The Prevention Fund actually is like a bankbook that you can use and make a withdrawal to pay for advertising to advertise about the Affordable Care Act, correct?

Secretary SEBELIUS. Sir, we are not talking about advertising. We have recently put out, for instance, a grant that will be available to community organizations, faith-based groups, provider groups in States around the country so that they will actually work—I don't know if you are familiar with the Senior Health Insurance Patrol program. Individuals work with——

Mr. BURGESS. Reclaiming my time because our time is limited. We do need to talk about these people who are——

Secretary SEBELIUS. I am trying to.

Mr. BURGESS [continuing]. In the preexisting-condition program, which unfortunately ended. Chairman Pitts had a hearing——

Secretary SEBELIUS. It hasn't ended, sir.

Mr. BURGESS. Well, enrollment has been suspended.

Secretary SEBELIUS. That is correct. We are——

Mr. BURGESS. So Chairman Pitts has a hearing and we hear from a young woman who is a lawyer in private practice, unfortunately contracted lymphoma. She has been paying her claims as best she can, waiting to fulfill the 6-month uninsured requirement to get into the preexisting-condition program, and the day before she is to enroll, she is told sorry, sister, we are now closed. So is it Obamacare or Obama don't care? Tell me which it is.

Secretary SEBELIUS. Well, for the individual you are talking about, the good news for her and millions of Americans is that beginning January 1, 2014, no American ever again will be locked out of an insurance pool because of a preexisting health condition, and that will benefit millions of people including the woman that you have discussed.

Mr. BURGESS. Here is the question: rather than spend the money on advertising for a program that may not even work come October 1st or January 1st, why should we not transfer money from that fund to actually help the people that you promised to help, the people with preexisting conditions?

Secretary SEBELIUS. Well, sir, the preexisting-condition pool, as you know, was always designed to be a temporary bridge to full insurance coverage. What I hear from people all over this country is they are eager for the day when the rules will change once and for all for insurance companies. They will never again be able to lock anyone out because a preexisting health condition, and that is very different from segregating them into a high-risk pool, which most people cannot afford.

Mr. BURGESS. But the important thing is that this individual and many individuals like her are essentially lost at sea until January 1st at the very least, and we have——

Secretary SEBELIUS. The good news is——

Mr. BURGESS. And we have the ability to prevent that from happening, which would be the Prevention Fund.

Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the ranking member emeritus, Mr. Dingell, 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, thank you for your courtesy.

Madam Secretary, thank you for being here today to talk to the committee about the Administration's 2014 budget. I want to take a moment to thank you for the fine work you have been doing to implement the Affordable Care Act in the face of some rather nasty opposition by all kinds of folks including some members of this committee. You and your staff have worked tirelessly to implement health reform, a historic undertaking, and I look forward to continuing to work with you as this process continues.

I would also like to note that you are the daughter of a former member of this committee, and you are always welcome. I am sure you view this as something of a home too, so welcome.

Secretary SEBELIUS. Thank you.

Mr. DINGELL. In any event, Madam Secretary, yes or no questions. You are working now on the FDA Food Safety Modernization Act. The legislation made historic improvements in our food safety system and provided new authorities to help FDA to prevent food safety problems before they occur throughout the food supply. This

legislation, which I authored, included a dedicated source of funding for the implementation of food safety through a facility fee, a reinspection and recall fee and a fee for importers and exporters. Unfortunately, some of our friends on the other side of the Capitol did not see the wisdom of the fees that they passed overwhelmingly here in the House. The President's fiscal 2014 budget requests $225 million in resources through fees to help fund the implementation of the food safety law. Is that correct?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. Now, these proposed fees include a food facility registration and inspection fee and a food importer fee. Is that correct?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. Madam Secretary, can you explain briefly what these activities and these fees will be used for?

Secretary SEBELIUS. Well, there is no question that in the 70 years between the time that Congress passed the new food safety measure a few years ago and the last time food safety measures were updated that the market has changed dramatically. We have a global market. About half of our fruits and vegetables and two-thirds of our seafood come in from overseas. We have a different kind of——

Mr. DINGELL. Huge imports occupy a very high proportion of American consumption.

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. And we are finding that that seems to be about the only way we can get the FDA properly funded to carry out its mission. Is that right?

Secretary SEBELIUS. They definitely need new resources to build a new food safety system.

Mr. DINGELL. Particularly in the area of new drug approvals. Is that right?

Secretary SEBELIUS. That is correct.

Mr. DINGELL. Now, Madam Secretary, do you believe these fees help FDA to implement the food safety law effectively and in a timely manner? Yes or no.

Secretary SEBELIUS. I do.

Mr. DINGELL. Another area of interest to me is cosmetics. FDA's authorities over this industry are woefully outdated. The industry itself has requested improved authority for the FDA in this area to better ensure the safety of cosmetics, and I know the industry has requested this to their great and lasting credit. The Administration has proposed a cosmetic user fee of $19 million. Is this correct?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. Madam Secretary, can you explain the fees' purposes and the activities that this user fee will be used to support?

Secretary SEBELIUS. Again, it will be used to really update the regulatory capacity and add new technical expertise. As you say, it is requested by the cosmetics industry so we are very hopeful to work with Congress on implementing this update to the reinventing cosmetic fee initiative.

Mr. DINGELL. Now, Madam Secretary, this business of fees for FDA began when this committee worked out a deal with the phar-

maceutical industry to enable the pharmaceutical industry to get better service from FDA on new drug applications. Is that right?

Secretary SEBELIUS. New drug applications and new device applications, yes, sir.

Mr. DINGELL. Well, actually it has moved through new drug, new devices, over-the-counter and all kinds of things, and that has worked out very, very well from the standpoint of industry and the standpoint of government and consumers. Is that right?

Secretary SEBELIUS. It has definitely expedited the ability to put things on the market more quickly.

Mr. DINGELL. And it is actively supported by the industry?

Secretary SEBELIUS. Yes, sir.

Mr. DINGELL. And prior to the time of that legislation, it is interesting to note that Food and Drug would take as much as 10 years of the 17-year period on the patent, the end result of which was that the industry lost hundreds of millions or even billions of dollars. People were denied the availability of useful new pharmaceuticals, which could help deal with some of the serious medical and health problems in the country. Is that right?

Secretary SEBELIUS. That is correct. We were losing to global competitors because of the pace of approvals.

Mr. DINGELL. Madam Secretary, thank you for being here, and good luck in implementing the legislation that is so important, the Affordable Care Act. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you.

Madam Secretary, I appreciate you being here today. I have, first of all, a question, and I recognize in your position you may not get the letters that we send over, but there was a bipartisan letter sent to your office signed by myself, Chairman Upton, Ranking Member Waxman, Diana DeGette and others regarding a follow-up on number of mental health issues. I am not sure if you saw that, but we had asked for a response in February. We have not received a response yet. I brought another copy here. Can I get that to you and get it right to your desk?

Secretary SEBELIUS. Yes, sir.

Mr. MURPHY. I appreciate that. It is important as we make sure. And I appreciate your focus on mental health. I am a psychologist myself. I also know in your statements you had requested some funding increases in a number of areas.

Another thing, and I hope you can take this message to the President as well is, I have reviewed or tried to review what the federal government spends on mental health in a wide range of areas: in HHS, Judiciary, Education, Department of Defense, Veterans Administration. It appears that no one has a handle on how much money we spend in mental health in a broad perspective. No one has ever done an inventory on that. So Representative DeGette and I sent a letter over to the Office of Management and Budget with a copy to the President asking for an inventory of all that we do, and I think that would be important because we need to know how much we spend, where we spend it, and following that, is it

even effective such as does it get to the level of the patient. When you are talking about one in five people at any given time have a mental health disorder and that perhaps only 40 percent of those with mental illness get treatment, that we heard before during a hearing we did post Newtown from the head of NIMH that it is about 112 weeks before someone even gets treatment for a psychotic disorder, and you also pointed out in your testimony that it is about ages 14 to 25 when some of these disorders appear and that every one of these mass murderers was generally in that age range, I think all but one was male, psychotic symptoms and other things. We recognize severe mental illness are not all violent. A vast majority are not. But it is an area that we are all deeply concerned. We need to know what we are doing and are we doing the right thing. And so will you be able to get us a response to that letter?

Secretary SEBELIUS. Yes, sir, we will definitely.

Mr. MURPHY. Thank you. Another issue has to do with mental health parity. That bill was passed over 4 years ago, and we still have not seen regulations. Do we have a date yet by which we might see something?

Secretary SEBELIUS. We are committed to finalizing the rule this year and are in the process of doing just that. We do have interim final rules that have been promulgated 2 years ago and so those are in place right now.

Mr. MURPHY. Thank you. And another area, we were talking a little bit about the FDA here. I noticed recently a substance by the name of Jacked with a backwards 3 and therefore the letter E was recently put out as a ban because some substance within it was perhaps associated with—we don't have a direct link—but perhaps correlated with a couple deaths. I know the military has asked that all these products be removed from commissaries and exchanges on military bases. I don't know if you have had a chance to look at this but my question is, are these products still being sold online or in stores, and if you could get back to me with information on that, because I recognize we don't want a dangerous or potentially dangerous substance out there for people to take.

Another area I wanted to bring to your attention to in terms of supplements, the December issue, I think it was Military Medicine, said that with regard to supplements, they did a survey of supplements sold on military bases. They found that only 12 percent of manufactured supplements actually had an independent body verify what is in it. We have seen studies that said even vitamin D content in vitamin pills may range from less than 10 percent of what it is supposed to have 140 percent of what it is supposed to have. So 12 percent have an independent verifier. About 28 percent verify themselves the content whatever that is, a mineral, a supplement, a vitamin, and the rest, 60 percent, have nobody verifying at all what is in them. Somewhere within your agency I am sure someone is taking a look at that, and I would appreciate information back on that. It is a massive industry in America geared to help people stay healthy. We want people to stay healthy. But I sure would like to know what is in that.

Secretary SEBELIUS. Well, Congressman, I can tell you, we would love to work with you around that issue. A lot of these supplements

and additives fall into a very gray area where they are not sold as medical products, they are not sold as pharmaceuticals, they are sort of food additives and that often is kind of outside the FDA jurisdiction, but we would love to pursue that issue with you.

Mr. MURPHY. Thank you. I look forward to meeting with you. Thank you very much, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from California, Ms. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman, and welcome, Madam Secretary.

As you know, my State of California has consistently taken a leadership role in health reform implementation, and now I have heard concern from hospitals in my district about the financial impact of the disproportionate-share hospital, the DSH program cuts, and reductions on the providers who are in States like California making a good-faith effort to implement the Affordable Care Act. Could you speak to the proposed DSH reduction schedule and how this proposal will help facilitate a smooth transition of full ACA implementation?

Secretary SEBELIUS. Congressman, we were hearing similar reports from hospital executives around the country, and in the midst of an attempt to really fully engage in the health market so the determination that we have made recently is that the Medicare cuts, which have a specific timeline around DSH, will proceed with implementation in 2014. We are committed to fully reducing DSH payments by the amount suggested in the ACA schedule but not beginning the Medicaid DSH reductions until 2015.

Mrs. CAPPS. When DSH cuts are set to take effect, how is CMS going to recalculate the hospital's needs for the funds? Will hospitals in States like California where we are embracing a Medicaid expansion have a fair shot at the funds when up against the—in other words, do we get our fair share? Thank you.

Secretary SEBELIUS. Well, and the goal, as you know, when you authored or helped to author the Affordable Care Act is that as additional Americans were able to be covered by health insurance or by Medicaid expansion, that would reduce the level of uncompensated care that hospitals currently experience. So it is designed to be a complement but we are conscious of the notion that that won't be a direct match and we are looking very carefully and doing a lot of outreach about what is the most effective way to implement the cuts that are proposed in the law.

Mrs. CAPPS. Well, I appreciate that and your willingness to do all you can to ensure a smooth transition as the ACA goes into full effect. We want to be partners with you, and I want to highlight, however, that we are watching carefully. It would be unfair if States that are acting in good faith like California are harmed because of other States' policies, and I am sure you are aware of that and I know you are going to keep that in mind.

One last question. This delay in DSH reductions is just a proposal, right?

Secretary SEBELIUS. It is proposed in the budget this year.

Mrs. CAPPS. Right, a proposal.

Secretary SEBELIUS. I know it was proposed. I just wanted to make sure.

Mrs. CAPPS. Exactly. This is an important distinction. I believe as implementation continues to be hampered by politics, some governors are using the proposed delay in DSH cuts as an excuse to delay in making a decision on Medicaid expansion. I think this is irresponsible and pretty cruel to constituents. Anyway, while cut delays are just a proposal, the impact of delaying the decisions is not.

There is a little over a minute left. As someone who was formerly a visiting nurse myself, I believe the renewed commitment to maternal, infant and early childhood home visiting programs is just excellent and a good preventive and cost-saving way to deliver health services. Their support is bipartisan, and they are evidence based. These programs work and they are critical to improving health outcomes for women and children and really for families. Could you detail the proposed investment in these programs over the next 10 years? There is not much time to do it but highlight it so we can follow up.

Secretary SEBELIUS. Well, I think one of the very exciting second-term initiatives that the President believes in very strongly is an infrastructure around early childhood starts. So it includes Health and Human Services, increases in investments in home visiting programs which, as you say, are evidence based and not only are wonderful for health but also very proven to reduce violence and is a great strategy for resilience in children, increases in our early Head Start childcare partnership effort, and then in the Department of Education budget is a significant increase in pre-K programs in partnership with States around the country and that infrastructure, to make sure that by the time children are 5 and hit school, they are not only ready to learn but they are socially and emotionally ready to be in a classroom we see as a critically important investment to make in the future.

Mrs. CAPPS. Thank you, and this really gets at our disparities in health care as well in a very clear way.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Dr. Gingrey, for 5 minutes for questions.

Mr. GINGREY. Thank you, Mr. Chairman.

Madam Secretary, as one of the physician members of the committee, you know I have always been unwavering in my commitment to the full repeal of Obamacare, but now as we approach full implementation, however, I believe that we must chip away at the most egregious parts of the law, and to that point, Secretary Sebelius, you stated in a speech in Philadelphia in late March of this year that some men and younger customers could see their insurance rates increase because of the Patient Protection and Affordable Care Act. Do you think that it is fair that young people will pay higher insurance rates because of this law?

Secretary SEBELIUS. Sir, I think we don't know what the rates will look like until the insurers file their plans, and the very good news is that State insurance departments around the country have additional resources to review those——

Mr. GINGREY. In the interest of time, I am asking you a simple question. Do you think that it is fair that Obamacare asks young

people to pay higher insurance rates? I know you don't know what they will be but is it fair? Do you think it is fair?

Secretary SEBELIUS. Well, there is nothing in the law that asks young people to pay higher rates.

Mr. GINGREY. Well, Secretary Sebelius, actuarian Oliver Wyman's firm produced a study that identified how wealthy a young person had to be before their health costs went up because of Obamacare. I ask you this: Do you happen to know how wealthy a young person in 2014 when you have fully implemented these exchanges will have to be, how wealthy that person would have to be to not pay higher out-of-pocket insurance premiums?

Secretary SEBELIUS. It is an impossible question, but what we know about young people right now who are not insured, a number of them are on their parents' plans until age 26.

Mr. GINGREY. Well, we are talking about, assume that this person is 27 years old.

Secretary SEBELIUS. Then anyone under 400 percent of poverty will quality for a tax subsidy, an upfront tax subsidy, and will have insurance policies with far lower copays and coinsurance and out-of-pocket——

Mr. GINGREY. Well, Madam Secretary, the answer, according to this actuarial study, is $25,000. Secretary Sebelius, do you think that asking a young person who makes $25,500 to pay more for their insurance under Obamacare, is that fair?

Secretary SEBELIUS. Well, that isn't accurate, unfortunately. Somebody who is making $25,500 would definitely qualify for a subsidy if he or she is purchasing coverage in the individual market so they will not pay more out of pocket than——

Mr. GINGREY. I don't know how much that subsidy might be, Madam Secretary, but even with the subsidy, they will be paying more under Obamacare than they would be paying 4 years ago for the same insurance coverage.

Secretary SEBELIUS. That is absolutely not true.

Mr. GINGREY. That is absolutely true, and let me ask you this next question. Has your Department created contingency plans in the event that young people like I just described choose to pay the penalty instead of purchasing the insurance that they can't afford? Have you developed a contingency plan in the event that that occurs?

Secretary SEBELIUS. No, sir. We intend to implement the law, but I think educating young people about what options they will have that they do not have now, that they will be in a larger pool, that there are subsidies available to them which they absolutely do not know and that they will have full insurance coverage. Young women know that no longer will it be legal for an insurance company to charge 50 or 75 percent more for exactly the same coverage.

Mr. GINGREY. Well, I only mentioned young men because that was who you addressed in that speech in Philadelphia. And look, you are lot more optimistic obviously about how this is going to work in these exchanges on January 1, 2014, than I am, but I would highly recommend to you, Madam Secretary, that you do develop a contingency plan in the event that so many of these young people look at that and say hey, look, here I am straight out of col-

lege, I am now 27 so I am not on my parents' policy, and furthermore, they kicked me out of the basement, I have got $250,000 worth of higher education debt, I am engaged, I am trying to build a life, I have got a job. I strongly suggest that your Department create this contingency plan, and I would suggest that you submit that to me and this committee and furthermore not let a train wreck or any other excuse slow it down, and I yield back the balance of my time.

Secretary SEBELIUS. Well, Congressman, the other thing that is available to your young person who is engaged is a choice of a fully insured plan or a catastrophic plan. What we know is putting that young person in a large pool automatically by entering the marketplace will be significantly more beneficial than he or she shopping in the individual market where they have no rules and no protection, and if indeed they get any kind of preexisting condition, they could be booted out in a heartbeat.

Mr. GINGREY. Mr. Chairman, since you let her go a little bit over, just let me address the issue of age banding because of your rules, you are going to force these young people to pay higher rates than somebody 58 years old who can well afford to pay better than they can, and you ought to let the States decide that.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Utah, Mr. Matheson, 5 minutes for questions.

Mr. MATHESON. Thank you, Mr. Chairman, and Madam Secretary, thanks for coming before the committee today.

In the Department's fiscal year 2014 budget is included the implementation of copayments for Medicare home health beneficiaries per MedPAC's recommendations. The new copays on home health would be a tool to reduce overutilization and create savings for the program. Now, looking at ways to reduce the overutilization and create savings is something we all want to do. I do have some concerns, though that with the proposals that ask beneficiaries to pay more out of pocket, particularly those who would be paying are probably a little more sick, less financially secure. And allied to that, I have concerns with asking seniors to pay more when there are strong indications of fraud and abuse in certain geographic areas of our country in the home health care industry because MedPAC's March report identified—there are basically five big ones, five specific geographic areas where there is strong reason to believe that fraudulent billing practices are in play in the home health care industry. For example, it is a nice comparison, there are about 190,000 Medicare beneficiaries in my State and there are about that many in Miami-Dade County. In Utah with the same number of beneficiaries, we have about 100 home health care providers. In Miami-Dade County, it is nearly 700. The average benefit per beneficiary in Miami-Dade County is five or six times what it is in Utah.

So we have a situation where in a few geographic areas, there seems to be some bad actors, if you will, and it strikes me that there is something wrong in places like Miami-Dade County. So I guess my point, which I am sure you understand, is, in terms of looking for savings and efficiency, it seems to me we might be looking at situations where those geographic disparities reflect that there may be some activities going on that are not right. And I was

wondering if you looked at what your authority might be or using your authority to limit issuance of new provider numbers in these geographic regions which have strong indications of this type of overutilization.

Secretary SEBELIUS. Well, Congressman, we are doing more than looking at re-credentialing providers. We actually have at the President's direction really ramped up our antifraud efforts around particular durable medical equipment where there are very erratic billing patterns. Home health is another high target. We recently have seen some mental health services and some pharmaceutical services. We have a very active strike task force, a HEAT task force including U.S. attorneys and on-the-ground folks from our Inspector General's office working together in Miami-Dade County and a number of other areas. They are not in Utah right now because we are not seeing that kind of billing practice but fraud and abuse we are taking very seriously. We have returned historic returns to the Medicare trust fund and in fact to Medicaid programs around our strike efforts, which is why we are asking for new mandatory funding, frankly, because we are returning about $8 for every dollar that we are appropriated, and I think that is an incredibly important investment to make sure that people don't steal from these programs and that the services are delivered to people who want them and need them.

Mr. MATHESON. Do you feel like you have the appropriate authority based on legislation to use data analysis and analytics to really target these areas that have these problems?

Secretary SEBELIUS. Actually, we have finally for the first time built over the last couple of years predictive modeling, the same kind of computer analysis that credit card companies and other banks have used for years. Medicare has never done that. So we are actually able not only to target areas where they are great billing irregularities but actually target the types of services and focus a lot of time and attention with our prosecutors, with our investigators, and our goal is to shut it down before it happens, not to continue to do the pay and chase but actually to move in and shut down these operations.

Mr. MATHESON. Are there any particular impediments you see in front of you that are limiting your ability to do this?

Secretary SEBELIUS. Well, the biggest impediment is resources. Ironically, the return is so great and yet for the last number of years we have not gotten the appropriation even up to our budget limit. So I would just urge the committee, I think fraud and abuse is something that people agree on. We have a great track record. We can show you dollar for dollar what is going on but our restrictions are really on resources.

Mr. MATHESON. Thank you, Madam Secretary. I yield back, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Louisiana, Dr. Cassidy, for 5 minute for questions.

Mr. CASSIDY. Thank you, Madam Secretary. As you know, we have got 5 minutes, so if I seem like I am speaking like an auctioneer, I am, and if I occasionally interrupt, it is not to be rude; it is to maximize our time.

I will start off with a couple yes or no questions. In January 2012, the President announced plans to streamline government agencies like the Department of Commerce with this statement: "Our economy has fundamentally changed as has the world but our government has not. Often it has grown more complex." He has also stated that he supports reforms to federal agencies that result in more efficiency, better service and leaner government. Yes or no, do you believe that federal agencies should be mindful of our current economy and operate in ways that result in more efficiencies?

Secretary SEBELIUS. Yes.

Mr. CASSIDY. Second yes or no. The President's fiscal year 2014 budget proposal for HHS is $967 billion and seeks $80 billion in discretionary spending, roughly $60 billion more than last request. Yes or no, understanding the President's commitment to efficient government agencies and knowing the difficult budget situation our Nation faces, could you accept a 2 percent reduction in your agency's total HHS request?

Secretary SEBELIUS. No, sir.

Mr. CASSIDY. And if you can't, can you defend all the expenditures in the agency as outlined in the President's budget, not even a 2 percent cut anyplace?

Secretary SEBELIUS. I am happy to do that in a more robust conversation but I think the 5 minutes probably won't allow that to happen.

Mr. CASSIDY. Well, thank you, and I understand that, and I appreciate your sensitivity to the time.

Next, following up on what Ms. Capps said, my State also has a lot of uninsured. Our governor has not yet indicated that he is going to accept the Medicaid expansion. It is going to cost our taxpayers $1.2 to $1.8 billion in State tax money to implement. But I am a doc that takes care of the uninsured. The DSH program, as we know, has helped support care for those folks. If a State does not accept the Medicaid expansion, obviously there is concern that they would lose the DSH based upon a decrease in the national uninsured rate, although the uninsured rate within the State may still stay higher.

We sent a letter to your office dated February 11th asking for a reply by March 1st. It may have been a tight timeline. I apologize. But have really not received a reply since. Can I give you a clean copy of this letter and ask if you guys can respond to it? I don't mean this as a gotcha. I mean it totally as a fellow who is advocating for his uninsured.

Secretary SEBELIUS. Certainly.

Mr. CASSIDY. Thank you. Next, my gosh, don't we all still have a heartbreak for the issue of mental illness in our Nation? There was an article in the Wall Street Journal from 2006 but apparently still apropos, "A Death in the Family" regarding William Bruce. Mr. Bruce was hospitalized with severe schizoaffective disorder, I believe, and there is an agency that got federal dollars, Protection and Advocacy for Individuals with Mental Illness who, according to the article, and I have been in communication with the father, they actually coached the young William as to how to give his answers to providers that he could get released. He did. The providers did not inform the family that he was still psychotic, and he went out

and he murdered his mother. Incredible. Now, this agency, we have looked to see if they put in reforms to ensure that they are no longer doing this, have been unable to. I do see that they continue to receive $36 million a year. Can you provide us follow-up or some guarantee that the Protection and Advocacy for Individuals with Mental Illness receiving $36 million a year in some way is no longer doing this?

Secretary SEBELIUS. Well, Congressman, I have no idea what the agency is or does or what they advocate.

Mr. CASSIDY. I accept that.

Secretary SEBELIUS. I can tell you, though, that about 65 million Americans who currently have no mental health or substance abuse benefits either through access to new marketplaces and new affordable health insurance or Medicaid expansion will finally have——

Mr. CASSIDY. I don't mean to interrupt. And that again was not a gotcha question and I didn't expect you to know that kind of micro level, but I think we all are concerned that this is not being funded by our federal government, or if it is, that there is some reform. So we will give you some information on that if you could reply please.

Next, in his Now is the Time plan to address gun violence, the President promised to do the following: address unnecessary legal barriers, particularly related to HIPAA, which may prevent States from making information available to background check systems; two, releasing a letter to health care providers clarifying no federal law prohibits them from reporting threats of violence to law enforcement authorities; and three, starting a national dialog on mental illness. Can you just give us an update of progress as regards these three things?

Secretary SEBELIUS. Sure. The letter to providers went out fairly immediately after the President's announcement of the package of administrative initiatives that we were going to put in place, and I would be happy to provide this committee with a copy of that letter, reminders providers that there actually is a duty to warn and there are no HIPAA barriers against coming forward when somebody is likely to be dangerous to themselves or others. Secondly, we have just put an ANPRM, an Advanced Notice of Proposed Rulemaking, that would ask the States to identify what they see as the barriers. Our frustration is, we don't think there are barriers to collecting the information that is requested. States have said that they see those barriers, so we want to know what they are so we can directly address them, and that has gone out this week, and we are in that dialog, and within the next month or so, we intend to launch the national dialog. We already are working with mayors and community groups in communities across this country. It will be a public-private partnership, privately funded, community dialogs, toolkits by our office, meetings in communities, but the dialog will be a yearlong effort to really bring mental health conditions out of the shadows and make it clear to people where they can go for help.

Mr. CASSIDY. If I can help you, please let know.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Texas, Mr. Green, 5 minutes, sir.

Mr. GREEN. Thank you, Madam Secretary, for your time, and I commend you and the President for writing a budget proposal that as a whole puts our country's health system on the right path forward.

My first question, I am a strong supporter of the Affordable Care Act and I look forward to the next few months to learn how it will be implemented across the country, especially in my home State of Texas, and I know you were there last year and we talked briefly about this in one of your visits to one of our level I trauma centers in Houston. We have spoken about the importance of providing a robust exchange in States like Texas that opt out of creating their own system. Our time today is so short and so it is not necessary to get into it now, but in the next few days could you or your office provide us in writing a status report on the creation of the implementation of the Texas State exchange? Again, you don't have a partner so we need to make sure, and I know we are not the only State that is in that boat. We may be on Medicaid but not on that.

Secretary SEBELIUS. We would be glad to do that.

Mr. GREEN. My next question is something we haven't contacted you about, about the disproportionate share hospital payments. It was recently brought to my attention in an informal process that CMS changed their DSH payment procedures to children's hospitals in certain instances. As I understand it, children's hospitals having their DSH payments reduced because of commercial insurance revenue is counted as Medicaid revenue. It is important to note that despite CMS continuing insisting that this is double dipping, it is my understanding that this happens even though the patients may be enrolled at Medicaid, that their private insurance is paying the bills. There is no payment for Medicaid being made and the children's hospitals never include these children in their Medicaid cost reports in any way because they are never considered Medicaid-program patients. However, for some reason, CMS determined that these are Medicaid payments and reduces their DSH payments. Are you familiar with the problem?

Secretary SEBELIUS. I am somewhat familiar but would love to have a chance to get back to you with specifics.

Mr. GREEN. OK. What I would like to do is work HHS to remedy the problem, and we have a great hospital and medical center in Texas Children's Hospital and we have hospitals all over the country that are children's, and erroneous reductions have come close to eliminating their DSH payments, and they do cover a lot of uninsured children who are not under Medicaid. In States like Texas where Medicaid may not expand, DSH is a critical revenue stream, so TCH provides a valuable service to our community and it should receive all the funding they are entitled to under the law, and this is an urgent issue, and I don't think it is the intent of HHS to harm our children's hospitals, and it cuts across State lines. This is not a Texas-only problem.

Secretary SEBELIUS. We would be very willing to follow up with you, Congressman. I think the issue that was trying to be addressed was in the dual-eligible area if you double count what is happening, but I am a little unclear how exactly that impacts children and what is happening in the children's hospitals.

Mr. GREEN. We will get you some information. I appreciate it. My next question deals with sequestration and the effect on Part B drug payments to providers such as cancer clinics. It is my understanding that because of the sequester and because of the way the underlying ASP is calculated to include prompt payment discount, many providers have been reimbursed less than they pay for the drug. Madam Secretary, does HHS have any flexibility if access to providers becomes an issue for beneficiaries to modify the payments so that providers are reimbursed at a rate that allows them to continue to offer those drugs?

Secretary SEBELIUS. We do not have any flexibility with the sequester implementation.

Mr. GREEN. And I understand that the sequester was brought on by Congress and we are tasked with finding a way out. On this Part B drug matter, my colleagues, both Mr. Whitfield on the majority side and Ms. DeGette and I have a bill that we have introduced for the last few sessions. This bill would exclude the prompt payment discount from the ASP calculation.

And Mr. Chairman, I think we should seriously consider taking this bill up in our committee to mitigate the problems I have described, and again, I will yield back 43 seconds to you.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentleman from Kentucky, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you, Mr. Chairman, and thank you, Madam Secretary, for coming today. I appreciate you being here.

I want to talk about prevention funds in the budget or the use of prevention funds, and I have been to a dialysis center. As you walk through, and it is not just the numbers of the money we are spending in dialysis centers, it is the lives, and a lot of that is preventable. So I am for prevention. The last time you were here, we spoke specifically about using prevention funds for lobbying State and local ordinances.

Secretary SEBELIUS. I am sorry. Could I interrupt for one second? Dr. Cassidy, I have just learned that the rulemaking that I mentioned, it goes out tomorrow, so I just wanted to clarify. It isn't out the door yet but it goes out tomorrow. I am so sorry.

Mr. GUTHRIE. No problem. The prevention funds we talked about last time, and I remember you saying that the examples I cited were State and local lobbying so therefore it wasn't lobbying as prevented by the federal. It was only limited to the federal government, which that actually wasn't accurate according to the law.

The second thing that you said that the grants that I cited went out prior to the Labor and HHS rider in the appropriations bill, therefore, it wasn't covered by the lobbying prevention, but actually 18 U.S.C. governed it as well, and we talked about that, and your own internal regulation A.R. 12 governs that. And so after that exchange, I thought you would go back and look at the programs and say OK, these would be covered by those, and I was even interviewed. I don't have the transcript but somebody asked me about the Department. I said I have all faith that they are going to go back and correct the way these grantees are behaving, and I don't think they behaving incorrectly to themselves because their actual grant proposals stated exactly what they were doing. So I sent a

letter along with Congressman Whitfield, and the letter came back and it concerned me because it said the HHS staff has determined that they believe the activities are not lobbying, and what is frustrating about it, it appears, it is like, OK, these groups were advocating for local and State policy. They put it in their grant requests, and let us find some interpretation of the law that allows them to do it, and the letter quoted a 1989 DOJ interpretation of 18 U.S. Code 1913 that was updated in 1992. So we have a 1989 interpretation of a law dated in 1992. And even your own A.R. 12 says any activity designed to influence action in regard to a particular piece of pending legislation would be considered lobbying, and it says federal or State levels—so it just seems like we did bring this up and brought it to your attention and you said you would address it, and then we are back here now saying well, that really didn't violate, we have an interpretation and they can continue to go the way that they were going. And that was frustrating to me because I thought we were going to be able to address that.

Secretary SEBELIUS. Well, Congressman, I can tell you that CDC, the Centers for Disease Control and Prevention, takes their rider that Congress added to the legislation and the provisions that govern the anti-lobbying seriously. They have revisited the grantees. They have put out new technical assistance. They are proceeding to inform people as the money goes out the door, there is now language that goes with every grant that a grantee has to sign which reminds them about the prohibition to do lobbying at the State, local or federal level. So we are trying to be very responsive to both the Congress direction and the original law.

Mr. GUTHRIE. But it is not just—but if you don't define what they are doing as lobbying, then they can continue to move forward.

There was one in South Carolina, you said—well, you didn't say but the letter we got, there was a South Carolina one that was noted as a violation, and it said they sent email message and scheduled a press conference for purpose of getting a city ordinance, but there was one that wasn't. It was Nevada that said they advocated for the passage of Senate Bill 27, and so we just want to make sure we know that lobbying, according to the regulation, is any activity, not just if it is large scale of heavily funded. That is what the interpretation of 1989 says. I guess that is what was disappointed. We thought we were going to get that addressed, and when the letter that I received back, and I am sure you have it, was that that really didn't violate the law or not.

Secretary SEBELIUS. Well, again, I think CDC takes those responsibilities seriously and we are trying to make sure that grantees do too.

Mr. GUTHRIE. And then the letter was about a year late coming back—not a year late. It was a year later, so for oversight, it would be better if we could do it more promptly. I appreciate that very much.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentlelady from the Virgin Islands, Dr. Christensen, 5 minutes for questions.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and welcome, Madam Secretary. Let me just say before I ask my questions, the

country is very fortunate to have you as Secretary at this particular time, not only bringing your experience as governor but insurance commissioner as we implement the Affordable Care Act.

I am going to try to ask my questions all at once in the interest of trying to get through my 5 minutes. We have the first-ever national strategy to eliminate health disparities, and we thank you for that, but it relies heavily on the Offices of Minority Health, both the one in your office and the other agencies. So what I would like to know is, how does your budget and how do your plans support strengthening the Offices of Minority Health and supporting and funding those in the other agencies.

The second one is on REACH. REACH has been widely documented as being extremely effective—the Racial and Ethnic Approaches to Community Health—in eliminating or reducing health disparities, and I know that the Department thinks that the community transformation grants and the community putting prevention to work initiative are good replacements, or that is what I understand the Department thinks. But looking at the increasing health disparities in communities of color, I think that that requires some specific targeted attention, and so I would like to know what evidence the Department has that supports that those would be good programs to replace REACH, which we don't think they are. There is a non-discrimination provision in the Affordable Care Act and we would like to know when the regulations for that will be issued.

Two more, one concerning the Navigator program. Why does it only reimburse for recruiting for exchanges and not for enrollment in Medicaid? That is one question on that. And also, there is a great concern that organizations from inside the communities that are going to be approached by the navigators are the ones that would be receiving the grants. We have experience with the Minority Age Initiative where organizations from outside communities came in, and they don't have the trust of the communities so we want to be assured of that.

And the last one is, how are we doing with the health care workforce? As a physician, I am particularly interested in physicians. For example, the Department projects that urologists would be facing a 32 percent deficiency in the number of providers needed in 2030.

So that is OMH, REACH, Navigator program, adequacy of the workforce, and non-discrimination provisions.

Secretary SEBELIUS. Well, Congresswoman, you know that I share your keen interest in not only documenting health disparities but closing them. I don't think there is any question that the full implementation of the Affordable Care Act with Medicaid expansion and affordable health insurance is probably the single biggest step we can take to addressing health disparities and so we are eager to work with you on that full implementation. I know that there is question about resource allocation to REACH and to other programs. We have targeted the community transformation projects in areas where there are large numbers of health disparities as part of the criteria for doing this and actually in a better budget time I think we would fund everything but we had to pick and choose and make some decisions going forward. But again, I

think the combination of the implementation and the specific community projects aimed at communities of color and the National HIV/AIDS Strategy which, again, is targeting for the first time resources to those most in need have great potential for moving forward. Health homes around chronic conditions is another area, I think, that isn't look at as health disparities but will actually impact communities of color significantly.

We share your concern about navigators coming from the community, being of the community, and that will be part of the criteria looked at as those funding proposals come in, and you will see in the 2014 budget request for resources, particularly in HRSA but also now with the mental health professionals to not only enhance workforce nurse practitioners, physicians assistants, more National Health Service Corps folks but also 5,000 mental health workers, which are part of the President's Now is the Time agenda, so we are keeping a keen eye on workforce issues.

Mr. PITTS. The chair thanks the gentlelady and now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman. Thank you, Madam Secretary, for being here.

In an address to the Democratic National Committee in September 2012, you stated first if you already have insurance you like, you can keep it. Madam Secretary, I hear from constituents every week lamenting the fact that they have lost or at risk of losing their employer health insurance plan that they like because of Obamacare, and here is the dilemma that many business folks are being put into. A constituent of mine called me and sat down with his accountants and his experts and his medical people, and what they said to him was, you have three choices. The business that you have owned for 33 years that you started out with small and started growing and growing, you have 59 employees, so here are your choices. You pay the $43,000 fine, you close down the third shift that is the least profitable of your three shifts, just get rid of that and then you don't have to do anything, or you pay even more than the $43,000 to insure all of your employees. Now, most of his employees are already covered or a large number of his employees he already pays for them, and he pays for them in full, and he is struggling with these dilemmas, knowing that some of his people won't be able to afford the insurance that he is already paying for if he drops it completely, and he has not made a decision, but that is the dilemma that businessmen and women across the United States are having to go through.

And again at the DNC you said but for us Democrats, Obamacare is a badge of honor because no matter who you are, what stage of life you are in, this law is a good thing. And I have to ask you, can you really believe that to the 7,000 employees who are part-time employees for the Commonwealth of Virginia who are facing a cutback in the number of hours because the Commonwealth has decided based on trying to make sure that they keep their costs in control that they are not going to allow the part-time employees to have more than 29 hours, do you really believe that to those people it is a badge of honor or that Obamacare is a good thing? Because now their hours are going to be cut. Yes or no.

Secretary SEBELIUS. Well, sir, I don't like anybody's hours to be cut. We need to actually make sure that people get paid and work to take care of their families——

Mr. GRIFFITH. But you do understand——

Secretary SEBELIUS [continuing]. But health costs are part of that overall——

Mr. GRIFFITH. I have to move on because I only have a limited amount of time, but the examples go on. In my district, we have a county, Wythe County, Virginia. They hire retired law enforcement folks to work court security as court security employees. Now, many of these people already have insurance. They are usually retired, or a lot of them are. They have insurance or they have Medicare. Now the county is going to have to cut back their hours because they don't want to have to pick up insurance for people who already have insurance, and so they are going to have to cut back their hours, and for many of that folks, that translates into a 30 percent pay cut for their retirees. I don't believe that is a good thing, and I will take your previous answer as the answer to that question as well, that you hate to see that happen but sometimes things happen.

And do you really believe that the 30-year-old——

Secretary SEBELIUS. Sir, I didn't answer any question that way.

Mr. GRIFFITH [continuing]. Whose premiums will skyrocket next year, do you think he thinks that Obamacare is a good thing? And how about my 82—I have to keep going because my time is running out. How about my 82-year-old mother enrolled in a Medicare Advantage program, which is a highly popular program, which has been cut to pay for the ACA, can you really believe—deep down in your heart, can you really believe that she thinks Obamacare is a good thing?

Secretary SEBELIUS. The good news, your mother is paying less now than she did. I don't know about your mother's plan but Medicare Advantage plans are down 10 percent, enrollment is up almost 20 percent, so your mother actually is in better shape than she was before the Affordable Care Act.

Mr. GRIFFITH. Well, and she also got a lot of her stuff done. When she saw this coming down the pike, she said anything that I know is wrong with me now, I am getting it fixed. And how about Susan Zurface, the 42-year-old single mother who was recently diagnosed with leukemia and turned away from enrollment in the High Risk Pool program because the ACA established fund was depleted? I can't believe that she thinks that Obamacare is a good thing.

Secretary SEBELIUS. If repeal had gone forward, there would be no preexisting plan whatsoever.

Mr. GRIFFITH. And what I would have to say, Madam Secretary, is that for so many of these folks who are facing uncertainty as to what is going to happen, who may not be able to pay, the employers who like to pay for their long-term employees who may not be able to afford to do that. They don't think Obamacare is a good thing. They don't see it as a badge of honor. I have to tell you, Madam Secretary, and I know we disagree on this, but when I talk to my constituents, it appears to me that thinking that Obamacare is a good thing and is a badge of honor is just wrong thinking, and

in fact, I believe it is going to make a majority of Americans losers in the health care arena.

Mr. Chairman, I thank you so much for the opportunity and I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you, Mr. Chairman, and welcome. I want to thank you, Secretary Sebelius, and the President and your team here because what this budget does, it stays true to American families, especially our parents and grandparents that stay on Medicare. This is very interesting what my colleague has raised because what we know about the Republican budget that was passed is their plan for Medicare is to turn it into a voucher. That doesn't save anybody money. It simply shifts costs to the beneficiary, probably including the family members of my colleagues, and what it will do over time is really force Medicare to wither on the vine. Meanwhile, the contrast here with President Obama's budget is it again strengthens Medicare, lengthens the life of the Medicare trust fund and does so in a smart way. It is something that we have all discussed, and that is, by moving from a fee-for-service system that has proven wasteful to a new value-based system. Did you all know that 10 percent of Medicare beneficiaries now are involved in these value-based coordinated-care models that are saving significant money? These are many times voluntary efforts by doctors and hospitals and health systems that have realized now that the way we deliver health care in America has to change. So that is the good news out of this budget. Sure, you can pick certain circumstances and with the implementation of the ACA there are a lot of challenges ahead, but we would do better by working together to make it happen for our families, to lengthen the life of the Medicare trust fund, not turn into a voucher. That is the Republican vision. And we haven't even started on Medicaid because under the Republican budget for Medicaid, they in essence break the promise to our older neighbors and our parents and grandparents. What Medicaid means to me, I think of my neighbors down the street that are able to stay out of a nursing home because Medicaid has been there for them or at the end of their life they had to rely on skilled nursing, they could go there. But under the Republican budget, in contrast to this one before us, the Republicans in essence take that safety net away entirely. I mean, have you looked at the numbers of the Republican budget cuts when it comes to Medicaid? So I am sorry, I sat through budget hearings a few weeks ago and it is very apparent to me, so I am sorry, Madam Secretary to take up time that I wanted to ask questions on that. But there is a very important contrast in the visions for this country for our older neighbors, and if it is not apparent after looking at these budgets, then you all really need to do some studying.

Madam Secretary, I want to change the subject a little because another piece of good news in this budget is a new innovative proposal that I think holds great promise for this country, and that is the new innovative plan for brain research, the collaboration with our academic institutions, the NIH, the private sector on brain research. This is an ambitious project that is necessary and

important to develop the tools now as we confront greater diagnosis of Alzheimer's, mental illness, and others. Could you give us an outline of how this collaborative effort will work and your vision for the coming years here?

Secretary SEBELIUS. Well, Congresswoman, I share your enthusiasm for this new frontier, and Dr. Collins, who is the head of the National Institutions of Health, has enthusiastically put together this plan with colleagues in the academic sector and the private sector, feeling that it is very much like the Human Genome Project, that we need to map the brain, we need to understand what is happening and what is not happening, and that will lead a much faster pathway to cures and identification of how to deal with everything from Alzheimer's to autism and, as you say, very parts of mental illness. So there are certainly some federal government new resources. There are also private partners in foundations stepping up, academic researchers, and we put together what Dr. Collins describes as sort of the dream team, some of the foremost authorities at universities across this country who are going to be leading this initiative and effort. Also, our colleagues at the Department of Defense are very much involved because brain injury is one of the most significant impacts from the wars in Afghanistan and Iraq. Returning warriors are often suffering everything from post-traumatic stress syndrome to issues around the brain, so understanding what is going on and having ways to effectively deal with that, I think, help our entire country.

Mr. PITTS. OK. The gentlelady's time is expired. I now recognize the gentleman from Maryland, Mr. Bilirakis—or Florida. Mr. Bilirakis for 5 minutes.

Mr. BILIRAKIS. Thank you very much. I appreciate it. Thank you, Madam Secretary, for being here. Thank you, Mr. Chairman.

Madam Secretary, I am receiving calls, an increasing amount of calls and correspondence from my constituents who are concerned about what to expect in 2014 with regard to the ACA. Many are certain that the law means higher costs, increased taxes and less jobs. As a matter of fact, I have a tweet here from @TheKipWilson. She wants to know why middle-class workers are going to be subject to increased premiums and more taxes under Obamacare. I keep hearing that.

Yesterday in your testimony before the Senate Finance Committee, your responses left one of the law's leading architects to conclude that the implementation of this law might be "a train wreck." I must tell you, that leaves me, my constituents and the American taxpayers with even less confidence that we had before the law was passed. I guess it is beginning, you are going to launch it October 1st. Secretary Sebelius, I want to give you an opportunity to respond to the questions yesterday by our Senate colleagues. With thousands of pages of regulations issued, hundreds of new Washington acronyms and uncertainty mounting, can the Department share a written timeline and implementation with this Committee and to the American people so they can better understand what the Administration's intent is and what they can expect. If you can elaborate on that, I would appreciate it.

Secretary SEBELIUS. Yes, sir. What I said yesterday and here today and will continue to say is, starting October 1st in every

State in the country, new marketplaces will be available for open enrollment. Some of those will be federal marketplaces but contain private market plans, choices and competition, and some are going to be run by the States in advance of that. Hopefully this summer there will be individuals trained to answer questions and do outreach so people can become aware of what is developing and the choices they can make for themselves and their family. There is an up-and-running Web site with a very clear timeline, healthcare.gov, which gives steps along the way. We will have open enrollment by October 1st where people by Web site or on paper can pre-enroll in plans that will be up and running on January 1, 2014, in every State in the country.

Mr. BILIRAKIS. What about again the tweet that I just received from @TheKipWilson? Are we going to be subject to increased premiums and higher taxes under Obamacare?

Secretary SEBELIUS. Well, the insurers right now, Congressman, are just beginning to file their planned rates for the new marketplaces. There is then a negotiation period either at the State level or with the federal marketplaces about what those rates are, so I think any description of what people will be paying I think is just invented at this point. The rates are not filed, they are not certain, and we are very confident that not from our standpoint but from the Congressional Budget Office analysis that the combination of competition, elimination of a lot of the overhead costs and subsidies available to a lot of these Americans who for the first time will have full insurance coverage, they will be looking at a much more competitive rate and lower prices than they are paying right now if they have insurance coverage.

Mr. BILIRAKIS. So you don't anticipate increased premiums under Obamacare?

Secretary SEBELIUS. I do not anticipate the kind of rate shock that people are describing, and again, there are no rates filed so anyone who is giving quotes about what rates will be paid is just really inventing that.

Mr. BILIRAKIS. Thank you, Madam Secretary. Next question. According to reports, HHS believes it has the authority to shift money from certain accounts to fund any remaining expenses related to implementation of the new health care law, specifically from any non-reoccurring expense fund. Yes or no, do you believe you have such authority to shift funds between HHS accounts to cover expenses related to implementation of the health care law? Yes or no, please.

Secretary SEBELIUS. I do have legal transfer authority that is part of and it is limited. The non-recurring expense fund is a specific Congress that established within the Department of Health and Human Services that is for one-time IT costs, so those are two different things.

Mr. BILIRAKIS. Can you please provide a list of the authorized accounts you believe you have the ability to use to make such transfers for implementation purposes and accounting of what funds have been transferred or used for such purposes and also the legal analysis for such authority?

Secretary SEBELIUS. Yes.

Mr. BILIRAKIS. Thank you very much. I yield back.

Mr. PITTS. The gentleman's time has expired.

We are voting on the floor. We have 8 minutes plus before the vote ends. I would like to ask the members if they can be as concise as possible. Everybody can then ask a question or two. And the gentleman from New York, Mr. Engel, is recognized.

Mr. ENGEL. Thank you, Mr. Chairman. Madam Secretary, I have watched you as you have been Secretary. You have done an outstanding job, and your testimony here today just continues it, so thank you very much for the job you are doing.

I am from New York, and many New York hospitals are working hard to move toward more effective and efficient systems by participating in ACOs and bundled payment programs. The reality is, these reforms are going to take many years to fully implement. In the meantime, I think there needs to be a recognition that funding streams such as GME DSH or bad-debt payments are essential for hospitals investing in delivery system or form. Hospitals need these various funding streams to treat those who will remain uninsured even after the ACA and train our next generation of physicians. Of course, in New York we train a lot of physicians. So in the face of significant cuts year after year, it adds another layer of certainty to a rapidly evolving and challenging health care system for our hospitals. So Madam Secretary, what is HHS doing to help ensure our Nation's hospitals have the resources, stability and flexibility they need for the coverage expansions included in the ACA as well as move toward providing higher quality, more coordinated care?

Secretary SEBELIUS. Well, we are working very closely with hospital leaders across the country who are key health care leaders, and I think what is incredibly impressive is the amount of transformative care underway, trying to get to a higher quality of care for every patient and deliver it at an affordable cost. I think it is also very good news that the President has nominated Marilyn Tavner, who not only was a practicing nurse but ran hospital systems and is very closely attuned to the needs and economics of hospital care moving forward. She has been nominated to be the Administrator of the Centers for Medicare and Medicaid Services, and we are hoping that she will be confirmed shortly.

Mr. ENGEL. Thank you. Let me ask you one other quick question and I will yield back some of my time, as the chairman asked. I was very pleased with this Administration's efforts to develop and implement a national HIV/AIDS strategy. It is a roadmap to help us reach the point where new HIV infections are rare, and when they do occur, every person has access to high-quality treatment. We have made strides forward, but with approximately 50,000 new HIV infections each year, we still have a long way to go. As a member of this committee and as ranking member on the House Foreign Affairs Committee, I have had the opportunity to work on legislation that has made a significant impact in the fight against HIV and AIDS.

The President's budget recognizes the critical role played by the Centers for Disease Control in preventing new HIV infections and monitoring the epidemic and also directs vital treatment funding provided through the Ryan White program. So can you share with us how we are moving forward with the National HIV/AIDS Strat-

egy and how this strategy is reflected in the President's budget priorities?

Secretary SEBELIUS. I think the President shares your commitment and concern and also the opportunity to really look forward to an AIDS-free generation in the future. So we are doing important research at NIH. We will continue and be part of the funding that NIH will hopefully receive through the allocations in the budget with the CDC work not only in communities throughout the United States but internationally has been hugely impactful and effective, and I think we certainly intend to continue that, and we have re-gathered resources and focused them on communities most at risk where the infection rate is the highest, where the transmission is still underway in an attempt to stop transmission, cut down on the number of new infections and really focus on communities that need not only initial testing but connection to treatment, and the Affordable Care Act again offers a huge step forward for a lot of patients right now who have been diagnosed and determined but do not have insurance coverage to move forward with ongoing treatment.

Mr. ENGEL. Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman and he yields back 27 seconds. And I might say, I was just notified that Mr. Griffith's mother just tweeted that her Medicare Advantage rates were just increased.

Secretary SEBELIUS. I can give her a list of plans that she can look for an open enrollment that have gone down.

Mr. PITTS. The chair recognizes the gentlelady from North Carolina, Ms. Ellmers.

Mrs. ELLMERS. Thank you, Mr. Chairman, and Secretary Sebelius, thank you for being here, and I have a lot of questions for you so I am going to blow through this as quickly as possible, so if you can answer with a yes or no, that would be very, very helpful because I am being respectful of my colleagues.

Number one: On April 5, the federal court issued a ruling requiring that the morning-after pill or Plan B pill can be available for all people of all ages including young adolescents. Do you plan to appeal this ruling? Yes or no.

Secretary SEBELIUS. It isn't a yes or no. I have no jurisdiction over a federal judge.

Mrs. ELLMERS. OK. No jurisdiction, so you do not plan to approach this in any way?

Secretary SEBELIUS. The Justice Department is currently evaluating an appeal.

Mrs. ELLMERS. They are evaluating an appeal at this time, the Justice Department?

Secretary SEBELIUS. Yes. That is not our jurisdiction.

Mrs. ELLMERS. OK. Thank you. I would like to move on. You know, there again——

Secretary SEBELIUS. I would like answer your question.

Ms. ELLMERS. No, I appreciate that, but I only have so many minutes. Now, there again, reaching out, the idea of the ACA, I have a constituent back home who just contacted my office 2 days ago. He has 200 employees. He cannot afford to provide health care for them at this time. He knows that he is going to be hit with a

$2,000-per-person penalty. He basically is saying look, 80 percent of my employees are minority, I will have to lay off 60 employees just to be able to deal with the penalty itself. In doing some research, doing some homework here, 61 percent increase in insurance rates in North Carolina, there will be a 61 percent. According to the Kaiser Family Foundation, for a family of 4, there will be a $5,600 for an insurance plan with, that is a 20 percent increase as a result of the ACA. My staff has done some research as well. For a plan for a family of four, the cost would be $271 per month with a $25,000 deductible. That is unbelievable.

My question to you, ma'am, because you have talked about this ACA creating a thriving middle class, helping create jobs, does what I just laid out to you create a thriving middle class? Yes or no.

Secretary SEBELIUS. There are no rates filed in the new marketplaces so I have no idea what you are quoting.

Mrs. ELLMERS. As it is right now, so what you are saying is that the cost——

Secretary SEBELIUS. There is no implementation.

Mrs. ELLMERS [continuing]. Of insurance would drop that drastically for a family?

Secretary SEBELIUS. Ma'am, all I am telling you is, I have no idea what rates you are quoting but that is not an effect of the Affordable Care Act.

Mrs. ELLMERS. The Kaiser Family Foundation.

Secretary SEBELIUS. They may be quoting what is happening right now in the marketplace——

Mrs. ELLMERS. OK. Let us move on. I also had my staff reach out to the, as you stated it, a one-stop shop Web site. Incredibly, non-user-friendly, categorizes Medicaid for the poor, under 26, co-op plans. There is one standard plan to compare anything to. How can anyone plan for the future, employees, individuals? How can anyone plan for the future? I know you keep citing the 2014 date. However, we live in real time. Americans are scared.

Secretary SEBELIUS. And in real time, insurers are currently filing rates. Insurers are currently making their plans to come to the market.

Mrs. ELLMERS. OK. Let us move on. I have a minute and 30 seconds. To the issue of the 2 percent sequester, there was an OMB memo that went out to federal agencies about the cut asking that life, safety and health of Americans be protected. Now, it is my understanding, I believe I heard you say that CMS has absolutely no ability to act on this, no ability to address the 2 percent cut. Yes or no.

Secretary SEBELIUS. That is correct.

Mrs. ELLMERS. As it is right now?

Secretary SEBELIUS. Yes, that is correct.

Mrs. ELLMERS. OK. The reason that I am asking is because right now as you know, there are cancer patients who are being turned away from community cancer centers who need their chemotherapy if they have Medicare. Is that correct? And you did—I did hear your Ways and Means testimony and you said that right now there are patients who are being turned away.

Secretary SEBELIUS. Part of the sequester was a 2 percent across-the-board cut for every division of CMS, every program, every category. That is what was implemented by the United States Congress.

Mrs. ELLMERS. OK. And it affects physicians who are giving life-saving treatments to patients, correct? Because it attacks the Part B. Yes or no.

Secretary SEBELIUS. A 2 percent cut is in effect because of sequester, yes, ma'am.

Ms. ELLMERS. Well, I would like you to know that I have a piece of legislation, H.R. 1416, that addresses this issue. There are families in crisis right now who have received an incredible devastating piece of information. However, I would like to further this by saying that the President's budget actually increases that formula, decreases payment in reimbursement to those physicians by another 1 percent. It makes it an ASP plus 3 percent rather than the 4.3 percent. Are you aware of this?

Secretary SEBELIUS. I am aware of it, but the way the President's budget would be implemented is that there would be far more flexibility, which we did not have in the sequester, to actually——

Mrs. ELLMERS. And by flexibility, are you referring to the fact that the manufacturers would be required to provide the rebates as directed by the Secretary? Is that the flexibility we are talking about?

Secretary SEBELIUS. No, we are talking about the ability to administer the administrative costs differently than the costs of the drug. The important thing is to——

Ms. ELLMERS. So you have that jurisdiction but you do not have jurisdiction to——

Secretary SEBELIUS. The way the sequester bill was written, Congresswoman, we were told to cut across the board every program, every category 2 percent for Medicare and that is what we did.

Mrs. ELLMERS. Even though the OMB directed to protect life, safety and health?

Secretary SEBELIUS. OMB directives don't overrule Congress, and you passed a bill that——

Mr. PITTS. The gentlelady's time is expired.

Mrs. ELLMERS. Thank you.

Mr. PITTS. I apologize for interrupting. The time has run out on the floor. We are going to try to wrap this up. The chair recognizes the gentleman from Maryland, Mr. Sarbanes.

Mr. SARBANES. Thank you, Madam Secretary. I think you are doing a terrific job. It is a big challenge. We have run out of time all over the place on the floor, in this committee. You have to leave, I know.

We had a hearing the other day with some representatives from the business community, and what became clear is, until the issue of whether implementation of the Affordable Care Act was going to go through was settled by the outcome of the election, there were, I think, many small businesses around the country that frankly I can understand this didn't really take the time to learn the rules and regulations and what was coming down because they didn't know whether it would be in place. What is happening, I think, is,

as they focus in on something about which they got a lot of misinformation over time, they are discovering to their relief that there really is a lot of support there for small businesses, and many of us were motivated to support the Affordable Care Act because of the relief we thought it would bring to small businesses across the country.

I don't have a question, but I just wanted to make a suggestion. I think it would be terrific, and I am sure that the Department is working on this, to sort of put together, you know, the 1040EZ version of what benefits are now going to be available to small businesses out there because they are primed now to be looking for that information, and I think we have provided them with accurate information about these opportunities. It will come as a relief to them, and they can really kind of invest in the opportunity that it presents. So I hope the Department is working on something like that that we can turn around and share with our constituents and small businesses across the country.

Secretary SEBELIUS. We are working on it. We would be glad to provide it to you. And we are doing presentations with the colleagues in the Small Business Administration across this country. So we are happy to do a number of things. But you are absolutely right. I think a lot of the misinformation once it is corrected and people understand what the rules are and what is going to be available to small business owners who often are paying 15 to 20 percent more for insurance right now, they are very pleased about what opportunities they may have.

Mr. PITTS. The chair thanks the gentleman. I have been notified, the leader is holding the vote for us. We will have one follow-up. Dr. Burgess.

Mr. BURGESS. Thanks for staying with us, Madam Secretary. Dr. Gingrey brought up the issue of contingencies. Gary Cohen in addressing the AHIP Foundation a couple of weeks ago brought up the issue of contingency. So you indicated this morning in your answer to Dr. Gingrey's question, there are no contingency plans, and yet there is discussion that I am aware of, of people talking about actually narrowing the scope of the ACA. It is called descoping. So are you in your Department talking about descoping or narrowing the scope of ACA provisions?

Secretary SEBELIUS. No, sir.

Mr. BURGESS. Are you talking about work-around plans?

Secretary SEBELIUS. No, we are not. We are moving ahead. We have the federal hub on track and on time. We are moving ahead with the marketplaces that we will be individually responsible for and we are working very closely with our State partners on their plans and their timetable for the State-based marketplaces.

Mr. BURGESS. So the federal hub will be available?

Secretary SEBELIUS. Yes.

Mr. BURGESS. Unless it is not, and if it is not, you have no contingency plans.

Secretary SEBELIUS. At this point, our energy and resources are focused on getting it up and running, and we are on track and the contracts have been led and we are monitoring it every step along the way.

Mr. BURGESS. Let me just say that if the promises that you will be ready and you are not, I think the United States Congress, which does hold the ability to fund things at the federal agencies, would have to look seriously about putting any other money into that exercise. You have had 3 years and billions of dollars. If you are not ready, I think the Congress needs to hold your agency accountable.

Secretary SEBELIUS. Well, I appreciate that, Congressman. I think that the CBO analysis when the bill was passed was that we would need about $10 billion in implementation money. One billion dollars was appropriated. I can tell you we are on track. We have judiciously used those resources and we intend to be open for open enrollment around the country October 1st.

Mr. BURGESS. Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentleman, and thank you, Madam Secretary, for your time.

As we move closer to implementation and enrollment in the exchanges, could you please agree to come before the committee again before October 1st?

Secretary SEBELIUS. We will make every effort.

Mr. PITTS. Thank you, Madam Secretary. We appreciate your information, your testimony today.

If members have additional questions, I will ask them to submit the questions and we will send them to you immediately. We ask that you please respond promptly to the questions. Members should submit their questions by the close of business on Thursday, May 2nd.

Thank you very much, Madam Secretary. You have been very generous with your time. Without objection, the subcommittee is adjourned.

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

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

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June 5, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20101

Dear Madam Secretary:

Thank you for appearing before the Subcommittee on Health on Thursday, April 18, 2013 to testify at the hearing entitled "A Financial Review of the Department of Health and Human Services and Its FY 2014 Budget."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

Also attached are Member requests made during the hearing. The format of your responses to these requests should follow the same format as your responses to the additional questions for the record.

To facilitate the printing of the hearing record, please respond to these questions and requests by the close of business on Wednesday, June 19, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at Sydne.Harwick@mail.house.gov and mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C., 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Secretary Sebelius Questions for the Record
House Energy & Commerce Subcommittee on Health
April 18, 2013

The Honorable Joseph R. Pitts

1. **Would you support legislation that places HHS employees in the exchanges?**

Answer: The Health Insurance Marketplaces are modeled after the Federal Employees Health Benefits Program (FEHB) where most HHS employees currently obtain health insurance. Like the FEHB, which permits federal employees to choose from various health benefits coverage options, the Marketplaces will allow individuals and small businesses to shop for a variety of affordable health insurance plans that provide comprehensive benefits. Current law does not allow for Federal Executive Branch agencies to provide health insurance coverage to their employees by contributing to coverage obtained through the Marketplaces.

2. **As you know GAO and MedPAC have examined the in-office ancillary Service Exception in depth and neither group has recommended repealing IOASE. I am concerned that the Administration's proposal would result in more patients receiving care in the more expensive hospital setting, thus undermining an integrated delivery of care and lead to more hospital acquisitions of physician practices.**

   Would you provide the quantitative analysis that supports the $6 billion score for the proposal? How much is attributable to each service?

Answer: The estimate of $6 billion in savings over 10 years was developed by the independent CMS Office of the Actuary based on its assumptions about predicted reductions in spending on services and behavioral changes related to the policy.

3. **With regard to radiation, are you aware that radiation utilization from 2007-2011 has been flat at the precise time physician offices have acquired the IMRT technology? Doesn't that suggest that there would be no savings from prohibiting physician ownership of radiation?**

Answer: The in-office ancillary services exception was intended to allow physicians to self-refer for services to be performed by their group practices for patient convenience. While there are many appropriate uses for this exception, evidence suggests that this exception may have resulted in overutilization and rapid growth of certain services over time, including radiation therapy. Effective calendar year 2015, this proposal would seek to encourage more appropriate use of select services by amending the in-office ancillary services exception to prohibit certain referrals for radiation therapy, therapy services, and advanced imaging, except in cases where a practice meets certain accountability standards, as defined by the Secretary.

4. **The President's budget would equalize payment rates for certain conditions that can be treated in both rehabilitation facilities and skilled nursing facilities. In the budget brief, this balancing of payment rates is described as "improving financial incentives to encourage efficient and appropriate provision of care by reducing the disparity in Medicare payment rates between settings." Please explain what the President hopes to accomplish by this?**

Answer: Currently, treatment of certain knee, hip and pulmonary conditions that do not require intensive therapeutic post-acute care can be performed in either an inpatient rehabilitation facility (IRF) or a skilled nursing facility (SNF), but Medicare payments are much higher if the treatment occurs in an IRF. This proposal would encourage care delivery in the most clinically appropriate and cost-effective setting. It would, beginning in 2014, reduce the differences among settings in Medicare payments for certain knee, hip, and pulmonary conditions, as well as other conditions selected by the Secretary.

5. **The proposed budget would also implement bundled payments - beginning in 2018 - for post-acute care providers including long term care hospitals, and home health providers. Has your department already begun work to prepare for implementation and, if so, would you please describe such work? If not, how do you envision such a roll out in 2018?**

Answer: The President's FY 2014 budget includes a proposal to implement bundled payment for post-acute care providers, including long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health providers, beginning in 2018. Payments would be bundled for at least half of the total payments made to post-acute care providers. The Secretary would specify the payment rate for an episode of care based on patient characteristics that covers the cost of all SNF, LTCH, IRF, and home health services. The Secretary has the authority to adjust payments based on quality of care, geographic differences in labor and other costs, and other factors as deemed appropriate.

Payments for a bundled episode of care would be reduced 0.95% in each of the years 2018, 2019, and 2020, with a 2.85% cumulative reduction by 2020. Beneficiary coinsurance levels would remain the same as those under current law (for instance, to the extent beneficiaries use SNF services, they would be responsible for the current law copayment rate).

CMS is interested in hearing from stakeholders about the implementation of this proposal and, chose the implementation date of 2018 so that CMS would have adequate time to prepare and apply lessons learned from the Center for Medicare and Medicaid Innovation's Bundled Payments for Care Improvement Initiative, which began earlier this year.

6. **Today, hospitals receive reimbursement from the federal government for bad debts. Changes were made in PPACA to lower that amount to 65% of the total bad debt amount a hospital incurs. The proposed budget would seek to further reduce this amount by 25% (to 40%). Can you explain the rationale behind this change?**

Answer: The National Commission on Fiscal Responsibility recommended gradually putting an end to payment for Medicare bad debt. Congress's action last year to reduce coverage of bad debt to 65% for all entities represented an important first step towards aligning Medicare's bad debt policy with private sector practices. However, even after this change, Medicare's reimbursement of bad debt remains unusually generous. We believe making further adjustments constitutes a smart, targeted approach to achieve further Medicare savings.

7. **The Office of Management and Budget (OMB) directed all federal agencies to "use any available flexibility to reduce operational risks and minimize impacts on the agency's core mission in service of the American people" and to "identify and address operational challenges that could potentially have a significant deleterious effect on the agency's mission or otherwise raise life, safety, or health concerns."**

   On what legal opinion did HHS base its decision to apply the 2 percent cut to ASP?

Answer: Based on an assessment conducted by the Department of Health and Human Services (HHS), we do not have the authority to exempt Medicare payment for Part B drugs under the Budget Control Act of 2011. The sequestration exemptions, which are specified in 2 U.S.C. sections 905 and 906, do not apply to payment for Medicare Part B drugs.

8. **Does HHS believe applying the sequester three times to an oncologist's payments will raise life, safety or health concerns? If so, why hasn't HHS used its discretion to modify the sequester with respect to reimbursement for cancer treatment?**

Answer: We do not have the authority to exempt Medicare Part B drug payments from the sequestration cut. We share your concern about the potential adverse impacts of the payment cuts mandated by sequestration. We will continue to monitor the impact of provider payment cuts mandated under the Budget Control Act to assess their impact on Medicare beneficiaries and we are happy to share our results.

9. **Open enrollment in the Health Insurance Marketplace (State Exchanges) begins October 1, 2013. Will individuals shopping in these state marketplaces have complete transparency to and the ability to compare options for cost and availability of medical and pharmaceutical coverage?**

Answer: Yes, Marketplaces will make purchasing private health insurance easier by providing qualified individuals and qualified employers with one-stop shopping where they can choose qualified health plans that best fit their needs. Specifically the Marketplace will allow consumers to:

- Shop for private health insurance with comprehensive benefits

- See what their premium, deductibles, and out-of-pocket costs will be before they decide to enroll
- Make apples-to-apples comparisons of costs and coverage between health insurance plans
- Find out if they qualify for premium tax credits to help lower the costs of their monthly premiums, and cost-sharing reductions to lower their out-of-pocket expenses
- Learn if they can get free or low-cost coverage from Medicaid or CHIP

10. In response to reports from AHRQ and MedPAC regarding the health savings generated by Comprehensive Medication Management and Medication Therapy Management (CMM/MTM), will HHS commit to supporting a CMM/MTM component within Medicare?

Answer: Under the MMA, Part D plan sponsors were required to establish MTM programs to optimize therapeutic outcomes for targeted Part D beneficiaries through improved medication use. The initial CMS regulations established few requirements and a general framework that allowed sponsors flexibility to promote best practices. After an extensive analysis of the industry's best practices, the requirements were expanded in 2010 for increased consistency among plans, and CMS pushed the industry forward. Significant changes were made to the targeting criteria and CMS required a minimum level of MTM services that must be offered to the Part D beneficiaries who qualify for these programs. Additionally, Section 10328 of the ACA specified changes to Part D MTM programs to further strengthen the MTM programs offered to Part D beneficiaries. For the coming years, we expect increased standardization and industry consensus. CMS would like to expand access to better target the beneficiaries who most need MTM. In addition, through expanded data collection, we want to be better positioned to evaluate the impact of MTM at the beneficiary level.

11. Your administration has raised many expectations that PPACA will improve the health of Americans, because health insurance will improve access to health care. An important factor in healthcare access and delivery is the size of the healthcare workforce, which is currently inadequate. Would you explain why in the proposed HRSA budget, funding for Health Workforce and Children's Hospital GME has been reduced? And, would you explain who would provide the care in all those new community health centers that will be funded?

Answer: With regard to the CHGME program, while the program has benefited many facilities across the country, we are working within the context of a budget that requires tough choices. A challenging budget environment required a closer examination of how resources are spent. The FY 2014 budget provides $88 million to fund the CHGME payment. This funding is adequate to support expenses that directly support the residents and faculty so that training of pediatricians and other medical specialties can continue, but does not provide funding for the indirect costs.

Our investments in the health care workforce reflect our efforts to ensure Americans have access to health care in their communities. As a result of historic investments by both the Recovery Act and the Affordable Care Act, the numbers of primary care providers in the National Health

Service Corps (NHSC) are at all-time highs, nearly tripling between 2008 and 2012. Today, 10.4 million people in communities nationwide receive health care from nearly 10,000 National Health Service Corps clinicians. The National Health Service Corps has invested nearly $900 million in providing scholarship and loan repayment incentives to primary care providers and students in return for service in underserved areas, including many community health centers that serve those areas.

12. In the proposed HHS budget, the discretionary funding for the Vaccines for Children and the Breast and Cervical Cancer Program is reduced to reflect expanded access to health insurance. Yet funding increased for other programs, such as Ryan White and Family Planning that will also be affected by the expansion. Would you explain why, in this fiscal environment, these programs were not only spared from cuts, but received increases?

Answer: The FY 2014 budget request reflects continued support for the Ryan White HIV/AIDS Program (RWHAP) while HHS conducts an in-depth assessment of the interaction between the Affordable Care Act and RWHAP's continued provision of HIV services, and the potential for achieving one of the National HIV/AIDS Strategy's key goals: improving health outcomes for people living with HIV/AIDS.

While HHS does not expect a significant shift in the demand for clinical services in FY 2014, nonetheless, in FY 2014, the number of insured Ryan White clients is expected to increase to some extent. The FY 2014 Budget also supports Ryan White funded services not covered by public or private insurance, but which are essential to linking people living with HIV into care and maintaining them on drug regimens. These "continuum of care" services are critical to preventing the spread of the domestic HIV epidemic as recent studies have found that anti-retroviral (ARV) treatment reduces HIV transmission by 96 percent. Examples of these services include case management, transportation assistance, and treatment adherence, which are critical to keeping people in care and on drug regimens that decrease viral load and prevent the spread of the virus. Ryan White dollars are also used to support cost sharing, which leads to more consistent access to ARV drugs and increased adherence to treatment. Ryan white grants are also used by clinics to fund several core medical services not consistently covered by insurance, including comprehensive substance use treatment, mental health services, and care coordination services.

The FY 2014 budget request also reflects continued support for the Title X Family Planning program, which provides community-based preventive health services, including family planning, to approximately 5 million individuals annually, the majority of whom are low-income and uninsured. Services range from the provision of FDA-approved contraceptive methods to cervical and breast cancer screening to a host of other preventive health screenings. Title X services sites are considered the usual source of medical care for six in 10 women who seek services through them. The Title X program accomplishes its mission in a highly efficient manner, and are estimated to provide $5.3 billion in government savings. Studies have found that for each dollar invested in the program, approximately $5.68 is saved, through averting costs to Medicaid for prenatal care, delivery, and postpartum and infant care.

13. To the American public and Congress, the Prevention and Public Health Funds appears like your own personal slush fund. Since 2010, we learned that the first wave of funding was used by States to fund lobbying, park signage, dog neutering, and other questionable activities. By 2012, the fund has morphed into a budgetary tool to prop up discretionary programs or Obamacare implementation. Instead, would you support directing these funds to help patients with pre-existing conditions? Don't these Americans deserve to get the relief that this administration promised them?

Answer: The Prevention and Public Health Fund (PPHF) has been used to fund important investments in our nation's health, including improvements in our ability to immunize children, reduce health-care acquired infections, improve laboratory systems at the state level, and detect and respond to disease outbreaks. The PPHF also supports the Community Transformation Grant (CTG) program, which supports evidence and practice-based efforts in states and communities to reduce chronic diseases. Awardees are addressing the priority areas of 1) tobacco-free living; 2) active living and healthy eating; and 3) high quality clinical and other preventive services, including prevention and control of high blood pressure and high cholesterol.

HHS remains committed to proper oversight and monitoring of appropriated funds, and to awardees' compliance with all applicable regulations and statutes. HHS awardees, including those in the CTG programs, are informed about the applicable federal laws, regulations, and policies relating to the use of federal funds, including applicable anti-lobbying provisions.

The Administration strongly supports policies that ensure all Americans with pre-existing conditions have access to affordable health care. This is why the Affordable Care Act banned insurance companies from charging more or excluding coverage based on an individual's pre-existing condition starting in 2014. It is also why the health care law adopted the PCIP Program to provide a bridge to the new system between 2010 and 2014.

The PPHF provides for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. Assisting Americans in gaining affordable health care aligns with the purpose of the funds, which may be used for prevention, wellness, and public health activities. Implementing the Health Insurance Marketplace is the Administration's top public health activity, which has large potential to improve prevention in the next year by enabling individuals to enroll in coverage through private health insurance. The FY 2013 allocation reflects a broad and strategic portfolio of activities that supports the Administration's highest prevention and public health priorities.

14. Our nation continues to faces serious national security threats, and the need remains to protect the American people against chemical, biological, radiological and nuclear (CBRN) events. What impact has the availability of the Project BioShield Special Reserve Fund had on the development and procurement of medical countermeasures for national security threats over the past decade?

Answer: Project BioShield (PBS) has utilized the Special Reserve Fund (SRF) for nearly a decade to ensure the Nation is better prepared with new medical countermeasures (MCM) to address the dire medical consequences of catastrophic chemical, biological, radiological, and nuclear events in the civilian population. PBS has afforded eleven (11) new medical countermeasures for treatment or post-exposure prophylaxis against anthrax, smallpox, botulism, illnesses associated with radiological and nuclear events, and chemical agent intoxication (**Table 1**); recently two of these MCMs were the first products approved by the FDA under the Animal Efficacy Rule authorized under PBS. Additionally the SRF has supported the Biomedical Advance Research and Development Authority's (BARDA) establishment of a robust and diverse medical countermeasure development pipeline of 80+ product candidates for these threats. The future for PBS is even brighter, as this MCM development pipeline is expected to render at least twelve more new MCMs under PBS over the next five years to address anthrax, other biothreats including glanders and melioidosis, other illnesses associated with Acute Radiation Syndrome, thermal burns and blood replacement, and volatile chemical agents.

15. We are losing the fight against drug resistant pathogens. Our current antibiotic armamentarium is low and not regenerating fast enough. In the President's budget proposal, BARDA acknowledged this and is interested in helping advance new products. But manufacturers are fleeing the business, and only a few major companies are working in the field—it just doesn't make fiscal sense: the drugs are used infrequently—a good thing to keep resistance in check—and are meant to eradicate a pathogen in only a few doses. The FDA is putting in tremendous work to speed up product development, but what else can we be doing to further this critical therapeutic arena?

Answer: HHS agrees with your assessment of the emergence of drug resistant organisms and lack of new antibiotics. As the emergence of drug resistant organisms continues to increase, financial incentives for pharmaceutical companies to venture into this arena become scarcer. BARDA adopted in 2010 a strategic approach to incentivize companies developing novel antimicrobials for biothreats while having secondary public health benefits especially in the fight against antimicrobial drug resistance. Today BARDA supports the advanced development of seven (7) antimicrobial drug candidates for biothreats by partnering with five (5) companies and some clinical studies to evaluate these candidates for public health indications (e.g., MRSA). One obvious benefit to this strategy is the eventual availability of these new antibiotics in the commercial market will reduce the need to stockpile as much of these or similar antibiotics in the event of a biological attack. BARDA formed public-private partnerships with industry to share in the investments necessary to bring new drugs to market. **Figure 1** highlights BARDA's investment strategy in products that have the potential to impact both biothreats as well as emerging drug- resistant public health pathogens.

BARDA's investment strategy has received accolades from the Infectious Disease Society of America (IDSA) stating in public meetings "BARDA is keeping the antibiotic industry on life support". In addition, the PEW Charitable Trust sent a letter to Chairman Upton and Ranking Member Waxman stating "[BARDA's] program has become an important source of funding at a time when there are few promising new antibiotics in late stage development"...."the broad

spectrum antimicrobial program at BARDA is supported by industry and is a promising pathway for incentivizing new antibiotic development." BARDA is currently supporting multiple manufacturers developing products for both biothreat pathogens and public health concerns:

- Achaogen – completed Phase II preparing for a large Phase III for CRE
- Tetraphase/CUBRC – in Phase II for MRSA, Gram(-) acinetobacter
- GlaxoSmithKline – a portfolio of three candidates at various stages Gram (+) and atypical Gram (-) bacteria
- Cempra – Phase I CRE and MDR Gram(-) Pseudomonas, acinetobacter
- Baselia – Phase I CRE, MDR Gram(-), Pseudomonas, acinetobacter

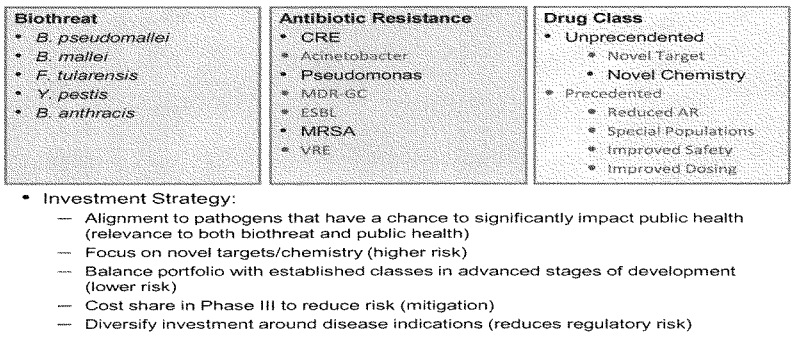
The partnership with GlaxoSmithKline (GSK) utilizes Other Transactional Agreement, an authority provided to HHS under the Pandemic All-Hazards Preparedness Act (2006). This is BARDA's first use of this authority for product development and allows BARDA to invest in a portfolio of products instead of awarding a FAR-based contract for each candidate product. The agreement allows BARDA to participate on a GSK advisory board. Additionally, BARDA will have a say in how GSK invests their own capital in this portfolio of products.

The FDA has been proactively working with sponsors to explore innovative approaches to developing antibacterial drugs, particularly those intended to treat infections caused by antibiotic-resistant organisms and that otherwise address unmet medical needs. For example, FDA is currently drafting guidance to industry to assist sponsors in the development of antibacterial drugs for patients with unmet medical need for the treatment of serious bacterial diseases. FDA is also actively implementing the Generating Antibiotic Incentives Now (GAIN) Act, which, among other incentives, provides for an additional five years of market exclusivity for certain drugs that treat serious or life-threatening bacterial and fungal infections, including those caused by resistant organisms. These efforts represent BARDA, the FDA and Congress working in concert to incentivize manufactures to develop products to address the emergence of antibiotic resistance.

Table 1. Medical countermeasures acquired under Project BioShield in FY2004-FY2013.

MCM	Start Date	SNS Delivery	Industrial Partner	Funds Obligated
ANTHRAX				
Anthrax Antitoxin Monoclonal Antibody (Raxibacumab®) FDA approved (2012)	9/2005 7/2009	Completed Completed	GlaxoSmithKline (formerly Human Genome Sciences)	$174 M $160 M
Anthrax Antitoxin Anthrax Immune Globulin (AIG®)	9/2005	Completed	Cangene	$160M
Anthrax Antitoxin	FY2013	Active Solicitation - Procurement Sensitive		
Anthrax Vaccine (BioThrax®)	5/2006 9/2007	Completed Completed	Emergent Emergent	$243M $465M
SMALLPOX				
Smallpox MVA vaccine (IMVAMUNE®)	6/2007 4/2013	Ongoing 2014	Bavarian Nordic	$541M $110M
Smallpox antiviral drug (Arestvyr®)	5/2011	Ongoing	SIGA Tech, Inc.	$433M
BOTULISM				
Botulinum antitoxin (HBAT®) FDA approved (2013)	9/2006	Completed	Cangene	$476M
RAD/NUC THREATS				
Potassium Iodide (ThyroShield®) FDA approved	3/2005	Complete	Fleming	$18M
DTPA - Ca FDA approved	12/2005	Completed	Akorn	
DTPA - Zn FDA approved	12/2005	Completed	Akorn	$22M
Anti-neutropenia cytokines	FY2013	Active Solicitation - Procurement Sensitive		
CHEMICAL THREAT				
Anti-convulsive drugs	FY2013	Active Solicitation - Procurement Sensitive		

Figure 1. BARDA strategic approach to antibiotic drug development for biothreats with secondary benefits towards antimicrobial drug resistance in the public health sector.



16. In August 2012, CDC found that three-fourths of all persons infected with Hepatitis-C are among the baby boom birth cohorts, with the vast majority unaware of their infection, and recommended that every boomer get screened once in their life regardless of risk factors (risk based screening was deemed of "limited success.") Meanwhile a sister agency, USPSTF, issued its draft guidelines for HCV screening that wants to continue on using risk-based screening and ignores the high density of HCV positive people in the baby boom generation. HCV costs are about to explode on Medicare—even though it's easy to test and then treat these populations, with new treatments literally curing people of the disease—and the ACA requires health plans to follow the USPSTF guidelines, and HHS does not seem ready. What is the Department doing to navigate and head off this looming medical and fiscal crisis?

Answer: In regard to Medicare coverage of screening for Hepatitis C Virus amongst the baby boom birth cohort, CMS has limited authority to consider coverage of new preventive and screening services. Specifically, the Medicare statute authorizes the Secretary to add coverage of "additional preventive services" – that is, preventive services not already covered under specific statutory provisions – if the service is recommended at the "A" or "B" level by the U.S. Preventive Services Task Force (USPSTF), and the service is determined through the Medicare national coverage determination (NCD) process to be appropriate for Medicare beneficiaries.

As you noted, the USPSTF recently initiated a reconsideration of their 2004 recommendation on routine screening for Hepatitis C Virus and issued a draft updated recommendation for public comment in November 2012. Until the USPSTF issues a final recommendation, Medicare lacks authority to consider coverage of this service. When a final recommendation is available, we will consider whether it warrants the opening of a national coverage analysis (the first step in the NCD process). The status of the Task Force's work on this subject can be monitored at http://www.uspreventiveservicestaskforce.org/uspstf/uspshepc.htm.

In regard to the Affordable Care Act provision for private insurance coverage of preventive services recommended by the USPSTF, the law requires that non-grandfathered plans cover services with an A or B recommendation without cost-sharing. Screening for Hepatitis C does not currently have an A or B Recommendation from USPSTF, and it is therefore not required to be covered.

17. The President's Budget proposal uses language suggesting ACA expansion efforts will take over much of the medical services of HIV patients, currently provided under Ryan White programs, ostensibly freeing up federal support for ancillary services for HIV patients—but what are the actual funding needs of this population, how should funds be used appropriately? What is HHS doing to help Ryan White grantees become federally qualified health centers to help beneficiaries in providing health services after ACA implementation?

Answer: The Affordable Care Act will provide coverage for primary medical care through Medicaid expansion and access to private insurance for many PLWH. As the Affordable Care Act is implemented, HHS anticipates changes in how Ryan White Program funds are utilized. The RWHAP will continue to provide core medical and "continuum of care" services to clients as needed. Core medical services not covered by insurance, include comprehensive substance use treatment, mental health services, and care coordination services. The details of this will vary from state to state depending on coverage decisions in Marketplaces and Medicaid. The RHWAP will also continue to have an important role in supporting community-based systems of care responsive to local needs and will support "continuum of care" needs of PLWH. Examples of services include case management, transportation assistance, and treatment adherence, which are critical to keeping people in care and on drug regimens that decrease viral load. Providing such services leads to improved clinical outcomes and prevents the spread of the domestic HIV epidemic, as recent studies have found that anti-retroviral treatment reduces HIV transmission by 96 percent.

By statute, the RWHAP is the payer of last resort. The program will only pay for eligible services that are not covered or minimally covered by other private or public insurance. The program currently provides, and will continue to provide, medical coverage completion and continuum of care services for those patients with or without insurance to ensure that vulnerable populations receive the full range of services necessary to remain in care and improve health outcomes.

HRSA's Bureau of Primary Health Care (BPHC) received increased funding for the Health Center Programs. In FY 2013, an estimated $19 million will be awarded to establish approximately 25 new health center access points. The Health Center Program New Access Points is a competitive Health Center Program funding opportunity to support new service delivery sites for the provision of comprehensive primary and preventive health care services. All applicants must demonstrate a high level of need in their community/population, a sound proposal to meet this need by ensuring the availability and accessibility of essential primary and preventive health services, including oral health, mental health and substance abuse services, responsiveness to the health care environment, collaboration and coordination with other area

health care providers, and readiness to rapidly implement the proposal. HRSA Ryan White grantees interested in becoming a health center were eligible to apply. To support this effort, HRSA conducted a training session for Ryan White grantees interested in applying for Health Center Program funding in November 2012. The President's budget for FY 2014 includes funding for New Access Points. New funding opportunities are posted on the HRSA Grants Web site at http://www.hrsa.gov/grants and www.Grants.gov. Additionally, organizations may apply at any time to receive designation as a Federally Qualified Health Center (FQHC) Look-Alike. FQHC Look-Alikes must meet the same requirements as section 330 grantees, but do not receive Health Center Program funds. FQHC Look-Alikes are eligible to receive cost-based reimbursement for services provided under Medicare, be reimbursed under their State Medicaid Prospective Payment System (PPS), and participate in HRSA's 340B Drug Discount Program, among other benefits. Other webinars that have been hosted by HRSA include: Protecting the Health Safety Net: Models to Help Non-FQHCs Prepare for Health Care Reform Implementation. This webinar focused on models for safety net providers in adapting to the new payer and provider environment under the Affordable Care Act.

HRSA's RWHAP National Technical Assistance Cooperative Agreement funded the HIV Medical Homes Resource Center (HIV-MHRC) whose overarching goal is to provide training and technical assistance to assist Ryan White HIV/AIDS Program grantees to understand, develop and successfully apply to become recognized Patient-Centered Medical Homes (PCMH). HRSA and CMS have co-sponsored webinars designed to orient Ryan White HIV/AIDS Program grantees and providers to the changing healthcare landscape of 2014. The webinars have focused on coordination across Medicaid and the Ryan White HIV/AIDS Program and highlight the differences between the current and future health care system for Ryan White providers.

HRSA also funded the AIDS Education and Training Center National Center for HIV Care in Minority Communities to provide intensive technical assistance to community health centers to increase the capacity of selected health centers to provide services or increase their level of services to PLWH. HRSA has also launched new Affordable Care Act website sections to house many resources and tools useful to Ryan White grantees to learn about, help enroll their patients in new coverage options, and get prepared as providers under the Affordable Care Act.

The Honorable Joe Barton

1. **Given recent reports from China about what could be a very serious emerging threat from a new flu virus, how will the Department of Health and Human Services (HHS) make sure its recently awarded Centers for Innovation and Advanced Manufacturing are fully utilized, including removing any unnecessary burdens from bureaucratic processes within the Assistant Secretary for Preparedness and Response (ASPR) office that seem to plague other similar contracts?**

Answer: The outbreak of novel H7N9 influenza virus in China is being closely monitored by HHS. Since February 2013, over 130 cases of infection caused by the H7N9 influenza virus have

been reported in China with an estimated 30% fatality rate. However, with the closure of the live animal markets in China, and the onset of summer, there has been a dramatic drop in the number of cases. The last reported case was in mid-May.

The Department has taken several steps to respond to the H7N9 outbreak, as BARDA has engaged nine influenza vaccine manufacturers to develop H7N9 vaccines and possibly establish a small pre-pandemic H7N9 vaccine stockpile. New vaccine technologies – cell- and recombinant-based vaccine technologies - supported by HHS over the past decade and resulting in FDA-licensure over the past six months are available now to make more and better vaccine sooner in the U.S.

Manufacturers, CDC, and others developed vaccine seed candidates for vaccine production and distributed to all FDA-approved influenza vaccine manufacturers. BARDA supported development of several vaccine seeds using a state-of-the-art biosynthetic technology affording rapid one-week turnaround and without the actual H7N9 virus. Clinical investigational lots of H7N9 influenza vaccine are under production presently for clinical evaluation with adjuvants later this summer by the NIH and vaccine manufacturers to determine safety and immunogenicity, and dosage

If the H7N9 influenza virus were to emerge into pandemic, then HHS would direct these vaccine manufacturers to produce vaccine (and the delivery of supplies) needed to protect the public. During a pandemic situation, HHS contracting and technical personnel work closely to ensure timelines are compressed so that HHS can rapidly respond to the public health emergency.

The three Centers for Innovation in Advanced Development and Manufacturing (CIADM) established by HHS under BARDA leadership (2012) are an important component of the HHS response to infectious disease outbreaks, such as pandemic influenza. The three Centers will support on a daily routine basis the advanced development and manufacturing of CBRN medical countermeasures and will produce in an emergency at least 50 million doses of pandemic influenza vaccine within four months of the declaration of a public health emergency using novel and flexible modern manufacturing technologies. This pandemic vaccine production capability is completed already at the Novartis-based Center located in North Carolina. The other two Centers in Texas and Maryland will utilize the expertise of GlaxoSmithKline and VaxInnate, respectively, to produce pandemic influenza vaccines later this decade.

2. **I am routinely informed that the contracting function handled by the office of the Assistant Secretary for Preparedness and Response is inefficient and lacks transparency. This has not only delayed procurement of needed medical countermeasures but also results in wasted effort, increased expense and deterred participation. What can HHS do to improve the performance by the contracting office within ASPR?**

Answer: HHS/ASPR has instituted numerous business practices since the MCM Review (2010) to make the contracting activities for medical countermeasures more efficient and accountable. The usage of Broad Agency Announcements to solicit proposals from potential offerors at any

time of the year has greatly encouraged new and better proposals and reduced the cycle time from proposal submission to contract award by more than 25%. In-Process Reviews with PHEMCE interagency panels that started in 2011 have held BARDA programs and industrial partners more accountable to timelines and milestones. The usage of Other Transaction Authority in 2013 for public-private partnership agreements for MCM development may provide another avenue to streamline the contracting process. Lastly ASPR regularly monitors and adjusts many other business practices affecting program and contracting activities.

3. **HHS has the authority under the recently reauthorized Pandemic and All Hazards Preparedness Act to use "other transaction authority" to allow contracts to run more efficiently. It has had this authority since 2006, yet has never used it. The Department of Defense (DOD) has similar authority and has used it to great effect. Why has HHS not used this authority? Aren't the new Centers for Innovation and Advanced Manufacturing precisely the type of effort that should be conducted under Other Transaction Authority? Has this been considered?**

Answer: BARDA utilized OTA in May 2013 to reach an agreement with GlaxoSmithKline (GSK) to develop antimicrobial drugs against biothreats using a portfolio approach. This was the first use of OTA by BARDA in product development since the authority was provided in 2006. The use of OTA with GSK allows BARDA to develop multiple drug candidates in parallel with this industrial partner and have input on the usage of resources by GSK towards development of these and other antibiotic drug candidates in the pipeline. Previously, BARDA awarded traditional FAR based contracts for each product candidate and terminated contracts if the product failed – an unfortunate but common occurrence in drug development. Under the OTA, BARDA and GSK share development costs over a portfolio of product candidates. If one fails, then GSK and BARDA decide its discontinuation and addition of other candidates in the GSK pipeline. Under this agreement BARDA will also participate on an Advisory board with a voice on how GSK will invest their own capital to support the products. Supporting a portfolio of candidate products is an excellent use of OTAs.

In many other instances such as manufacturing facility retrofitting with sanofi Pasteur and MedImmune, new manufacturing building with Novartis, and the CIADMs, BARDA was able to utilize the FAR to reach long-term and successful agreements by conventional FAR-directed contracts. Agreements using the OTA were considered in each of these instances, but a better solution was achieved using FAR-based contracts.

<u>The Honorable Ed Whitfield</u>

1. **For the past two years, about 100 bipartisan Members of Congress have signed a letter in support of the NDPP because it is one of the most innovative, evidence-based models we have to prevent a disease that is expected to impact one in two adults by the end of this decade. It has been estimated that this program could save the nation between $100-$191 billion over the next decade. That said, it is not mentioned in your FY 2014**

budget. Can you please explain the decision to not fund this important public-private partnership that will teach people personal responsibility while bending the cost curve?

Answer: CDC's National Diabetes Prevention Program (National DPP) was authorized in 2010 by the Affordable Care Act. In fiscal year (FY) 2012, CDC was awarded $10 million through the PPHF to implement the National DPP, evidence based program, which has been proven to prevent the onset of type 2 diabetes for individuals with pre-diabetes.

With the PPHF allocation, six awardees were funded to establish a network of structured, evidence-based lifestyle change programs. As part of this expansion, organizations are meeting with employers to discuss offering the lifestyle change program as a covered health benefit for employees and will work with third-party payers, including public and private health insurance companies, to facilitate reimbursement directly to organizations delivering the lifestyle change program. Over the life of the award, grantees are expected to achieve the lifestyle change program as a covered benefit for a minimum of 500,000 employees. CDC's initial efforts have resulted in five insurers and over 280 self-funded employers who provide coverage and access for the lifestyle change program.

A key component of the National DPP, CDC's Diabetes Prevention Recognition Program (DPRP), which sustains data analysis, provides technical assistance to organizations, and assures quality, consistency, and broad dissemination of the lifestyle intervention. The DPRP assures quality and fidelity of the intervention by recognizing programs that have shown they can effectively deliver a lifestyle change program to prevent type 2 diabetes.

No PPHF funding was committed to this program in FY 2013. CDC will partially sustain these activities with limited use of FY13 budget authority to maintain the essence of the program. In FY 2014, the President's Budget proposes $10 million in budget authority to the Diabetes line to support the National DPP activities. Additionally, through a Center for Medicare and Medicaid Innovation (CMMI) grant awarded in 2013, the National YMCA (Y-USA) was awarded $12 million over three years, to work with their local Y affiliates to conduct a demonstration project in 17 communities in 8 states (MN, NY, AZ, OH, TX, FL, IN, DE) to deliver the National DPP to 10,000 Medicare FFS enrollees and assess cost savings.

2. **The Centers for Medicare and Medicaid Services (CMS) currently covers the fasting blood glucose test and oral glucose tolerance test to screen for diabetes in Medicare enrollees at risk for diabetes or those already diagnosed with prediabetes. However, physicians and other primary care providers are finding that the A1C test is actually the most convenient way to screen patients for diabetes. In a letter to Senator Hagan in December 2011, you said "this test has been recommended by the ADA for diagnosis and is under consideration by CMS for coverage by Medicare." Yet, in 2013, CMS does not cover the cost of an A1C test for purposes of screening. What can be done to encourage use of the A1C test for screening?**

Answer: CMS has had several contacts with the American Diabetes Association (ADA) in regard to the ADA's recommendation that the A1C test be added to the options covered by

Medicare for diabetes screening purposes, including a meeting with CMS' Chief Medical Officer in August 2012. CMS concluded that Medicare's transparent, evidence-based National Coverage Determination (NCD) process would be the best avenue for CMS' consideration of this issue. However, we have not, to date, received a complete formal coverage request for coverage of the A1C test as a diabetes screening test from the ADA or any outside party. If the any stakeholder decides to pursue such a request, including the submission of relevant evidence, we will consider it.

3. **I thank the CDC's Division of Diabetes Translation for releasing the first-ever Diabetes Report Card in 2012. This initial Diabetes Report Card is a baseline, and law requires it to be updated every two years and to include national and state trend data. In light of continual improvement, areas that could be expanded include additional data on gestational and undiagnosed diabetes (including state data), inclusion of average A1c level data trends among individuals with diagnosed diabetes, and the mention of Medical Nutrition Therapy counseling as a Medicare benefit proven to positively impact diabetes outcomes. How can we work with you to continue to improve the Report Card before it is next issued in 2014?**

Answer: CDC is preparing for the 2014 Diabetes Report Card. The Report Card will be responsive to the requirements of Section 10407 of the Affordable Care Act. This section directs the Secretary, in collaboration with the Director of CDC, to biennially prepare a national diabetes report card that aggregates data about health outcomes related to individuals diagnosed with diabetes and prediabetes.

CDC continues to look for ways to improve future Report Cards. Currently, CDC is reviewing our established data sources to prioritize and select information that best represents national and state diabetes data about prevalence, preventive care practices and the quality of care, risk factors, health outcomes and national progress in meeting Healthy People goals. CDC will consider including national estimates for A1c, gestational diabetes and undiagnosed diabetes. CMS receives claims data related to Medical Nutrition Therapy counseling, which is covered for Medicare beneficiaries with diabetes or renal disease. CDC will explore opportunities to incorporate relevant information on this benefit in future Report Cards.

4. **As you know, this Committee has been very concerned about CDC grantees using CPPW funds to engage in activity to change laws and regulations at the state and local level. Unfortunately, CDC grantees across the country appear to be continuing to engage in similar activity with PPHF funds.**

   For example, the State of Minnesota advised its CTG grantees that their Community Transformation Grant (CTG) funds could be used to make changes to state ordinances. A Q & A document available on the State's website reads "*...a CTG strategy could include updating the ordinance to increase the price of tobacco retail licenses to pay for the program...*" Similarly, the County of Fairfax, Virginia includes the following CTG strategy on its website, "*increase the tax on packs of cigarettes purchased in Fairfax*

County". **Houston/Harris County, Texas encouraged their CTG sub-grantees to** ***"limit density of fast food outlets and other outlets featuring high calorie, high sodium, and low nutrition foods"*** **through** ***"zoning: regulate the number of fast food restaurants in a given area."***

In order to fulfill our Congressional oversight responsibilities, I would like to respectfully request the following documents in relation to the CDC grants identified in Appendix A in the document attached to this letter:

- **copies of all documents associated with the grants, whether competed or not, solicited or unsolicited, including your proposals and award documents.**
- **copies of the grant program files pertaining to the funded activities, including but not limited to budget detail and worksheets and regular progress reports including narratives, budget information and all correspondence with CDC grantees and subgrantees regarding the intent, purpose and use of the grant dollars.**
- **copies of all communications involving or by grantees or subgrantees, describing meetings or correspondence with public officials at the state and local level.**
- **copies of all materials received re training, educating and monitoring grantees' use of the grant, including Powerpoint presentations, background preparatory materials and memoranda describing the programmatic goals and success of changing laws and policies at the state and local level.**
- **copies of all materials addressing or analyzing whether grantees or subgrantees have violated any anti-lobbying statutes (*e.g.*, 18 USC §1913; 31 USC §1352(a), appropriations bills (www.gpo.gov/fdsys/pkg/BILLS-111hr3288enr/pdf/BILLS-111hr3288enr.pdf) or administrative regulations (*e.g.*, AR-12).**
- **copies of all materials addressing proposed or actual remedies for violating anti-lobbying statutes or regulations, including all materials describing or listing grantees or subgrantees that have violated anti-lobbying statutes or regulations.**
- **Copies of any correspondence or notes regarding minutes of meetings or public or private reports describing the intent, purpose and use of the grant dollars, including any reference to descriptions of activity involving efforts to change policy, laws, regulations at the state and local government level.**

Answer: The Communities Putting Prevention to Work (CPPW) program, primarily funded in FY 2010 through American Recovery and Reinvestment Act (ARRA), is essentially completed. Through the program, the CDC has worked with award recipients in all 50 states, the District of Columbia, Puerto Rico, and six Pacific Island territories to address chronic disease risk factors, including obesity and tobacco use. These grantees made substantial progress on priorities identified by communities across the United States, tackling significant public health problems and achieving real results to improve the health of communities.

In 2010, Congress established the PPHF as part of the ACA. The PPHF has been used to fund important investments in our nation's health, including improvements in our ability to immunize children, reduce health-care acquired infections, improve laboratory systems at the state level, and detect and respond to disease outbreaks. This Act also established the Community Transformation Grant (CTG) program, which supports evidence and practice-based efforts in

states and communities to reduce chronic diseases. Awardees are addressing the priority areas of 1) tobacco-free living; 2) active living and healthy eating; and 3) high quality clinical and other preventive services, including prevention and control of high blood pressure and high cholesterol.

We will work with the Committee to respond to your requests, but it is important to note that not all activities proposed in an application were ultimately funded by CDC. Following the initial application (proposal), CDC worked with the applicant to review and identify funded activities. We can assure you that HHS remains committed to proper oversight and monitoring of appropriated funds, and to awardees' compliance with all applicable regulations and statutes. HHS awardees, including those in the CPPW and the CTG programs, are informed about the applicable federal laws, regulations, and policies relating to the use of federal funds, including applicable anti-lobbying provisions.

HHS and CDC staff continue to follow rigorous procedures for monitoring all grant awards, including those funded from the ARRA and PPHF. As a result of CDC's oversight of awards, CDC has identified a total of three grantees that engaged in impermissible lobbying activities with CDC funds through the CPPW program, and enforcement actions have been taken. CDC followed its risk mitigation procedures, conducted calls with the grantees, and elevated the issue within CDC to determine whether the activities were conducted with CDC funds, and whether the activities were impermissible. After a thorough review, CDC determined that these three grantees conducted impermissible lobbying. In accordance with applicable grant regulations, CDC has taken enforcement actions against the grantees and disallowed these costs.

We have provided a substantial amount of additional education and guidance in the past several years to both grantees and staff on the appropriate use of federal funding, particularly related to anti lobbying restrictions. In July 2012, the HHS Office of Inspector General (OIG) recommended that we reinforce our efforts in the CPPW program to inform grantees of applicable restrictions through multiple avenues. CDC has embraced and implemented OIG's recommendations and has applied them to all agency grants. CDC's response to the Inspector General is attached. More recently, over the past year the Government Accountability Office (GAO) conducted a performance audit on CDC's policies on lobbying and CPPW award recipients' activities. The final report was released on May 31, and documented the robust procedures CDC has in place to ensure appropriate use of CDC funds by grantees. GAO's report is available at http://www.gao.gov/assets/660/654272.pdf.

Congress added language to section 503 of the Labor, HHS, and Education Appropriations Act for FY 2012. In June 2012, CDC distributed written guidance reflecting the changes in the Appropriations Act to its staff and to CDC grantees. This more detailed CDC guidance document includes the revised CDC anti-lobbying policy (AR-12), which is consistent with the provisions in the HHS Appropriations Act. This new guidance, a copy of which is attached, also provides specific examples of restricted and allowable activities. CDC undertook an intensive effort to communicate the new guidance to all of its grantees, and has incorporated the revised AR-12 into all new grants.

At HHS, we are committed to fulfilling the mandate from Congress to empower communities to pursue high-quality programs that make a real difference in the health of Americans. Awardees are working to reduce the impact of chronic diseases on our population and health system. The Department will continue to enable their success and to ensure that federal funds are used efficiently and appropriately.

The Honorable Mike Rogers

1. **Recently, we have had some frightening reminders of the threats we continue to face in this country. The bombs in Boston and the ricin laced letter addressed to our Senate colleague and President Obama demonstrate that we must remain committed to preparing for the threats we know about, as well as build capacity to respond to those we cannot anticipate.**

   In that vein, reauthorizing the Pandemic and All-Hazards Preparedness Act (PAHPA) was a top priority for the Committee over the last two years. One of the key components of the recently enacted legislation is a provision to reauthorize the Project BioShield Special Reserve Fund (SRF) at $2.8 billion to be available for the next 5 years. The SRF was originally created as a guaranteed market incentive to encourage companies to develop and produce medicines and vaccines to protect Americans from identified threats, since there is no commercial demand for these products.

   I am very concerned by the level of funding provided to the SRF in the President's Budget. Shifting to an annual appropriation, and at only $250 million, would create extreme uncertainty in the medical countermeasures market. The funding provided is not even one fifth of the five year authorized level of $2.8 billion and is less than many individual BioShield procurement contracts. In addition, the new multi-year contracting language is NOT sufficient to make up for the lack of funds.

   In your professional opinion, what has been the impact of the Project BioShield Special Reserve Fund over the last 10 years? How will you ensure that the Project BioShield Special Reserve Fund is available for the next 5 years to give confidence to the pharmaceutical and biotechnology companies that are developing and delivering essential medicines to our national stockpile?

Answer: The Special Reserve Fund has resulted in HHS's creation of a robust development pipeline containing more than 80 medical countermeasure candidates for chemical, biological, radiological, and nuclear threats. This development has resulted in the delivery of 11 new medical countermeasures (MCMs) to the Strategic National Stockpile (accessible by Emergency Usage Authorization) and the FDA licensure of two of these MCMs.

Over the past nine years, HHS has developed additional tools to foster its relationship with the provision of ARD funding, and the expansion of authorities under Project BioShield – most notably the introduction of milestone payments in contracts. More recently, per

recommendations from the Secretary's Review of the Public Health Emergency Medical Counter Measure Enterprise (PHEMCE) following the 2009 H1N1 pandemic, came the establishment of Centers of Innovation for the Advanced Development and Manufacturing (CIADM). These public-private partnerships allow BARDA to pair large established pharmaceutical companies with smaller firms. These pairings mitigate the scientific and manufacturing risks associated with MCM development by providing the necessary expertise to bring promising technologies to the marketplace. Additionally, the PHEMCE Review recommended the establishment of a MCM Strategic Investor, an independent non-profit entity, which would use HHS funding to support capital investments in private companies with promising technologies. By providing critical capital in exchange for a strategic role in the management of these small firms, HHS would be able to mitigate the financial and management risk that some small firms face, thereby increasing the probability of successful technologies and products.

Since the development and procurement of MCMs is an inherently risky endeavor, BARDA remains focused on keeping sufficient incentives in place for its industry partners. This effort includes an HHS intra-agency multi-year budgeting practice driven by the long-lead time necessary for MCM development and acquisition. Large pharmaceutical companies (e.g., Amgen, GlaxoSmithKline, etc.) are now joining the biodefense MCM sector, using long-range budget planning routinely as a good business management practice. Venture capital investors, which fund many small biotech companies in the biodefense sector, may choose to support biotech companies in a different sector that has a better benefit-to-risk profile than biodefense. These circumstances support the critical need to ensure a long-term funding commitment is maintained with annual appropriations in the future. Maintaining the progress that has been achieved in the recent years requires Congress' continued support for these future activities.

The Department agrees that providing industry with a clear indication of long-term support of medical countermeasure development is important to the success of Project BioShield. The Budget explicitly states the FY 2014 request represents a multi-year renewed commitment to Project BioShield. Additionally, as an added incentive, the FY 2014 President's Budget proposes language to provide BARDA with the authority to modify the standard government-wide authority for multi-year contracting (41 USC 3903). This sends a clear message of commitment because the modified language included in the FY 2014 President's Budget authorizes BARDA to enter into an "incrementally-funded", multi-year contract for up to ten years. Additionally, the language modifies the existing authority's requirement of set-aside contract termination costs by allowing BARDA to repurpose any un-used termination costs to pay contract invoices in subsequent years. This differs from traditional multi-year contracting authority, which specifies termination costs can be used for that purpose alone. These modifications allow BARDA to effectively utilize the valuable tool of multi-year contracting authority to engage in long-term contracts with companies that develop medical countermeasures.

The Honorable Michael C. Burgess

1. **The Administration's proposed budget includes legislative proposals pertaining to rehabilitation hospitals, one of which seeks to pay rehabilitation hospitals nursing**

home-based rates for certain conditions because, according to the President's budget, IRFs are services that "may not be appropriate" for certain conditions. A second proposal would elevate the IRF "60% Rule" to a "75% Rule" to "ensure that [IRFs] are classified appropriately."

As you know, Medicare expenditures for IRF services have remained relatively flat for the past 6 years, the number of IRFs is not increasing, and the number of beneficiaries treated in IRFs is not growing faster than the overall growth in Medicare beneficiaries. What specific data or evidence does HHS have to justify support for these proposals?

Answer: Studies by MedPAC and the Institute of Medicine indicate that there is wide variation in the utilization of post-acute care services.[12] This overutilization is driven, in part, by Medicare payments that significantly exceed costs in certain post-acute care settings, and by higher payments for care provided in more intensive care settings (for example, IRFs), even though the care provided is similar to that provided in other types of post-acute care facilities (for example, SNFs).

One of the goals of the post-acute care proposals in the President's FY 2014 Budget is to encourage care delivery in the most appropriate care setting. Under current law, IRFs receive higher payment rates than other medical facilities, including SNFs, which often provide care similar to that provided by IRFs for those IRF patients that are not part of the "60 percent rule." We believe that facilities that are paid as IRFs should predominantly provide services to patients requiring more intensive care than can be provided at other medical facilities. As you know, the classification criteria for IRFs require that at least 60 percent of an IRF's patients need intensive rehabilitation services for treatment of one or more of 13 specified conditions. After an initial phase in period, this classification requirement was originally set to peak at 75 percent, but was later reduced to no more than 60 percent by the Medicare, Medicaid, and SCHIP Extension Act of 2007. If adopted, the proposal would return the classification standard maximum to 75 percent to ensure that Medicare-paid IRFs are even more focused on treating patients who require specialized, intensive care that would justify the higher payments to IRFs.

The proposal to equalize payments for certain conditions treated in IRFs and SNFs also seeks to distinguish between different post-acute care settings by defining which conditions are best treated at IFRs—and which are not. Currently, treatment of certain knee, hip and pulmonary conditions that do not require intensive therapeutic post-acute care can be performed in either an IRF or an SNF, but Medicare payments are much higher if the treatment occurs in an IRF. This proposal would, beginning in 2014, make Medicare payments more equal for certain knee, hip, and pulmonary conditions, as well as other conditions selected by the Secretary. These conditions are commonly treated at both IRFs and SNFs.

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[1] MedPAC (January 2011). Regional Variation in Medicare Service Use. pp 6-7. Retrieved (May 24, 2013) at http://www.medpac.gov/documents/Jan11_RegionalVariation_report.pdf

[2] Institute of Medicine (2013) Interim Report of the Committee on Geographic Variation in Health Care Spending and Promotion of High-Value Health Care: Preliminary Committee Observations. Retrieved (June 3, 2013) at http://www.iom.edu/Reports/2013/Geographic-Variation-in-Health-Care-Spending-and-Promotion-of-High-Care-Value-Interim-Report.aspx

2. **If either or both of these proposals were adopted by Congress, more Medicare beneficiaries would be shifted into nursing homes. In light of repeated concerns expressed by the HHS-OIG, MedPAC, and CMS that Medicare may be overpaying nursing homes for rehabilitation and therapy services, why would Congress enact policies that would effectively compound the problems underlying these concerns, especially without quality and outcomes measurements in place to ensure that beneficiaries are not receiving substandard care in a nursing home, relative to what they would receive in an IRF?**

Answer: The President's Budget proposal to equalize payments between IRFs and SNFs for certain types of patients is not requiring patients to be moved from one setting to another but to make payment more nearly equal for similar services provided in different post-acute care settings. One of the goals of the post-acute care proposals in the President's FY 2014 Budget is to encourage care delivery in the most clinically appropriate and cost-effective care setting. Under current law, the classification criteria for inpatient rehabilitation facilities (IRF) require that at least 60 percent of an IRF's patients need intensive rehabilitation services for treatment of one or more of 13 specified conditions. The President's Budget proposal to change this criteria to 75 percent is to ensure that these IRFs are primarily furnishing services for patients who need intensive therapy and therefore eligible for the significantly higher payments for their patients.

To help beneficiaries choose a quality nursing home, Medicare.gov has a Nursing Home Compare that has a Five-star rating system based on a nursing home's performance in health inspections, quality measures, and hours of care provided by nursing staff. This is an important tool for beneficiaries to ensure they choose high quality nursing home for their needs.

3. **In the past your agency has stated its priority to ensure diversity in the health professions as well as to ensuring health professionals practice in underserved communities. How do the cuts to Title VII in the agency's FY 2014 budget, which eliminate these programs, achieve the agency's diversity objectives and increase the number of diversity of health professions?**

Answer: While the FY 2014 Budget required difficult choices, it includes a strong commitment to HRSA's priorities. Increasing the diversity of the health professions workforce is an area of focus for HRSA. For the most recent academic year, 46% of graduates from HRSA-funded programs were disadvantaged and/or underrepresented minorities.

The FY 2014 budget request maintains funding for several programs that specifically aim to boost the diversity of the health professions workforce:

<u>The Centers of Excellence program</u>: This program assists eligible schools in supporting programs of excellence in health professions education for underrepresented minority (URM) individuals and to strengthen the Nation's capacity to produce a culturally competent healthcare workforce. COE grantees use grant funding to increase the pool of competitive URM student applicants; enhance URM students' academic performance; improve recruitment and retention of URM faculty; improve clinical education, curricula, learning resources and cultural competence

as they relate to minority health issues; and facilitate faculty and student research on health issues affecting URM groups.

Scholarships for Disadvantaged Students program: The purpose of this program is to increase diversity in the health professions workforce by providing grants to eligible health professions and nursing schools for use in awarding scholarships to financially needy students from disadvantaged backgrounds.

Nursing Workforce Diversity program: The purpose of this program is to increase nursing education opportunities for individuals who are from disadvantaged backgrounds, including racial and ethnic minorities who are underrepresented among registered nurses.

The National Health Service Corps (NHSC):
The NHSC is a network of primary care providers serving communities with shortages of medical, dental, or mental/behavioral health care. The Affordable Care Act (ACA) significantly increased funding for the NHSC, which made it possible to nearly triple the number of clinicians in the NHSC, and broadened the NHSC's racial and ethnic diversity of doctors, nurses, and other health care professionals. For example:

- NHSC African American physicians represent 17.3% of the Corps physicians and exceed their 6.3% share in the national workforce.
- NHSC Hispanic physicians represent 16.2% of the Corps physicians and exceed their 5.5% share in the national workforce.
- NHSC Asian dentists represent 14.7% of the Corps dentists and exceed their 11% share in the national workforce.

Diversity is an integral part of the NHSC recruiting strategy. The NHSC is national in scope and conducts outreach to target underrepresented minorities for recruitment. Overall, NHSC participation compared to national workforce and student averages remain strong.

In addition, other HRSA grants help increase diversity through eligibility requirements, funding priorities and/or required activities, depending on the authorizing statute. These programs include, for example, the Primary Care Training and Enhancement program, the General, Pediatric and Public Health Dentistry and Dental Hygiene Program, and the Mental and Behavioral Health Education and Training Grants program, and the Advanced Nursing Education program. The President's FY 2014 budget has maintained or requested additional funding to support these programs.

4. **NIH has recently acknowledged problems with the availability of resources for awarding minorities with R01 grants. How will your agency deal with this issue in the midst of your proposed cuts to the Research Centers at Minority Institutions (RCMI) program at NIH's National Institute on Minority Health and Health Disparities program in the FY 2014 budget?**

Answer: As a leader in scientific discovery and innovation, NIH not only recognizes the underrepresentation of individuals from underserved communities in biomedical research, but it is committed to supporting and developing a diverse cadre of scientists from all sectors of the nation. NIH has initiated the implementation of several recommendations from the Advisory Committee to the Director (ACD), which recently formed a Working Group on Diversity in the Biomedical Research Workforce. This working group was charged with evaluating the diversity of the biomedical research workforce and making recommendations to the ACD for improvement in recruitment and retention.

The FY 2014 NIH Congressional Justification includes a decrease for the RCMI program due to the need to balance the scientific investments of the National Institute on Minority Health and Health Disparities (NIMHD), by identifying and reducing areas of duplication in its program portfolio. The RCMI program, along with other new and existing initiatives, will bolster NIH's efforts to improve the recruitment and retention of a diverse workforce. Recently, NIH launched three inter-related initiatives to address this issue. These are (1) NIH Building Infrastructure Leading to Diversity (BUILD), (2) the National Research Mentoring Network (NRMN), and (3) the Coordinating and Evaluation Center (CEC). In addition, a search is currently underway to recruit a Chief Officer for Scientific Workforce Diversity. This individual will be responsible for enhancing the diversity of the NIH extramural and intramural biomedical research workforce, by identifying new and effective, evidence-based strategies to enhance diversity, and promoting synergy among existing programs.

Programs such as BUILD, NRMN, CEC, RCMI, and other existing NIH programs will complement one another and support NIH's efforts to enhance the diversity of the biomedical research workforce. By utilizing the synergy between these programs, NIH can move forward in enhancing the diversity of the biomedical workforce, and maximize the return on investment from the available resources.

- The BUILD initiative intends to test new, innovative approaches to recruitment and training of scientists from diverse backgrounds. The emphasis is on development of culture-changing methods to motivate young scientists for careers in biomedical research and to enable them to thrive in the NIH-funded environment. It will support research training at multiple career stages and promote faculty development at comparatively under-resourced institutions with a concentration of students who receive Pell Grants. This initiative recognizes the critical role that the faculty-student relationship plays and intends to provide salary offset and other mentor-promoting activities to enable outstanding mentors to work with students and train new mentors.

- The NRMN is intended to augment local mentoring efforts for undergraduate students through junior faculty members by creating a national group of scientific leaders who are willing to serve as external mentors. The NIH intends to identify an entity that will engage and assemble multiple persons and/or professional organizations into a single, nationwide, consortium of mentors. The NRMN intends to develop contemporary methods to facilitate networking between mentors and mentees and also intends to promote face-to-face experiences as needed. This initiative will address the standard wisdom that says that success depends on "who you know," by ensuring that contacts are

made between mentees and mentors with shared interests and by facilitating subsequent interactions.

- The goal of the CEC is to assess efficacy of the new approaches being developed via BUILD and the NRMN and to disseminate lessons learned across the community at large. It will help ensure optimal coordination of the BUILD and NRMN activities, minimize redundancy, and facilitate data tracking and analysis.

The RCMI program provides resources for several critical areas of support for biomedical, clinical, behavioral, and social sciences research. Infrastructure development creates a foundation for the research enterprise through renovation/alteration of new research facilities and the development of specialized research support capabilities such as biomedical informatics and research design/biostatistics expertise. Instructive training and mentored research training experiences for early-stage investigators interested in health disparities research facilitate career advancement for junior faculty members. Together these activities address many of the challenges faced in promoting diversity in the biomedical, clinical, behavioral, and social sciences research workforce. RCMI institutions as well as other institutions supported through ongoing NIH-funded activities are expected to benefit from the innovative approaches being tested through BUILD, the NRMN, and the CEC.

NIH anticipates greater collaboration, partnership and networking among its various programs aimed at contributing to the diversity of the workforce, including but not limited to these programs.

5. **In regards to molecular pathology services in Medicare, CMS eliminated stacking payment codes last year in favor of a re-pricing process called "gap-fill" to establish pricing for these services. While these molecular tests provide the foundation for personalized medicine, the gap-fill process has resulted in a lack of transparency, prices below the cost of providing some tests, and unnecessary delays in payments from the MAC's to clinical labs.**

   Would you please provide the Committee with a status report on the gap-fill process to date, in addition to what steps CMS plans to take to improve the gap-fill process in the near future to ensure adequate Medicare beneficiary access to molecular pathology services?

Answer: As you know, CMS regularly uses Current Procedural Terminology (CPT) codes developed by the AMA in establishing payment rates for Medicare services. The AMA CPT Panel developed 114 new CPT codes for CY2012 and CY2013 to replace multiple "stacking codes" (based on component steps) that were previously used to bill for molecular pathology tests. The old "stacking codes" were deleted at the end of 2012 and are no longer available.

The majority of the new codes were issued for CY 2012, but CMS decided to delay their use for a year to carefully consider whether they should be paid under the physician fee schedule (as physicians preferred) or the clinical laboratory fee schedule (as preferred by laboratories). After

requesting comments as part of the CY 2013 physician fee schedule proposed rule, we finalized a policy to pay for these codes under the clinical laboratory fee schedule, with an additional payment available for interpretation by a physician under the physician fee schedule.

New rates for these tests are being established through the "gapfilling" process, which enables the local Medicare contractors to use a wide range of relevant data to determine payment amounts for these tests. CMS will then use the contractors' gapfill prices to set "national limitation amounts" for these tests. The contractors' prices were submitted to CMS in April and will be posted on the CMS website in May and open for public comment for a 60-day period.[3] CMS will post final payment amounts in September, at which point stakeholders have 30 days to request reconsideration. The 2014 clinical laboratory fee schedule, including national limitation amounts for the new test codes, will be issued in November.

While this process is underway, these molecular pathology tests are being paid at interim rates set by the contractors, which may reflect invoice amounts, the previous price amounts known as "stacking codes," or case-by-case determinations by the contractor medical directors. CMS has asked laboratories to bring to our attention any areas where the Medicare contractors have not taken action on submitted claims. As indicated above, a 60-day public comment process is currently underway on the prices proposed by the contractors. We urge laboratories to bring cost information to our attention to assist with final pricing of these services over the next several months. As we obtain more information on the costs of these services from laboratories, we are optimistic that we will be able to establish prices satisfactory to both Medicare and the laboratory industry.

The Honorable Phil Gingrey

1. **Why does the budget propose excluding certain services from the in-office ancillary services exemption (IOASE) when both the GAO and MedPAC reviewed the exception and did not recommend closing it?**

Answer: The in-office ancillary services exception was intended to allow physicians to self-refer for services to be performed by their group practices for patient convenience. While there are many appropriate uses for this exception, there is evidence that suggests this exception may have resulted in overutilization and rapid growth of certain services. In a report released last September, GAO found that in that in 2010, providers who self-referred likely made 400,000 more referrals for advanced imaging services than they would have if they were not self-referring. GAO found that these additional referrals cost Medicare about $109 million.

[3] Information on the current 60-day public comment process is available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Gapfill-Pricing-Inquiries.html.

2. **Recent MedPAC data suggests that the growth of advanced diagnostic imaging services has slowed in recent years. If this is the case, why does this budget include provisions to eliminate imaging services from the in-office ancillary services exception?**

Answer: It is true that MedPAC's March 2013 report stated that utilization rates for imaging services slightly declined in 2010 and 2011. However, the report also stated that despite the decrease in 2010 and 2011, the use of imaging services has remained much higher than it was a decade ago. The cumulative decrease in imaging volume in 2010 and 2011 was less than 4 percent, while the cumulative increase that occurred from 2000 to 2009 was 85 percent. According to MedPAC, the growth in imaging volume last decade was more than double the cumulative growth rates for evaluation and management (E&M) services and major procedures respectively. During this period, many physicians have been outspoken about the overuse and duplication of these services. Other studies have supported this assertion. From this strong evidence, the Administration feels that it is appropriate to include advanced imaging in the list of services that should be excluded from the in-office ancillary services exception.

3. **How are the "accountability standards" defined that would allow providers to continue providing services under the IOASE?**

Answer: This proposal allows the Secretary flexibility to determine these standards, which would be done through a rulemaking process. Factors to be considered could include quality, value, efficiency, utilization, and access.

4. **The ability for physicians to provide ancillary services in the office setting achieves both lower cost treatment and increased care coordination. Are you concerned that closing the IOASE will result in higher costs and fragmented patient care?**

Answer: The in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services. While there are many appropriate uses for this exception, the services covered under this proposal are rarely performed on the same day as the related office visit. Additionally, there is reason to believe this exception has resulted in the overutilization and the inappropriate use of certain services. Receiving unnecessary tests, such as additional CTs, can actually pose risks to beneficiaries. This proposal is designed to encourage appropriate use of services while providing exceptions (to be specified by the Secretary) that would ensure beneficiaries continue to have access to appropriate, medically necessary care.

5. **As an obstetrician and gynecologist, I know how important it is for OBGYNs to have up-to-date nutrition advice based on the latest science, and doctors look to FDA for that advice. Unfortunately, FDA's advice to pregnant women on seafood consumption is far outdated, leaving expectant mothers with old information that has resulted in a decline in seafood consumption to the detriment of fetal development. You've been saying for over two years that the advisory to pregnant women on seafood consumption will be updated. As FDA continues to miss deadlines for releasing the advice, it is time that you**

personally engage in the finalization process to get this advice out. Would you provide an update on the seafood advisory's status and commit to completing the final advice by this summer?

Answer: The Food and Drug Administration (FDA or the Agency) first issued fish consumption advice relating to methylmercury in 1994. The advice was updated in 2001 and again in 2004. The 2004 advice was issued jointly by FDA and the Environmental Protection Agency (EPA). Its purpose was to protect against the possibility of neurodevelopmental harm to the fetus and to infants from methylmercury as a result of their mother's consumption of fish in excess of recommended amounts and to protect young children from the possibility of neurodevelopmental harm from methylmercury as a result of their own consumption of fish. Since then, studies published in the scientific literature indicate that, under certain circumstances, fish consumption by pregnant women and young children may actually improve neurodevelopment. The Dietary Guidelines for Americans 2010, the government's nutritional recommendations issued every five years by the Departments of Health and Human Services and Agriculture, have already taken this development into account by recommending that pregnant and nursing women eat at least 8 and as much as 12 ounces per week of fish lower in mercury. The 2004 FDA/EPA advice does not contain this consumption target nor does it mention a potential neurodevelopmental benefit from fish since the evidence for it did not exist in 2004. We have devoted a significant effort to update the advice and to complete a quantitative assessment of the net effects of fish consumption during pregnancy on neurodevelopment in order to have a sound analytical underpinning for that advice. We are making every effort to complete that process as soon as possible and please be assured that your concerns are being taken into account.

The Honorable Cathy McMorris Rodgers

1. **This Committee has spent a great deal of time reforming the way pharmacies are paid for generic drugs in the Medicaid program.**

   The Deficit Reduction Act, and later the Affordable Care Act, established that Average Manufacturer Price (AMP) would be used to set Medicaid Federal Upper Limits (FULs) for pharmacy reimbursement. Because AMP has never been used in this manner, Congress gave CMS flexibility to increase the multiplier to calculate FULs, should they prove to provide insufficient payment to retail pharmacies.

   As you know, CMS has been publishing AMP—based FULs in draft form on a monthly basis, and the pharmacies in my district/state tell me that the FULs change dramatically in value from month to month, and that in many cases they are below pharmacy's cost to purchase these medications.

   Given this is a new reimbursement model that has yet to be fully tested in the marketplace; it seems premature to make any changes.

(a) Consequently, I was surprised to see the provision in the president's budget, "Lower Drug Costs" that alters the way FULs are to be calculated. I am also surprised that CMS has chosen to ignore the authority granted by Congress to increase the multiplier to calculate FULs if necessary. Why has the Administration proposed this change to the calculation of FULs?

Answer: The Medicaid Federal Upper Limit (FUL) is used to limit reimbursement for certain multiple source drugs, and is currently calculated based on the weighted average price of all brand-name, authorized generic, and other multiple source generic drugs for each product. This proposal removes brand and authorized generic prices from the FUL calculation. Currently, the inclusion of both brand and authorized generic drugs in the calculation of the FUL unduly inflates the FUL. Removing both categories of drugs ensures that the government remains a prudent purchaser of prescription drugs.

(b) What portion of the $8.8 billion in savings from this budget provision is attributed to reduced pharmacy payments?

Answer: The Medicaid prescription drug proposals in the President's FY 2014 Budget strengthen the fiscal management of the Medicaid program. If enacted, we estimate the proposals will save money by bringing down FULs that are inflated by generic prices. To the extent that pharmacy payments may be reduced, the reduced payment will more accurately reflect the price of the generic drugs for which Medicaid pays.

(c) Why has CMS chosen to disregard the authority provided by Congress to increase the multiplier to set Federal Upper Limits, even on a case by case basis?

Answer: CMS has issued monthly draft AMP-based FULs and three-month rolling average FULs. The draft three-month rolling average FULs were developed in response to comments that the draft AMP-based FULs fluctuated from month to month. States can use the draft monthly AMP-based FUL, or the draft three-month rolling average FUL, once they are finalized, depending on the approved state plan, to develop a pharmacy reimbursement methodology that will allow their pharmacy payments to remain within the FUL in the aggregate. CMS is continuing to accept comments on these methodologies and will consider those comments when we finalize the FULS. Based on recent work by the OIG and the GAO, we continue to believe the FULs will provide sufficient payment to retail pharmacies.

2. Under the mandate requiring all insurance plans cover sterilization and contraception including the morning-after and week-after pills, many non-profits and family owned businesses will no longer be able to operate in keeping with their principles and values, while also offering health insurance to their employees. Because you have not provided an exemption that fully respects religious freedom, over 160 plaintiffs have filed suit against this mandate—seeking the courts grant them relief from the mandate that

infringes of their fundamental Constitutional rights. The family owned business' cases are moving forward, but the non-profits' cases are delayed until a final rule is issued. Since both the advance notice of proposed rulemaking and the proposed rule have been similarly rejected by religious objectors, they have little hope that the final rule will address their concerns. Therefore, they expect to be forced to rely on relief in court. However, their cases cannot move forward until the rule is finalized.

(a) Faith-based charities, hospitals and schools are still waiting for their day in court, waiting for a final rule, and time is running out for them—they must comply starting August 1st of this year with the mandate or face ruinous fines. When will HHS issue the final rule, so that these faith-based charities, hospitals and schools who want to provide good health care to their employees and continue to keep that health care in line with their deeply held beliefs can go to court and protect their religious liberty?

Answer: This rule was published in the Federal Register for public comment on February 6, 2013. The deadline for comment submissions was April 8, 2013. HHS is still examining comments and expects to issue a final rule when we have completed our analysis and response to comments.

(b) As I mentioned previously, Americans have been seeking redress through the courts because the administration continues to push forward a rule that violates deeply held moral and religious beliefs. In issuing a final rule, will you seek to protect the First Amendment rights of all Americans?

Answer: HHS cannot comment on the contents of any final rule before it is released to the public.

The Honorable Leonard Lance

1. **Much has been made about the issue of drug rebates to the Medicare program. This committee has done much work in exploring the ways in which Medicare Part D drugs have kept down costs in the Medicare program. In proposing to apply Medicare drug rebates to the Medicare program, did your office conduct an analysis to ascertain what impact on innovation or access these rebates might have?**

Answer: The Medicare Part D program is working well and providing valuable savings to seniors and people with disabilities with their prescription drug costs, particularly for dually eligible Medicare-Medicaid beneficiaries who automatically receive Extra Help from the government with their premiums and copayments. Given the fiscal challenges our country faces, however, Medicare must continue to find ways to ensure the program is providing the best value to beneficiaries and taxpayers.

The FY 2014 budget proposal would obtain price concessions from pharmaceutical manufacturers for individuals who are dually eligible and for the poorest Medicare beneficiaries, who receive the Part D Low Income subsidy. The Part D Low Income Subsidy (LIS) is the largest component of Part D spending, totaling $22.8 billion in 2012. These price concessions, or rebates, are the same rebates that the Medicaid program currently receives from manufacturers. This proposal stems from a recommendation by the bipartisan National Commission on Fiscal Responsibility and Reform and reinstates savings that taxpayers previously received when dually eligible individuals received their drug benefit through the Medicaid program.

2. **The proposed budget would seek to expand Medicare claims data sharing with qualified entities for such purposes as fraud prevention. Would you explain how this policy would work?**

Answer: The Affordable Care Act includes a provision that allows CMS to make Medicare Part A, B, or D claims data available to qualified entities for the purpose of publishing reports evaluating the performance of providers and suppliers. The budget proposal would expand the scope of how qualified entities can use Medicare data beyond simply performance measurement. For example, entities would be allowed to use the data for fraud prevention activities and value-added analysis for physicians. In addition, qualified entities would be able to release raw claims data, instead of simply summary reports, to interested Medicare providers for care coordination and practice improvement.

Qualified entities (QEs) offer a unique mechanism for CMS to share data with providers. Many of the organizations that have been approved as QEs were already doing provider performance measurement, so have established relationships with providers in their region. In many cases, these organizations already share claims data from other payers with providers, offering not only access to the data, but also value-added analytics. Many QEs charge for their value-added analytics; however, this offers an important service to providers, who don't necessarily have the infrastructure to store and analyze raw claims data, which allows them to gather further information on the quality of care they deliver.

3. **Citing concerns with the way CMS has handled fraud prevention to date, and alarmed by the tens of billions CMS loses to waste, fraud and abuse each year, this committee recently put out a proposal on its intention to identify and reform the ways in which CMS manages fraud prevention. Yet the President's budget would request that fraud prevention funding in 2015 be mandatory and fall outside of Congressional oversight. Would you explain how giving CMS more autonomy with regards to fraud funding will help address concerns on capitol hill that CMS is not properly conducting fraud prevention in the Medicare and Medicaid programs?**

Answer: CMS launched the Fraud Prevention System (FPS) as part of a broad effort to shift the agency beyond a "pay and chase" approach to preventing fraud before it happens. Created under the Small Business Jobs Act of 2010, the FPS analyzes all Medicare fee-for-service claims using risk-based algorithms developed by CMS and the private sector, prior to payment, allowing CMS

to take prompt action where appropriate. CMS uses the FPS to target investigative resources to suspect claims, providers, and suppliers, and swiftly impose administrative action when warranted. Early results from the FPS show significant promise and CMS expects results to increase as the system matures over time. As reported in our Report to Congress in its first year of implementation, the FPS:

- Prevented or identified an estimated $115.4 million in improper payments;
- Achieved a positive return on investment, saving an estimated $3 for every $1 spent in the first year;
- Generated leads for 536 new fraud investigations;
- Provided new information for 511 existing investigations; and
- Triggered 617 provider interviews and 1,642 beneficiary interviews regarding suspect claims or provider activity.

In addition to CMS' fraud prevention work, HHS and DOJ continue to coordinate investigations and prosecutions of health care fraud, waste, and abuse under the Health Care Fraud and Abuse Control Program (HCFAC). As reported in the 2012 HCFAC Report to Congress, these activities returned $4.2 billion dollars to the Department of Treasury and Medicare Trust Funds in 2012. The HCFAC account has returned over $23 billion to the Medicare Trust Funds since the inception of the program.

The Budget Control Act of 2011 recognized that a multi-year strategy permitting agencies to pay closer attention to the risk of improper payments, commensurate with the large and growing costs of the programs administered by that agency, is a laudable goal. Despite enactment of these multi-year discretionary cap adjustments, annual appropriations bills have not provided the full amount of program integrity funding authorized in BCA. Billions of dollars in savings over the next ten years from curtailing improper payments will not be realized if consistent, additional funding for program integrity is not provided. The President's Budget proposes to provide a dedicated, dependable source of additional mandatory funding beginning in FY 2013 that will ensure HHS and the Department of Justice (DOJ) have the resources that they need to conduct necessary program integrity activities and make certain that only the right people receive the right payment for the right reason at the right time. CMS will continue to report to Congress on program integrity efforts.

The Honorable Bill Cassidy

1. **In 2006, government-funded patient advocates coached schizophrenic William Bruce to say the right things in order to be released from a psychiatric facility- despite his doctor's recommendation. Two months later, he murdered his mother with a hatchet. Today, he is receiving effective treatment (including medication) and lives in a state psychiatric facility. (See "A Death in the Family" in the WSJ). He is quoted as saying of the advocates, "They helped me immensely with getting out of the hospital, so I was very happy (but) the advocates didn't protect me from myself." It seems the patient advocates (who are funded to protect against patient abuse and neglect) do a better job**

advocating for the irrational and often dangerous voices of the disease than advocating what is in the best interest of the individual. I see the budget will again allocate 36 million to this program. What has been done since the 2006 death of this boy's mother to prevent government funded patient advocates from coaching seriously mentally ill individuals, who are clearly in need of treatment, to forego it to their detriment, their families and their communities?

Answer: Protection and Advocacy for Individuals with Mental Illness (PAIMI) project officers and grants management staff provide routine fiscal, programmatic and monitoring oversight of all aspects of the PAIMI formula grants within states. In this capacity, the project officer and monitors work to ensure that the federal PAIMI funds are being utilized consistent with the statutory authority and in compliance with the PAIMI applications' requirements and annual program priorities that are established by the respective PAIMI Advisory Councils.

SAMHSA receives allegations and complaints relating to health and safety concerns from both the HHS Office of Inspector General Hotline and directly from the general public. Upon receipt, SAMHSA's allegations point of contact convenes a meeting with appropriate program officials who communicate with and gather information from the grantee in question and take appropriate actions, which may include a site visit and corrective action plan depending on the circumstances.

2. **Assisted Outpatient Treatment (AOT, also known as outpatient commitment or "OPC") allows a judge to order an individual with serious mental illness, who is unable to live safely without supervision and treatment, to follow a treatment plan while living in the community. In 2010, NIMH director Thomas Insel wrote, "One of the challenges we face in correcting (the problem of SMI individuals ending up in jail) is the absence of an institution for longer-term, evidence-based care for people with severe mental illness." With state psychiatric hospital beds being closed every day, AOT not only provides what Insel was describing, but also provides it in a way that allows an individual to remain in the less restrictive setting of his/her community. Unfortunately, lawyers paid by SAMHSA's PAIMI program actively advocate against programs like AOT despite the fact that the DOJ rates the program as a cost-saver and crime-preventer. While a small subset of people with severe mental illness are at significant risk of committing violent acts (including homicide and suicide) at far higher rates than national averages, research has shown that those with schizophrenia and other severe psychiatric diseases are no more violent than those without SMI if their psychosis is controlled. What is SAMHSA doing to address the needs of seriously mentally ill individuals whose brain disease prevents the person from voluntarily seeking treatment before they end up in the criminal justice system? Please provide a detailed list of SAMHSA funding that has supported implementation of evidence-based AOT/OPC programs over the last ten years. If no funding or limited funding has gone to these programs, please explain why.**

Answer: AOT/OPC is a form of leveraged, court ordered treatment. Since 2002, SAMHSA has supported court-ordered treatment through the Grants for Jail Diversion Program. Jail diversion

programs are aimed at persons who have mental illness, who have violated a law, and who can improve with treatment and support. In alignment with the authorizing language (Section 520G of the Public Health Service Act), Requests for Applications have announced funding opportunities to states, municipalities and tribes to divert individuals from incarcerated settings to comprehensive community based mental health and recovery oriented services. Communities proposed and implemented grants to support screening and community treatment for individuals with mental illness and co-occurring substance use disorders who were diverted at police encounter, after arrest and booking, in pre-screening, at first appearance in court, in mental health courts and at violation of probation and parole. Mental health courts issue court-ordered treatment to individuals with mental illnesses and monitor progress at regular hearings, offering rewards or sanctions depending on whether or not participants are adhering to their treatment plans and other conditions.

Based on funding appropriated by Congress for the SAMHSA Center for Mental Health Services Criminal and Juvenile Justice Program Summary Listing of Activities line, during FYs 2003 – 2012, a total of $56.4 million was spent on the Grants for Jail Diversion Program.

3. **The President's budget requests $1.5 billion in new funding for federal fallback exchanges (FFEs). This includes $554 million in "education and outreach." Congress denied the request for $1 billion additional funding for FFEs in last year's continuing resolution. Without congress providing these funds, how are you funding federal exchanges? Please provide a detailed accounting chart of what internal accounts the money is coming from.**

Answer: The President's Budget requests $1.5 billion for the Federal Marketplace. CMS is committed to carrying out the Secretary's ongoing statutory responsibility to establish and operate a Federally-Facilitated Marketplace in states that do not elect to establish and operate their own Marketplaces, or that the Secretary determines will not have any required Marketplace operational by January 1, 2014 or that have not taken the actions she determines necessary to implement the requirements for operating a State-Based Marketplace.

4. **In August 2012, CDC found that three-fourths of all persons infected with Hepatitis-C are among the baby boom birth cohorts, with the vast majority unaware of their infection, and recommended that every boomer get screened once in their life regardless of risk factors (risk based screening was deemed of "limited success.") Meanwhile a sister agency, the U.S. Preventive Services Task Force (USPSTF), issued its draft guidelines for HCV screening that wants to continue on using risk-based screening and ignores the high density of HCV positive people in the baby boom generation. The ACA requires health plans to follow the USPSTF guidelines. HCV costs are about to explode on Medicare—even though it's easy to test and then treat these populations, with upcoming treatments literally curing people of the disease while safety and efficacy increase. What is the Secretary office doing to navigate and head off this looming medical and fiscal crisis?**

Answer: In regard to Medicare coverage of screening for Hepatitis C Virus amongst the baby boom birth cohort, CMS has limited authority to consider coverage of new preventive and screening services. Specifically, the Medicare statute authorizes the Secretary to add coverage of "additional preventive services" – that is, preventive services not already covered under specific statutory provisions – if the service is recommended at the "A" or "B" level by the U.S. Preventive Services Task Force (USPSTF), and the service is determined through the Medicare national coverage determination (NCD) process to be appropriate for Medicare beneficiaries.

As you noted, the USPSTF recently initiated a reconsideration of their 2004 recommendation on routine screening for Hepatitis C Virus and issued a draft updated recommendation for public comment in November 2012. Until the USPSTF issues a final recommendation, Medicare lacks authority to consider coverage of this service. When a final recommendation is available, we will consider whether it warrants the opening of a national coverage analysis (the first step in the NCD process). The status of the Task Force's work on this subject can be monitored at http://www.uspreventiveservicestaskforce.org/uspstf/uspshepc.htm.

In regard to the Affordable Care Act provision for private insurance coverage of preventive services recommended by the USPSTF, the law requires that non-grandfathered plans cover services with an A or B recommendation without cost-sharing. Screening for Hepatitis C does not currently have an A or B Recommendation from USPSTF, and it is therefore not required to be covered.

5. **The President's Budget demonstrates that the ACA will take over much of the medical services of HIV patients, currently provided by Ryan White funded programs. From current levels, by what amount are Ryan White expenditures expected to decline, and how does the Administration intend to devote those 'surplus' dollars to achieve the stated goals of the national HIV strategy, advance public health and reach an AIDs-free generation? If there are 'surplus' funds, are those funds not best deployed on core medical services and infrastructure strengthening in areas where there are growing populations of HIV patients or continued implementation challenges due to resource-poor setting? The Ryan White Treatment Act calls for 75 percent of funds to be devoted to core medical services. Is it the Administration position that this threshold is no longer prudent or necessary?**

Answer: The FY 2014 Budget request reflects continued support for the Ryan White HIV/AIDS Program (RWHAP) while HHS conducts an in-depth assessment of the interaction between the Affordable Care Act and RWHAP's continued provision of HIV services, and the potential for achieving one of the key goals of the National HIV/AIDS Strategy (NHAS): improving health outcomes for people living with HIV/AIDS.

While HHS does not expect a significant shift in the demand for clinical services in FY 2014, nonetheless, HHS does expect that in FY 2014 the number of insured Ryan White clients is expected to increase to some extent. The FY 2014 Budget also supports investments in Ryan White funded services not covered by public or private insurance, but which are essential to linking people living with HIV into care and maintaining them on drug regimens. These

"continuum of care" services are critical to preventing the spread of the domestic HIV epidemic as recent studies have found that anti-retroviral (ARV) treatment reduces HIV transmission by 96 percent. Examples of these services include case management, transportation assistance, and treatment adherence, which are critical to keeping people in care and on drug regimens that decrease viral load and prevent the spread of the virus. Ryan White dollars are also used to support cost sharing, which leads to more consistent access to ARV drugs and increased adherence to treatment. Ryan white grants are also used by clinics to fund several core medical services not consistently covered by insurance, including comprehensive substance use treatment, mental health services, and care coordination services

The Ryan White Program plays an essential role in meeting the goals of the NHAS and supporting its objective to reach an AIDS-free generation through the Program's critical role in filling gaps in the health system and its unique capacity, experience, and expertise in meeting the diverse and challenging health care needs of PLWH. If the NHAS goals are to be met, Ryan White Program funds must continue to be used to support care completion services (core medical and continuum of care services) for both newly diagnosed individuals and current clients who will be enrolled in Medicaid or private insurance options beginning in January 2014. The Ryan White Program not only works to ensure that individuals living with HIV gain access to care and life-saving anti-retroviral (ARV) drug treatment, it also works to ensure that people remain in care and adhere to their ARV drug regimens. Because ARV treatment suppresses the virus thereby reducing its transmission by 96 percent, the Ryan White program also plays a critical role in preventing the spread of the HIV epidemic.

By statute, the majority of Ryan White Program funds are distributed by formula with smaller amounts distributed as supplemental awards based on demonstrated needs in resource-poor settings. As noted earlier, based on what the Department learns from its assessment of the impact of the Affordable Care Act on the Ryan White Program, we will be better able to address challenges and future opportunities for changes.

The Ryan White HIV/AIDS Program legislation (title XXVI of the Public Health Service Act), requires that grantees expend 75 percent of Parts A, B, and C funds on core medical services, including antiretroviral drugs, for individuals with HIV/AIDS identified and eligible under the statute. The statute grants the Secretary authority to waive this requirement if there are no waiting lists for the AIDS Drug Assistance Program and core medical services are available to all individuals identified and eligible an applicant's service area. A Federal Register Notice (FRN) was published on May 24, 2013, that offered a proposed revision to the waiver policy for public comment. The FRN supports the Ryan White Program grantees' request for additional flexibility in the timing of waiver applications by providing grantees additional options for making waiver requests. HRSA will review the information from the comments to inform future action on the waiver.

6. **As you know GAO and MedPAC have examined the in-office ancillary Service Exception in depth and neither group has recommended repealing IOASE. I am concerned that the Administration proposal would result in more patients receiving care in the more expensive hospital setting, undermining the integrated delivery of care**

and leading to more hospital acquisitions of physician practices. Would you provide the quantitative analysis that supports the $6 billion score for the proposal? How much is attributable to each service?

Answer: The estimate of $6 billion in savings was developed by the independent CMS Office of the Actuary based on its assumptions about predicted reductions in spending on services and behavioral changes related to the policy.

7. **With regard to radiation, are you aware that radiation utilization from 2007-2011 has been flat at the precise time physician offices have acquired the IMRT technology? Doesn't that suggest that there would be no savings from prohibiting physician ownership of radiation?**

Answer: The in-office ancillary services exception was intended to allow physicians to self-refer quick turnaround services. While there are many appropriate uses for this exception, certain services, such as advanced imaging and outpatient therapy, are rarely performed on the same day as the related physician office visit. Additionally, evidence suggests that this exception may have resulted in overutilization and rapid growth of certain services over time, including radiation therapy. Effective calendar year 2015, this proposal would seek to encourage more appropriate use of select services by amending the in-office ancillary services exception to prohibit certain referrals for radiation therapy, therapy services, and advanced imaging except in cases where a practice meets certain accountability standards, as defined by the Secretary.

The Honorable H. Morgan Griffith

1. **Back in 2011, I asked your former colleague in the Cabinet, EPA Administrator Lisa Jackson, about the impacts of the administration's burdensome regulations would have on my poor and elderly constituents in Southwest Virginia by raising their heating prices. She responded along the lines of that there are programs to help those people. The President proposed to slash the Low Income Home Energy Assistance Program (LIHEAP) by $650 million from FY12 levels. I cannot fathom how this administration can push through policies that raise energy costs while suggesting that programs like LIHEAP be cut. How will people needing this assistance that have had their energy costs exacerbated by other policies from this administration survive without these LIHEAP funds?**

Answer: While the Low Income Home Energy Assistance Program (LIHEAP) remains an important program to the Administration, difficult budgetary choices need to be made across the board and new approaches have to be used to more strategically target resources where they are most needed. The Administration recognizes the importance of ensuring that grantees (States, Tribes, and Territories) retain as much flexibility as possible with their budget decisions for LIHEAP in terms of setting benefit levels and eligibility criteria.

For FY 2014, the Administration proposed a new funding stream of $50 million to assist LIHEAP grantees with repairing and replacing inefficient heating systems to help enable households to reduce their home energy burden and maximize the impact of their LIHEAP benefits. This pilot program will provide evidence of the effectiveness of different strategies to improve home energy efficiency and reduce home energy burden for low-income households.

The Honorable Gus Bilirakis

1. **First, in CMS's 45-day notice were changes made to the Medicare Advantage (MA) risk adjustment methodology? Do those changes in effect reward private plans for delaying patients' access to disease management programs and do you believe that this payment policy aligns with the President's stated priority, published in his own budget, to implement payment innovations that reward high quality care?**

Answer: CMS understands the clinical value of disease and care management programs in targeting conditions early and preventing or slowing the progression of disease, improving the health of beneficiaries, and potentially saving health care costs. The goal of risk-adjusted payments is to pay accurately using the appropriate relative risk for a beneficiary. Therefore, a key objective when we develop or update a risk adjustment model is to measure risk in the best way possible.

CMS balanced several goals when updating the CMS-HCC model for the Medicare Advantage program. One significant goal of the revised model was to conduct a fresh model build in order to clinically revise the model. Though CMS annually maps new ICD-9 codes into the existing HCCs, the base groupings in the CMS-HCC model are still based on ICD-9 codes from the late 1990s. CMS has not conducted a fresh model build since the model was created. Thus, a key feature of the proposed restructuring of the condition categories proposed for CY 2014 was achieved by taking into account ICD-9 codes that have been created in the decade since the original model was created. We also considered whether the condition categories predict expenditures, whether the diagnostic classifications measure disease burden, and whether diagnosis codes subject to discretionary or inappropriate coding should be excluded.

The risk adjustment model proposed for 2014 includes important clinical updates, as well changes to address differences in coding between MA plans and fee-for-service Medicare. Because of the concern regarding these risk adjustment changes being implemented at the same time as other program changes, the Final Rate Announcement substantially modified how we will implement the new risk model.

In the Final Rate Announcement, we announced that we will implement the updated, clinically revised CMS-HCC risk adjustment model proposed in the Advance Notice with the following differences: (1) we will not apply a budget neutrality adjustment to the denominator and (2) we will blend the risk scores calculated using this model with the risk scores calculated using the 2013 CMS-HCC model, weighting the risk scores from the 2013 CMS-HCC model by 25

percent and the risk scores from the 2014 CMS-HCC model by 75 percent. We finalized this approach to mitigate the changes in risk scores faced by individual MA organizations.

2. **Second, I am concerned about further changes to the MA program. Your colleague Ms. Tavenner stated at her Senate confirmation hearing that MA provides high quality coverage to beneficiaries who are satisfied with their coverage. I can say first hand that MA enrollees in Florida, with a penetration rate of 34%, would agree with that statement and truly value their ability to access private plans.**

   HHS's FY2014 budget proposed severe changes to the coding intensity adjustment for MA, raising it from 0.25 percentage points to 0.67 percentage points until the minimum adjustment plateaus at 7.59% in 2018. This is significantly higher than current law; under ATRA the adjustment plateaus at 5.9%. The ATRA increased the 2018 adjustment level over time from what was established under the ACA at a 5.7% adjustment in 2018 and beyond.

   In light of ACA's deep funding cuts to the program (most of which have yet to take effect) and the way the proposed cuts included in CMS's draft 45-day notice were found to jeopardize stability within the program (and since have been reevaluated), why does the agency find it prudent to increase the coding intensity adjustment at such an accelerated rate from what we have seen in the past?

Answer: The legislative proposals in the President's FY2014 Budget related to coding intensity adjustments and MA employer group waiver plans (EGWPs) are designed to improve the accuracy of MA payments.

The proposal to increase the MA minimum coding intensity adjustment would improve the accuracy of statutorily required risk adjustment of MA payments that accounts for the health status of each MA-enrolled beneficiary. MA plans tend to submit both more diagnosis codes and higher levels of diagnosis codes for beneficiaries with similar underlying health status than providers in FFS (and this difference between MA and FFS diagnosis codes increases over time). Beginning in 2010, the ACA requires CMS institute a minimum coding intensity payment adjustment for MA plans. The coding intensity adjustment is applied as a downward adjustment to beneficiaries' risk scores in each MA plan. In a March 2013 report the Government Accountability Office estimates that the coding intensity adjustment has been insufficient to account for the differences in coding between MA plans and fee-for-service Medicare[4]. This budget proposal is consistent with the GAO recommendation and reduces overpayments to plans resulting from coding pattern differences between MA and Medicare FFS providers.

3. **The Agency's budget also reduces funding to MA employer plans in which about 1 million beneficiaries are currently enrolled. Employers are already stretched thin by strict cost sharing mandates under ACA for their active workforce and the potential**

[4] http://www.gao.gov/assets/590/587637.pdf

buy-up in coverage to meet the EHB requirements in 2014 under the President's health law. What kind of impact could this funding reduction have on employers? Will it result in reduced benefits or potentially impact wages or job creation? Would you agree that this policy does not fulfill the "fundamental compact" the President's rhetoric would indicate he is committed to defend?

Answer: The President's FY2014 budget also proposes to set the base Part C payment amount for EGWPs in each county using the average standardized bid for individual plans in the county. EGWPs contract directly with employers and therefor have different bidding incentives from individual MA plans. CMS has found in recent years that the projected average risk scores for EGWP members were lower than for individual MA plan enrollees. However, the average EGWP bids were higher than those for individual MA plans. MedPAC also believes that payments for EGWPs could be made more accurate. The proposal would align MA payment policy for EGWPs more closely with Part D payment policy, which sets Part D payments to EGWPs based on the national average Part D bid amount and the national base beneficiary premium, not on Part D bids submitted by EGWPs. EGWP payments in both Parts C and D will be established on a set, prospective basis rather than letting EGWPs bid for their Part C payment level.

4. **Do you believe you have such authority to shift funds between HHS accounts to cover expenses related to implementation of the health care law? If so, would you please provide a list of the authorized accounts you believe you have the ability to make such transfers for implementation purposes? Would you provide an accounting of what funds have been transferred or used for such purposes? Please provide a legal analysis for such authority.**

Answer: HHS has used the following authorities to transfer funds between HHS appropriations in FY 2013, which includes monies from the Nonrecurring Expenses Fund (NEF), the PPHF, and amounts transferred under the HHS Secretary's transfer authority. Some, but not all, of these transferred funds are being used in accordance with their relevant statutes and to support the implementation of the new Health Insurance Marketplaces. These authorities are also being used to support other important public health priorities, improve the Medicare appeals process, and make improvements to HHS's financial management systems.

Nonrecurring Expenses Fund

The NEF was established by Section 223 of Division G of the Consolidated Appropriations Act of 2008 (42 U.S.C. 3514a; P.L. 110-161). This Act provides HHS with the authority to transfer unobligated, expired discretionary funds into a no-year NEF account to spend on specific purposes as authorized by Congress. Monies from the NEF can be used for purposes including capital acquisitions necessary for the operation of the Department, including information technology infrastructure and facility infrastructure. Consistent with the requirements of the law, HHS has notified the Appropriations Committees in the House and Senate of its plans to obligate up to $600 million from the NEF at this time. The notification includes a plan for CMS to

receive $200 million to assist with implementing the Marketplaces and $250 million to carry out other CMS activities.

Prevention and Public Health Fund

The PPHF is an annual account that received an initial appropriation of $1 billion for FY 2013, which was reduced to $949 million after the sequester. In FY 2013, funds were allocated to HHS operating divisions, including the Administration for Community Living, the Agency for Healthcare Research and Quality, the CDC, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and CMS.

The PPHF was established by Section 4002 of the Affordable Care Act and may be used to support prevention and public health activities, including activities related to implementing the Marketplaces created by the Affordable Care Act. The PPHF may be used for both programs authorized by the Public Health Service Act, and prevention, wellness, and public health activities. Assisting Americans in gaining affordable health care aligns with the purpose and authority of the PPHF which is to support prevention, wellness, and public health. The implementation of the Marketplaces is a top health care priority for the Department and the nation. New coverage options available in the Marketplaces will increase access to preventive care and improve health outcomes for millions of individuals who will be able to enroll in affordable private health plans. Ensuring Americans have access to affordable, quality care will help further the Department's objective of improving public health.

Secretary's Transfer Authority

Section 206 of Division F—titled "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2012"—of the Consolidated Appropriations Act, 2012 (P.L. 112-74), as continued under the Consolidated and Further Continuing Appropriations Act, 2013, authorizes the Secretary of HHS to transfer 1 percent of any discretionary funds which are appropriated for the current fiscal year for HHS in the Departments of Labor, HHS, and Education, and Related Agencies Appropriations Act between appropriations within HHS. Section 206 further specifies that no appropriation can be increased by more than 3 percent and requires that HHS notify the Committees on Appropriations of the House of Representatives and the Senate at least 15 days in advance of any transfer. Consistent with the requirements of the law, HHS has notified the Appropriations Committees in the House and Senate of its plans to transfer $114 million under this authority to CMS to implement the Marketplaces.

5. Would the Department share a written timeline of what we can expect with respect to upcoming ACA implementation?

Answer:

June 2013:
Web Re-Launch & Call Center Launch

- In late June, CMS will re-launch healthcare.gov, which will be the consumer destination for the Federally-facilitated and State Partnership Marketplaces and consumers will be able to access educational information. The site will add functionality over the summer before the October 1, 2013 open enrollment.
- At the same time, CMS' Federally-facilitated Marketplace consumer call center will begin taking calls from consumers, beginning with educational information and then assisting with enrollment and plan selection on October 1.

July 2013:

Final Qualified Health Plan (QHP) Evaluation Results Received & Data Finalized

- This refers to the period in which CMS conducts the final QHP review and quality assessment in advance of the plan preview period for QHPs in the Federally-facilitated Marketplaces.
- States send final QHP data and approval recommendations to CMS for State Partnership Marketplaces.

State Department of Insurance Approval of QHPs, State Partnership Review of QHPs Complete

- This refers to the time during which State Departments of Insurance (DOIs) will review QHPs.

August 2013

Navigator/ Agent/Broker Training Complete

- Consumer assisters, including Navigators, Non-Navigator Assistance Personnel, Certified Application Counselors, and Agents & Brokers will be available to help consumers with analyzing the coverage available in their state, selecting the coverage that is right for them, and completing eligibility applications. CMS will provide training to these consumer assisters in Federally-facilitated and State Partnership Marketplaces to ensure they are knowledgeable about the Marketplaces and the coverage that is available through them. CMS expects to have training modules available no later than August so that various types of assisters will be prepared when enrollment begins in October. Trainings will be ongoing.

QHP Plan Preview for Federally-facilitated & State Partnership Marketplaces

- This refers to a process by which issuers will be able to view their QHP offerings loaded onto the Marketplace website the way consumers will see them, identify any inaccuracies, and request corrections to the information before the plan offerings are made public.

September 2013

IT Development & Integration Testing Complete

- This refers to the date by which systems development will be complete for open enrollment, beginning on October 1, 2013.

October 1, 2013

Enrollment Begins

- This refers to the first day (10/1/2013) of the initial open enrollment period for the Marketplaces.

6. A number of news articles have noted higher premiums under the ACA. Would you provide your analysis on why this will or will not be the case?

Answer: In an effort to slow health care spending and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring insurance companies to justify rate increase, which has discouraged them from raising monthly premiums for unreasonable or unnecessary costs. Insurers must provide clear information so consumers can understand their reasons for significant rate increases. We know this is making a difference, and that the Affordable Care Act is driving down health insurance premium costs in the private market by holding insurers accountable.

A February 2013 report, *Health Insurance Premium Increases in the Individual Market since the Passage of the Affordable Care Act*,[5] shows that since the rule on rate review was implemented, the number of requests for insurance premium increases of 10% or more plummeted from 75% to an estimated 14% in 2013 as of the date of the report. The average premium increase for all rates in 2012 was 30% below what it was in 2010.

Even when an insurer decides to increase rates, consumers are seeing lower rate increases than what the insurers had initially requested the states to approve. As of the date of the study, more than half of the rate requests for 10% or more ultimately resulted in customers receiving either a lower rate increase than requested or no hike at all.

Furthermore, the rate review program works in conjunction with the 80/20 rule, which generally requires insurance companies to spend at least 80% (85% in the large group market) of premiums on health care, rather than administrative costs (such as executive salaries and marketing) and profits; otherwise, insurance companies must provide rebates to their customers. Insurers that did not meet the 80/20 rule have already provided $1.1 billion in rebates that benefited nearly 13 million Americans, at an average of $151 per family.

Insurance benefits and costs also will become easier to understand for millions of Americans and small businesses starting on October 1, 2013, when they will have the opportunity to shop in a Health Insurance Marketplace in their state. Consumers will be able to find information to make apples-to-apples comparisons of health plans by quality and price and buy the one that best fits their needs and budget.

Delivering smarter health care includes holding insurers accountable, and that is helping to hold down costs. In the past three years, we've seen the slowest growth in overall health care spending since the government started keeping records more than 50 years ago. The new Marketplaces will increase competition between issuers in the individual market. Whether individuals are uninsured, or just want to explore new options, the Marketplace will provide more choice and control over health insurance options. CBO projects that lower administrative costs, greater economies of scale, and increased competition will decrease premiums 7 percent to 10 percent in the non-group market.

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[5] http://aspe.hhs.gov/health/reports/2013/rateincreaseindvmkt/rb.cfm

The Honorable Phil Gingrey

1. **During the hearing, Dr. Gingrey asked about your comments you made in March during a speech in Philadelphia. During that speech, you stated that "...some men are going to see some higher costs. It's sort of a one to one shift...some of the older customers may see a slight decline, and some of the younger ones are going to see a slight increase. These folks will be moving into a really fully insured product for the first times, so there may be a higher cost associated with getting into that market." You did not address his question about whether you think it is fair that young people will pay higher insurance rates because of this law. Has your department created contingency plans in the event that young people choose to pay the penalty instead of purchasing the insurance that they cannot afford?**

Answer: The individual and small group markets—the markets that much of the Affordable Care Act is designed to improve in particular—are broken. People are currently locked out of these markets because of their pre-existing conditions, or if they are able to buy insurance, they may find out their coverage will not extend to the care they need when they get sick. Young women who currently pay for their own insurance plan may discover that, simply on account of their gender, they are sometimes charged 50 percent more than young men are for the same plan. This fall, people are going to be able to buy comprehensive insurance without discrimination based on gender or pre-existing conditions. Also, low- and middle-income people may qualify for premium tax credits to help them buy insurance.

Starting in 2014, people in the individual and small group market will be able to choose new health plans based on the actuarial value they think fits their needs and their budget. Actuarial value means the percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. Plans will range from 60 to 90 percent of actuarial value.

Additionally, the Marketplace will increase competition between issuers on the individual market. CBO projects that lower administrative costs, greater economies of scale, and increased competition will decrease premiums 7 percent to 10 percent in the non-group market.

Also, young adults and certain other people for whom coverage would otherwise be unaffordable may enroll in catastrophic plans, which have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing. Young people under the age of 26 are also generally allowed to stay on their parents' insurance, helping make insurance more affordable for that group.

There are also many provisions in the law to slow health care cost growth and create competition in the insurance marketplace. For example, the reinsurance and risk adjustment programs will help stabilize premiums.

Our outreach efforts will help ensure that young people across the country learn about the benefits of obtaining health coverage through the Marketplaces. We hope to reach this

population through both traditional and social media campaigns that highlight the importance of health insurance. Consumers can sign up for updates about the marketplace through a mailing list on HealthCare.gov,[6] by "liking" the Health Insurance Marketplace on Facebook,[7] or by following @MarketplaceGov on Twitter[8]. On HealthCare.gov[9] and on the HealthCare.gov YouTube channel[10] there are several short videos explaining how shopping for qualified health plans in the marketplace will work.

The Honorable Bill Cassidy

1. **Dr. Cassidy asked if you could accept a 2 percent reduction in your HHS request. Due to time constraints you could not elaborate on your answer that you would not be able to accept a 2 percent reduction. Please explain why you could not accept a 2 percent reduction in your HHS request.**

Answer: My FY 2014 request includes investments needed to support the middle class, grow the economy, and create jobs. A two percent cut to this request—a reduction of $1.6 billion—would limit the Department's ability to protect the nation's public health and national security, focus on responsible stewardship of taxpayer dollars, promote science and innovation, protect vulnerable populations, create opportunity and give kids the chance to succeed, and improve health care and expand coverage. Further, a two percent cut would result in fewer resources for proven program integrity initiatives that reduce the deficit in the long term and ensure that the programs millions of American rely on will be there for generations to come.

[6] https://signup.healthcare.gov/?x=135&y=17
[7] https://www.facebook.com/HealthInsuranceMarketplace
[8] https://twitter.com/MarketplaceGov
[9] http://www.healthcare.gov/marketplace/index.html
[10] http://www.youtube.com/user/HealthCareGov

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