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REVIEWING THE POLICIES AND PRIORITIES OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEARING

BEFORE THE

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

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, JULY 28, 2015

Serial No. 114–24

Printed for the use of the Committee on Education and the Workforce

Available via the World Wide Web: *www.gpo.gov/fdsys/browse/committee.action?chamber=house&committee=education*
or
Committee address: *http://edworkforce.house.gov*

U.S. GOVERNMENT PUBLISHING OFFICE

95–578 PDF WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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REVIEWING THE POLICIES AND PRIORITIES OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Tuesday, July 28, 2015
House of Representatives,
Committee on Education and the Workforce,
Washington, D.C.

The committee met, pursuant to call, at 10:02 a.m., in Room 2175, Rayburn House Office Building, Hon. John Kline [chairman of the committee] presiding.

Present: Representatives Kline, Foxx, Roe, Thompson, Walberg, Salmon, Guthrie, Barletta, Messer, Brat, Carter, Bishop, Grothman, Russell, Curbelo, Stefanik, Allen, Scott, Hinojosa, Davis, Grijalva, Courtney, Polis, Wilson of Florida, Bonamici, Pocan, Takano, Jeffries, Clark, Adams, and DeSaulnier.

Staff Present: Lauren Aronson, Press Secretary; Andrew Banducci, Professional Staff Member; Janelle Belland, Coalitions and Members Services Coordinator; Kathlyn Ehl, Professional Staff Member; James Forester, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Callie Harman, Staff Assistant; Christine Herman, Professional Staff Member; Tyler Hernandez, Press Secretary; Nancy Locke, Chief Clerk; Zachary McHenry, Legislative Assistant; Michelle Neblett, Professional Staff Member; Brian Newell, Communications Director; Krisann Pearce, General Counsel; Jenny Prescott, Professional Staff Member; Lauren Reddington, Deputy Press Secretary; Alissa Strawcutter, Deputy Clerk; Juliane Sullivan, Staff Director; Alexa Turner, Legislative Assistant; Joseph Wheeler, Professional Staff Member; Tylease Alli, Minority Clerk/Intern and Fellow Coordinator; Austin Barbera, Minority Staff Assistant; Jacque Chevalier, Minority Senior Education Policy Advisor; Denise Forte, Minority Staff Director; Christine Godinez, Minority Staff Assistant; Ashlyn Holeyfield, Minority Education Policy Fellow; Carolyn Hughes, Minority Senior Labor Policy Advisor; Brian Kennedy, Minority General Counsel; Veronique Pluviose, Minority Civil Rights Counsel; Dillon Taylor, Minority Labor Policy Fellow; and Arika Trim, Minority Press Secretary.

Chairman KLINE. A quorum being present, the Committee on Education and the Workforce will come to order.

Good morning, Secretary Burwell.

Secretary BURWELL. Good morning.

Chairman KLINE. Thank you for joining us to review the policies and priorities of the Department of Health and Human Services. As is often the case when a Cabinet Secretary appears before the committee, we have a lot of ground to cover in a short period of time. That is especially true for a Department as big, powerful, and costly as the Department of Health and Human Services.

Now, the end of the current fiscal year, HHS is expected to spend approximately $1 trillion administering numerous programs affecting millions of Americans including child care, welfare, healthcare, and early childhood development. At a time when families are being squeezed by a weak economy and record debt, we have an urgent responsibility to make sure the Federal Government is operating efficiently and effectively. It is a responsibility we take seriously, which is why this hearing is important, and why we intend to raise a number of key issues.

For example, we are interested to learn about the Department's progress implementing recent changes to the Child Care and Development Block Grant Program. Last year, the committee helped champion bipartisan reform of the program to strengthen health and safety protections, empower parents, and improve the quality of care. This vital program has helped countless moms and dads provide for their families, and we hope the Department is on track to implement these changes quickly and in line with congressional intent.

Another vital program for many low-income families is Head Start. Earlier this year, the committee outlined a number of key principles for strengthening the program such as reducing regulatory burdens as well as encouraging local innovation and better engagement with parents. The committee then solicited the public feedback that would help turn these principles into a legislative proposal.

It was in the midst of this effort to reform the law that the Department decided to launch a regulatory restructuring of the program. Some of the Department's proposed changes will help improve the program. However, the sheer scope and cost of the rulemaking raises concerns and has led to some uncertainty among providers who serve these vulnerable children. Strengthening the law is a better approach than transforming a program through regulatory fiat, and we urge the administration to join us in that effort.

These two areas alone could fill up most of our time this morning, and I haven't even mentioned services provided under the 1996 Welfare Reform Law and the *Older Americans Act.* Of course, as you might expect, Secretary Burwell, on the minds of most members are the challenges the country continues to face because of the President's healthcare law. Families, workers, employers are learning more and more about the harmful consequences of this flawed law.

For example, patients have access to fewer doctors, to control costs. It is estimated that insurance plans on the health exchanges have 34 percent fewer providers than non-exchange plans, including 32 percent fewer primary care doctors and 42 percent fewer oncologists and cardiologists. The law is plagued by waste and abuse.

In 2014, investigators with the nonpartisan Government Accountability Office used fake identities to enroll 12 individuals into subsidized coverage on a healthcare exchange. Just this month, GAO announced 11 of the 12 fake individuals are still enrolled and receiving taxpayer subsidies. More than 7 million individuals paid a penalty for failing to purchase government approved health insurance, roughly 25 percent more than the administration expected in the worst-case scenario. According to the Associated Press, at least 4.7 million individuals were notified that their insurance plans were canceled because they did not abide by the rigid mandates established under the healthcare law.

The nonpartisan Congressional Budget Office estimates the law will result in 2.5 million fewer full-time jobs. This reflects what we've heard over and over again from employers who have no choice but to cut hours or delay hiring because of the law's burdensome mandates. Healthcare costs continue to skyrocket. According to the New York Times, health insurance companies are seeking rate increases of "20 percent to 40 percent or more," suggesting markets are still adjusting to the, "shock waves set out by the *Affordable Care Act*."

Finally, after all the mandates, fraud, loss of coverage, fewer jobs, higher costs, and nearly $2 trillion in new government spending, it is estimated more than 25 million individuals will still lack basic healthcare coverage.

And yet, just last month, President Obama said the law "worked out better than some of us anticipated." Of course, for those who oppose this government takeover of healthcare, this is precisely what we anticipated and is precisely why the American people deserve a better approach.

In closing, Madam Secretary, I want to thank you again for joining us this morning. It is our responsibility to hold you and the administration accountable when we believe the country is moving in the wrong direction. However, there are areas where I believe we can find common ground and advance positive solutions on behalf of the American people. Today's hearing is an important part of those efforts, and I look forward to our discussion.

With that, I will now yield to Ranking Member Bobby Scott for his opening remarks.

[The statement of Chairman Kline follows:]

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

Good morning, Secretary Burwell. Thank you for joining us to review the policies and priorities of the Department of Health and Human Services. As is often the case when an agency secretary appears before the committee, we have a lot of ground to cover in a short period of time. That is especially true for an agency as big, powerful, and costly as the Department of Health and Human Services.

By the end of the current fiscal year, HHS is expected to spend approximately $1 trillion administering numerous programs affecting millions of Americans, including child care, welfare, healthcare, and early childhood development. At a time when families are being squeezed by a weak economy and record debt, we have an urgent responsibility to make sure the federal government is operating efficiently and effectively. It is a responsibility we take seriously, which is why this hearing is important and why we intend to raise a number of key issues.

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strengthen health and safety protections, empower parents, and improve the quality of care. This vital program has helped countless moms and dads provide for their families, and we hope the department is on track to implement these changes quickly and in line with congressional intent.

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It was in the midst of this effort to reform the law that the department decided to launch a regulatory restructuring of the program. Some of the department's proposed changes will help improve the program; however, the sheer scope and cost of the rulemaking raises concerns and has led to some uncertainty among providers who serve these vulnerable children. Strengthening the law is a better approach than transforming a program through regulatory fiat, and we urge the administration to join us in that effort.

These two areas alone could fill up most of our time this morning, and I haven't even mentioned services provided under the 1996 welfare reform law and the *Older Americans Act.* Of course, as you might expect, Secretary Burwell, on the minds of most members are the challenges the country continues to face because of the president's healthcare law. Families, workers, and employers are learning more and more about the harmful consequences of this flawed law. For example:

* Patients have access to fewer doctors. To control costs, it is estimated that insurance plans on the healthcare exchanges have 34 percent fewer providers than non-exchange plans, including 32 percent fewer primary care doctors and 42 percent fewer oncologists and cardiologists.

* The law is plagued by waste and abuse. In 2014, investigators with the nonpartisan Government Accountability Office used fake identities to enroll 12 individuals into subsidized coverage on a healthcare exchange. Just this month, GAO announced 11 of the 12 fake individuals are still enrolled and receiving taxpayer subsidies.

* More than seven million individuals paid a penalty for failing to purchase government-approved health insurance, roughly 25 percent more than the administration expected under the worst case scenario.

* According to the Associated Press, at least 4.7 million individuals were notified that their insurance plans were cancelled because they did not abide by the rigid mandates established under the healthcare law.

* The nonpartisan Congressional Budget Office estimates the law will result in 2.5 million fewer full-time jobs. This reflects what we've heard over and over again from employers who have no choice but to cut hours or delay hiring because of the law's burdensome mandates.

* Healthcare costs continue to skyrocket. According to the New York Times, health insurance companies are seeking rate increases of "20 percent to 40 percent or more," suggesting markets are still adjusting to the "shock waves set off by the *Affordable Care Act.*"

Finally, after all the mandates, fraud, loss of coverage, fewer jobs, higher costs, and nearly $2 trillion in new government spending, it's estimated more than 25 million individuals will still lack basic healthcare coverage. And yet, just last month, President Obama said the law "worked out better than some of us anticipated." Of course, for those who opposed this government takeover of healthcare, this is precisely what we anticipated and it is precisely why the American people deserve a better approach.

In closing, Secretary Burwell, I want to thank you again for joining us this morning. It is our responsibility to hold you and the administration accountable when we believe the country is moving in the wrong direction. However, there are areas where I believe we can find common ground and advance positive solutions on behalf of the American people. Today's hearing is an important part of those efforts, and I look forward to our discussion.

With that, I will now yield to Ranking Member Bobby Scott for his opening remarks.

Mr. SCOTT. Thank you, Chairman Kline.

And welcome, Secretary Burwell, and thank you for being with us today. I look forward to your testimony.

Today we'll hear about the President's Fiscal Year 2016 Health and Human Services budget proposals and the Department's budget priorities. While the budget was released months ago, I'm pleased to see that the word "priority" is included in the title of today's hearing. Budgeting requires making tough choices, and a budget is in fact a reflection of priorities. As legislators, we decide what our priorities are and how best to invest in our country.

I was pleased that the President's budget request was reflective of many important priorities such as protecting access to healthcare insurance for all Americans, giving all children a chance to succeed, and reducing inequality around the country.

In many areas, I believe that we've made great progress on these priorities. For example, the passage of the *Affordable Care Act* has given millions of Americans access to health coverage, some for the first time in their lives. The ACA has also helped slow the growth in healthcare costs, closed the doughnut holes for seniors, and encouraged and improved access to mental health services and preventive care.

Just weeks ago the Supreme Court decided in another case pertaining to the *Affordable Care Act,* in *King v. Burwell.* The legality of subsidies for those obtaining health insurance through the Federal marketplace instead of a Statewide marketplace was upheld. The *Affordable Care Act* was structured and designed to improve healthcare insurance coverage and access across the entire country, and it has, and now those living in Virginia have enjoyed access to insurance subsidies just like someone in Minnesota, and because of the outcome of the case, they will continue to do so.

I want to thank Secretary Burwell for her efforts and her Department's hard work in implementing the ACA. I recognize the challenge that your agency faces in implementing the law with limited resources and unlimited attacks, but despite these challenges, the ACA is working.

I was also pleased to see that the President's budget request placed priority on giving all children a chance to succeed by ensuring robust funding to increase both access to and quality of early learning and childcare programs.

The Republican budget adopted by the House earlier this year is not reflective of these shared national priorities, despite research showing for every dollar spent on early education, there is a return of $7 in reduced costs in other parts of the budget. We must invest in quality early learning programs because all children deserve being in kindergarten with the building blocks to success.

Now, decades of research has shown that properly nurturing children in the first five years of life is instrumental in supporting enhanced brain development, cognitive functioning, and emotional and physical health. But all too often low-income working families lack access to high-quality affordable child care and early childhood education, and these children tend to fall far behind. In addition to this achievement gap, children who don't participate in high-quality early learning programs are more likely to have weaker educational outcomes, lower earnings, increased involvement in the criminal justice system, and increased teen pregnancy.

Affordable high-quality child care is not just critical for children, it is also critical for working parents, because child care is a two-

generational program. Parents of young children need child care to go to work or go to school. And a lack of stable child care is associated with job interruptions and job loss for working parents.

Child care ought to be a national priority for America's children and to help grow our economy. Just two programs throughout the bulk of the Federal role in early education, the Head Start program and the Child Care Development Block Grant. Unfortunately, because of limited funding, too few children have access. This unmet need continues to grow. Only four out of 10 eligible children have access to Head Start and only one out of six federally eligible families receive child care subsidies. We have decades of evidence that investing in programs like Head Start and the Child Care Development Block Grant work, and the time is to invest in these programs and ensure that we're giving all children the chance to succeed.

Lastly, it's past time for Congress to raise the sequester-level discretionary spending caps that are stunting the progress that we can make as a Nation in important areas like health and education. These caps threaten nearly every program under the jurisdiction of this committee from low income home energy assistance program to the *Older Americans Act* and others. The sequester has led to woefully inadequate investment in critical National needs and puts us on a path to another government shutdown.

In coming back to the idea of priorities, investing in our Nation's future should be Congress' number one priority, not corporate tax breaks or lowering the estate tax. Our focus should remain on restoring investments that strengthen our Nation's middle class and help hard working American families get ahead.

So thank you, Mr. Chairman, and thank you Secretary Burwell for being here today.

Chairman KLINE. I thank the gentleman.

[The statement of Mr. Scott follows:]

Prepared Statement of Hon. Robert C. "Bobby" Scott, Ranking Member, Committee on Education and the Workforce

Thank you Chairman Kline, and welcome Secretary Burwell. Thank you, Secretary, for being with us and I look forward to your testimony.

Today we will hear about the President's Fiscal Year 2016 Health and Human Services Budget proposal and the Department's policy priorities. While the budget was released months ago, I was pleased to see the word "priority" included in the title of today's hearing. Budgeting requires making tough choices, and a budget is in fact a reflection of priorities. As legislators, we decide what our priorities are and how to best invest in our country. I was pleased that the President's budget request was reflective of the priorities that are important to the success of families and communities across the country – protecting access to health insurance for all Americans, giving all children a chance to succeed, and reducing inequality in this country.

In many areas, I believe we have made great progress in these priorities. For example, the passage of the *Affordable Care Act* has given millions of Americans access to health coverage, some for the first time in their lives. The ACA has helped to slow the growth in healthcare costs, closed the donut hole for seniors, and has encouraged and improved access to mental health services and preventive care.

Just a few weeks ago, the Supreme Court decided another case pertaining to the *Affordable Care Act*. In King v. Burwell, the legality of subsidies for those obtaining insurance through a federal Marketplace instead of a state-run Marketplace was upheld. The *Affordable Care Act* was structured and designed to improve health insurance coverage and access across the entire country. And it has. Those living in Virginia have enjoyed access to insurance subsidies, just like someone in Minnesota, and will continue to do so.

I want to thank Secretary Burwell for her efforts and her Department's hard work implementing the ACA. I recognize the challenge your agency faces in implementing this law with limited resources and unlimited attacks. Despite these challenges, the ACA is working.

I was also pleased that the President's budget request placed priority on giving ALL children a chance to succeed by ensuring robust funding to increase both access to and the quality of early learning and childcare programs. The Republican budget adopted in the House earlier this year is not reflective of these shared, national priorities despite research showing a return of over $7 for every $1 spent on early education. We must invest in quality early learning programs because all children deserve to enter kindergarten with the building blocks to success.

Decades of research has shown that properly nurturing children in the first five years of life is instrumental to supporting enhanced brain development, cognitive functioning, and emotional and physical health. But all too often, low-income working families lack access to high-quality, affordable child care and early childhood education, and these children tend to fall behind. Beyond the

achievement gap, children who don't participate in high-quality early education programs are more likely to have weaker educational outcomes, lower earnings, and increased involvement in the criminal justice system. Affordable high-quality child care is not just critical for children, it is also critical for working parents. Child care is a two-generation program. Parents of young children need child care to work or go to school. And a lack of stable child care is associated with job interruptions and job loss for working parents. Child care ought to be a national priority for America's children and to help grow our economy.

Just two programs provide for the bulk of the federal role in early education: the Head Start Program and the Child Care and Development Block Grant. Unfortunately, because of limited federal funding, too few young children have access. This unmet need continues to grow – only 4 out of 10 eligible children have access to Head Start and only 1 out of 6 federally-eligible families receive child care subsides. We have decades of evidence that investing in programs like Head Start and the Child Care and Development Block Grant works. It is time to invest in these programs and ensure that we are giving ALL children the chance to succeed.

Lastly, it is past time for Congress to raise the sequester-level discretionary spending caps that are stunting the progress we can make as a nation in important areas, like health and education. These caps threaten nearly every program under the jurisdiction of this Committee, from the Low Income Home Energy Assistance Program to the *Older Americans Act* supportive programs. The sequester has led to woefully inadequate investment in critical national needs and put us on a path to another government shutdown. And coming back to the idea of priorities, investing in our country's future should be Congress' number one priority – not corporate tax breaks, or lowering the estate tax. Our focus should remain on restoring investments that strengthen our nation's middle class and help hardworking families get ahead.

Thank you and Secretary Burwell, I look forward to hearing from you today.

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

It is now my pleasure to introduce our distinguished witness. The Honorable Sylvia Matthews Burwell is the Secretary of Health and Human Services. Prior to joining HHS in June of 2014, Secretary Burwell served as a director of the Office of Management and Budget, where she oversaw the development of President Obama's second term management agenda. During the Clinton administration, Secretary Burwell served as deputy director of OMB, deputy chief of staff to the President, chief of staff to the Secretary of the Treasury, and staff director of the National Economic Council.

Welcome, Madam Secretary. I will now ask the Secretary to stand and raise your right hand.

Thank you.

[Witness sworn.]

Chairman KLINE. Let the record reflect the witness answered in the affirmative.

Now, before I recognize you to provide your testimony, let me briefly remind you or, more importantly, my colleagues of our lighting system. We typically allow five minutes for each witness to present, although I will be flexible on this timeline, given you are our only witness and you are a Cabinet Secretary. I would ask you, though, to try to limit your remarks, because we have a lot of members who want to get to questions, and I will be strictly enforcing the five-minute rule and perhaps the four-minute rule. The Secretary has a hard stop time at 12:00. We will honor that, and I would ask my colleagues to be patient.

Again, on the lights, when you start, and we'll put the timer on, but you can effectively ignore it if you'd like, it will be green and then turn yellow when you have a minute to go and then red when the five-minute mark is over. And that applies only to the Secretary. To my colleagues, when five minutes is up, five minutes is up.

Now, you are recognized, Madam Secretary.

TESTIMONY OF THE HONORABLE SYLVIA MATTHEWS BURWELL, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON D.C.

Secretary BURWELL. Thank you, Mr. Chairman and Ranking Member Scott, as well as members of the Committee. Thank you for this opportunity to discuss the President's budget for the Department of Health and Human Services.

I believe firmly that we all share common interests and, therefore, we have a number of opportunities to find common ground. We saw the power of common ground in the reauthorization of the Child Care and Development Block Grant Program that happened last fall, as well as the bipartisan SGR repeal earlier this year. And I appreciate all of your all's work to get that passed.

The President's budget proposes to end sequestration fully, reversing it through domestic priorities in 2016, matched by equal dollar increases for the Department of Defense. Without further congressional action, sequestration will return in full in 2016, bringing discretionary funding to its lowest level in a decade adjusted for inflation. We need a whole of government solution, and I hope that both parties can work together to achieve a balanced and commonsense approach.

The budget before you makes critical investments in healthcare, science, innovation, public health, and human services. It maintains our responsible stewardship of the taxpayers' dollar; it strengthens our work together with Congress to prepare our Nation for key challenges at home as well as abroad. For HHS, the budget proposes $83.8 billion in discretionary budget authority. This 4.8 billion increase will allow our Department to deliver impact today and lay a stronger foundation for the Nation for tomorrow.

It is a fiscally responsible budget, which in tandem with accompanying legislative proposals, could save taxpayers a net estimated $250 billion. The budget is projected to continue slowing the

growth in Medicare by securing $423 billion in savings as we build a better, smarter, healthier delivery system.

In terms of providing all Americans with access to affordable quality healthcare, the budget builds on our historic progress in reducing the number of uninsured and improving coverage for families, who already have insurance. The budget supports our efforts to move towards a health delivery system that delivers better care, spends dollars in a smarter way, and puts the patient at the center of the care to keep them healthy.

The budget also improves access for Native Americans. To support communities throughout the country, the budget makes critical investments in health centers and our Nation's healthcare workforce, particularly in rural and other high-need areas. To advance our shared vision for leading the world in science and innovation, the budget increases NIH funding by $1 billion to advance biomedical and behavioral research, among other priorities.

It also invests in precision medicine, a new cross department effort focused on development treatments, diagnostics, and prevention strategies tailored to the individual genetic characteristics of a patient. To further our common interests in providing Americans with the building blocks of healthy and productive lives, this budget outlines an ambitious plan to make affordable quality child care available to working and middle-class families.

Specifically, the budget builds on important legislation passed by this Congress last fall to create a continuum of early learning opportunities from birth through age five. This change would provide high-quality preschool for every child, guaranteed quality child care for working families, grow the supply of early learning opportunities for young children, and expand investments in voluntary evidence-based home visiting programs.

To keep Americans safe and healthy, the budget strengthens health and public infrastructure with $975 million for domestic and international preparedness. It also invests in behavioral health services including more than $99 million in new funding to combat prescription opioid and heroin abuse.

Finally, as we look to leave the Department stronger, the budget invests in our shared priorities of addressing waste, fraud, and abuse—initiatives that are projected to yield $22 billion in gross savings.

The budget addresses the Department's Medicare appeals backlog with a coordinated approach. The budget also makes a significant investment in the security of the Department's information technology and cybersecurity.

I want to conclude by taking a moment to say how proud I am of the HHS team and the employees that work on Ebola, their work every day and their commitment every day. I want to assure you I am personally committed to a responsive and open dialogue with members of this committee as well as with your colleagues.

I look forward to working closely with you, and I welcome your questions. Thank you.

Chairman KLINE. Thank you, Madam Secretary. The light didn't even turn red. I'm unprepared now. I'm at a loss.

[The statement of Secretary Burwell follows:]

Statement by
Sylvia M. Burwell
Secretary
U.S. Department of Health and Human Services
on
The President's Fiscal Year 2016 Budget
before
Committee on Education and the Workforce

United States House of Representatives

July 28, 2015

Chairman Kline, Ranking Member Scott, and Members of the Committee, thank you for the opportunity to discuss the President's FY 2016 Budget for the Department of Health and Human Services (HHS).

I want to begin by thanking members of this Committee and your colleagues in the House of Representatives and Senate for the bipartisan, bicameral efforts you undertook in passing the Child Care and Development Block Grant (CCDBG) Act last November. This law reauthorizes the child care program for the first time since 1996 and represents an historic re-envisioning of the Child Care and Development Fund (CCDF) program, making significant advancements by defining health and safety requirements for child care providers, outlining family-friendly eligibility policies, and ensuring parents and the general public have transparent information about the child care choices available to them.

Thank you also for your work in passing the Medicare Access and CHIP Reauthorization Act of 2015. As you know, this Act, consistent with proposals included in the President's FY 2016 Budget, establishes a long-term policy solution to fix Medicare's flawed Sustainable Growth Rate (SGR) formula, replacing a broken system with one that offers predictability and advances

value-based payments that reward quality and efficiency. The legislation also includes other provisions that were proposed in the President's Budget, such as requiring that Social Security numbers be removed from Medicare identification cards. These policies, along with other changes in the legislation, will help protect the integrity of Medicare and contribute to slowing health care cost growth.

I also want to express my gratitude for continued funding for the Children's Health Insurance Program, which provides comprehensive and affordable health coverage to millions of children. In addition, thank you for your continued support for critical safety net programs, including our nation's health centers, the Home Visiting Program, and the National Health Service Corps. These programs will ensure that millions of Americans will continue to have access to the health care and services they need to lead healthy and productive lives.

Five years ago, another major piece of legislation was enacted. And today, thanks to the Affordable Care Act (ACA), middle class families have more security, and many of those who already had insurance now have better coverage. After five years of the ACA, about 16.4 million Americans have gained coverage. In the private market, millions more now have access to expanded coverage for preventive health care services, such as a colonoscopy or flu shot, without cost sharing. At the same time, as a nation we are spending our health care dollars more wisely and starting to receive higher quality care.

In part due to the ACA, households, businesses, and the Federal Government are now seeing substantial savings. Today, health care cost growth is at very low levels by historical standards,

and health care price growth has been at its lowest rate in fifty years since the Affordable Care Act. Across the board, the Department has continued its commitment to the responsible stewardship of taxpayer dollars through investments in critical management priorities. We have strengthened our ability to combat fraud and abuse and advance program integrity, further driving savings for the taxpayer while enhancing the efficiency and effectiveness of our programs.

The Department has done important work addressing historic challenges, including the coordinated whole-of-government responses to Ebola both here at home and abroad and to last year's increase in unaccompanied children crossing the Southwest border into Texas.

The President's FY 2016 Budget for HHS builds on this progress through critical investments in health care, science and innovation, public health, and human services. The Budget proposes $83.8 billion in discretionary budget authority, an increase of $4.8 billion from FY 2015 appropriations. This additional funding will allow the Department to make the investments that are necessary to serve the millions of American people who count on our services every day, while laying the foundation for healthier communities and a stronger economy for the middle class in the years to come. The Budget also further strengthens the infrastructure needed to prevent, prepare for, and respond to future challenges effectively and expeditiously.

The Department's Budget request recognizes our continued commitment to balancing priorities within a constrained budget environment through legislative proposals that, taken together, would save the American people a net estimated $249.9 billion in HHS programs over 10 years.

The Budget builds on savings and reforms in the ACA with additional measures to strengthen Medicare and Medicaid, and to continue the historic slow-down in health care cost growth. Medicare proposals in our Budget, for example, more closely align payments with the costs of providing care, encourage health care providers to deliver better care and better outcomes for their patients, improve access to care, and create incentives for beneficiaries to seek high value services.

Ensuring the Building Blocks for Success at Every Stage of Life

As part of the President's plan to bolster and expand the middle class, the Budget includes a number of proposals that help working Americans meet the needs of their families – including young children and aging parents.

Investing in Early Learning. High-quality early learning opportunities both promote children's healthy development and support parents who are balancing work and family obligations. Across the United States, many American families face real difficulties finding and affording quality child care and early education. In 2013, parents on average paid more than $10,000 per year for full-time care for an infant at a child care center –and in most States, child care costs more than the average cost of a year's in-state tuition and fees at a public 4-year college. The Budget outlines an ambitious plan to make affordable, quality child care available to every low-income and middle-class working family with young children; to build the supply of high-quality early learning opportunities through the Head Start and Early Head Start programs; and to invest in voluntary, evidence-based home visiting programs that have been shown to leave long-lasting, positive impacts on parenting skills, children's development, and school readiness. These

investments complement the Department of Education proposal to provide high-quality preschool to all four-year-olds from low- and moderate-income families and expand programs for middle-class children as well.

The President's child care proposal builds on the reforms passed by Congress in the bipartisan reauthorization of the Child Care and Development Block Grant enacted last fall. The proposal makes a landmark investment of an additional $82 billion over 10 years in the Child Care and Development Fund (CCDF), which by 2025 would expand access to more than 1 million additional children under age four, reaching a total of more than 2.6 million children overall in the program. At the same time, the proposal provides resources to help states raise the bar on quality, and design programs that better serve families facing unique challenges in finding quality care, such as those in rural areas or working non-traditional hours.

The Budget includes an additional $1.5 billion above FY 2015 to improve the quality of Head Start services and expand access to Early Head Start, including through Early Head Start – Child Care Partnerships. The proposal will ensure that all Head Start programs provide services for a full school-day and a full-school-year and increase the number of infants and toddlers served in high-quality early learning programs. It will also ensure that program funding keeps pace with inflation and that the program can restore enrollment back to the 2014 level.

The Budget also proposes $15 billion over ten years to extend and expand access to voluntary evidence-based home visiting programs building on research showing that home visits by a nurse, social worker, or other professional during pregnancy and in the early years of life can

significantly reduce child abuse and neglect, improve parenting, and promote child development and school readiness. More than 115,500 parents and children were served through home visiting programs in FY 2014, in addition to approximately 2,800 American Indian and Alaska Native parents and children served through tribal home visiting programs.

Research by the President's Council of Economic Advisers indicates that investments in high-quality early education generate economic returns of over $8 for every $1 spent. Not only that, studies show high-quality early learning programs result in better outcomes for children across the board – with children more likely to do well in school, find good jobs and greater earnings, and have fewer interactions with the criminal justice system. These programs also strengthen parents' abilities to go to work, advance their career, and increase their earnings. That is why the Administration has outlined a series of measures, including tax cuts for working families, to advance our focus on improving the quality of early care and education, while also dramatically expanding access to these important and cost-effective early learning services.

Supporting Older Adults. The number of older Americans age 65 and older with significant level of disability – defined as needing assistance with 3 or more activities of daily living – that are at greatest risk of nursing home admission, is projected to increase by more than 20 percent by the year 2020. With 2015 marking the year of the White House Conference on Aging, the Department's Budget request includes $1.7 billion for Aging Services within the Administration for Community Living for investments that address the needs of older Americans, many of whom require some level of assistance to continue living independently or semi-independently

within their communities. The Budget includes increased funding to support family caregivers and to expand home and community-based services and supports.

Improving Child Welfare. The Department's Budget also proposes several improvements to child welfare programs that serve children who have been abused and neglected or are at risk of maltreatment. The Budget includes a proposal that has generated bipartisan interest that would provide $750 million over five years for an innovative collaboration between the Administration for Children and Families (ACF) and CMS that would assist states to provide evidence-based interventions to youth in the foster care system to reduce the over-prescription of psychotropic medications. There is an urgent need for action: ACF data show that 18 percent of the approximately 400,000 children in foster care were taking one or more psychotropic medications at the time they were surveyed. It also requests $587 million over ten years in additional funding for prevention and post-permanency services for children in foster care, most of which must be evidence-based or evidence-informed. It includes savings of $69 million over ten years to promote family-based foster care for children with behavioral and mental health needs, as an alternative to congregate care, and provides increased oversight of congregate care when such placements are determined to be necessary.

Providing all Americans with Access to Quality, Affordable Health Care

The President's FY 2016 Budget request builds on progress made to date by focusing on access, affordability, and quality – goals that we share with Congress and hope to work on together, in partnership, moving forward. The Budget also continues to make investments in Federal public

health and safety net programs to help individuals without coverage get the medical services they need, while strengthening local economies.

Expanding Options for Consumers through the Health Insurance Marketplaces. The ACA is making quality, affordable health coverage available to millions of Americans who would otherwise be uninsured. On March 31, 2015, about 10.2 million consumers had "effectuated" coverage, which means those individuals paid for Marketplace coverage and had an active policy. At the same time, consumers are seeing more choice and competition. There are over 25 percent more issuers participating in the Marketplace in 2015 compared to 2014. Also, in 2015, nearly 8 in 10 Federal Marketplace customers had coverage options for $100 or less per month after applicable tax credits.

Partnering with States to Expand Medicaid for Low-Income Adults. The ACA provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the Federal poverty level through 2016, and covers no less than 90 percent of costs thereafter. This increased Federal support has enabled 28 states and the District of Columbia to expand Medicaid coverage to more low-income adults. In January, Indiana expanded their Medicaid program and is now bringing much needed access to health care coverage to uninsured low-income residents. Across the country, as of April 2015, over 12.3 million additional individuals are now enrolled in Medicaid and CHIP compared to the summer of 2013. As Secretary, I am personally committed to working with Governors across all 50 states to expand Medicaid in ways that work for their states, while protecting the integrity of the program and those it serves.

Improving Access to Health Care for American Indians and Alaska Natives (AI/AN). Reflecting the President's commitment to improving health outcomes across Indian Country, the Budget includes $6.4 billion for the Indian Health Service to strengthen programs that serve over 2.2 million American Indians and Alaska Natives at over 650 health care facilities throughout the United States. The request fully funds estimated Contract Support Costs in FY 2016 and proposes to modify the program in FY 2017 by reclassifying it as a mandatory appropriation, creating a longer-term solution.

Bolstering the Nation's Health Workforce. The Budget invests in our Nation's health care workforce to improve access to healthcare services, particularly in rural and other underserved communities. That includes support for over 15,000 National Health Service Corps clinicians, who will serve the primary care, mental health, and dental needs of nearly 16 million patients in high-need areas across the country. Nearly half of all current Corps providers work in rural communities. The Budget also creates new funding for graduate medical education in primary care and other high-need specialties, which will support more than 13,000 residents over 10 years, and advance the Administration's goal of higher-value healthcare that reduces long-term costs.

To continue encouraging provider participation in Medicaid, the Budget invests $6.3 billion to extend the enhanced Medicaid reimbursement rate for primary care services, and makes strategic investments to encourage primary care by expanding eligibility to obstetricians, gynecologists, and non-physician practitioners. A January 2015 study by University of Pennsylvania and Urban Institute researchers found that the availability of primary care appointments for Medicaid

enrollees grew by nearly 8 percentage points between 2012 and 2014, when the program was fully implemented.

Investing in Health Centers. Health centers are essential sites where America's most vulnerable populations can access the health care they need. This is true for over 174,000 individuals in Minnesota and over 286,000 individuals in Virginia. Health centers are also key in reducing the use of costlier care through emergency departments and hospitals. The Budget provides the resources to serve approximately 28.6 million patients in FY 2016, including an estimated 10.6 million rural Americans at more than 9,000 sites in medically underserved communities throughout the country.

Delivering Better Care and Spending our Health Care Dollars Wisely

If we find better ways to deliver care, pay providers, and distribute information, we can receive better health care and spend our dollars more wisely, all the while supporting healthier communities and a stronger economy. To build on and drive progress on these priorities, we are focused on the following three key areas:

Improving the Way Care is Delivered. The Administration is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients – with an emphasis on prevention and wellness. HHS believes that incentivizing the provision of preventive and primary care services will improve the health and well-being of patients and slow cost growth over the long run through avoided hospitalizations and additional office visits. The Administration's efforts around patient safety

and quality have made a difference – reducing hospital readmissions in Medicare by nearly eight percent, translating into 150,000 fewer readmissions between January 2012 and December 2013 and reducing hospital-acquired conditions by 17 percent from 2010 to 2013, saving 50,000 lives and decreasing health care spending by $12 billion according to preliminary estimates.

Improving the Way Providers are Paid. The Administration is testing and implementing new payment models that reward value, quality, and care coordination – rather than volume. HHS has seen promising results on cost savings with alternative payment models: already, existing Accountable Care Organizations (ACOs) programs have generated combined total program savings of $417 million to Medicare. To shift Medicare reimbursement from volume to value, and further drive progress in the health care system at large, the Department has announced its goal of making 30 percent of traditional, or fee-for-service, Medicare payments value providers through alternative payment models by 2016 and 50 percent by 2018.

Improving the Way Information is Distributed. The Administration is working to create transparency of cost and quality information and to bring electronic health information to the point of care – enabling patients and providers to make the right decisions at the right time to improve health and care. The Centers for Medicare & Medicaid Services (CMS) is making major strides to expand and improve its provider compare websites, which empower consumers with information to make more informed health care decisions, encourage providers to strive for higher levels of quality, and drive overall health system improvement. To improve communication and enhance care coordination for patients, the FY 2016 Budget also includes a

substantial investment ($92 million) in efforts supporting the adoption, interoperability, and meaningful use of electronic health records.

Leading the World in Science and Innovation

Investments in science and innovation have reshaped our understanding of health and disease, advanced life-saving vaccines and treatments, and helped millions of Americans live longer, healthier lives. With the support of Congress, there is more that we can do together. The President's FY 2016 Budget request lays the foundation to maintain our Nation's global edge in medical research. This Budget for the National Institutes of Health (NIH) supports ongoing research and provides real investments in innovative science.

Advancing Precision Medicine. The FY 2016 Budget includes $215 million for the Precision Medicine Initiative, a new cross-Department effort focused on developing treatments, diagnostics, and prevention strategies tailored to the genetic characteristics of individual patients. This effort includes $200 million for NIH to launch a national research cohort of a million or more Americans who volunteer to share their information, including genetic, clinical and other data to improve research, as well as to invest in expanding current cancer genomics research, and initiating new studies on how a tumor's DNA can inform prognosis and treatment choices. The Department will also modernize the regulatory framework to aid the development and use of molecular diagnostics, and develop technology and define standards to enable the exchange of data, while ensuring that appropriate privacy protections are in place. With the support of Congress, this funding would allow the Department to scale up the initial successes we have seen to date and bring us closer to curing the chronic and terminal diseases that impact millions of Americans across the country.

Supporting Biomedical Research. The FY 2016 Budget includes $31.3 billion for NIH, an increase of $1 billion over FY 2015, to advance basic biomedical and behavioral research, harness data and technology for real-world health outcomes, and prepare a diverse and talented biomedical research workforce. This research is critical to maintaining our country's leadership in the innovation economy, and can result in life-changing breakthroughs for patients and communities. For example, NIH estimates that it will be able to spend $638 million under this Budget request on Alzheimer's research, an increase of $51 million over FY 2015, which will position us to drive progress on recent advances in our understanding of the genetics and biology of the disease, including drugs currently in clinical trials, and those still in the pipeline.

Keeping Americans Healthy

The President's FY 2016 Budget strengthens our public health infrastructure, invests in behavioral health services, and prioritizes other critical health issues.

Investing in Domestic and International Public Health Preparedness. The health of people overseas directly affects America's safety and prosperity, with far-reaching implications for economic security, trade, the stability of foreign governments, and the well-being of U.S. citizens abroad and at home. The Budget includes $975 million for domestic and international public health preparedness infrastructure, including an increase of $12 million for Global Health Security Agenda implementation to build the capacity for countries to detect and respond to potential disease outbreaks or public health emergencies and prevent the spread of disease across borders.

As new infectious diseases and public health threats emerge, HHS continues to invest in efforts to bolster the Nation's preparedness against chemical, biological, nuclear, and radiological threats. This includes a $391 million increase for Project BioShield to support procurements and replenishments of new and existing countermeasures and to advance final stage development of new products, and an increase of $37 million to replace expiring countermeasures and maintain current preparedness levels in the Strategic National Stockpile.

Combating Antibiotic Resistant Bacteria. The Centers for Disease Control and Prevention estimates that each year at least two million illnesses and 23,000 deaths are caused by antibiotic-resistant bacteria in the United States alone. The Budget nearly doubles the amount of federal funding for combating and preventing antibiotic resistance within HHS to more than $990 million. The funding will improve antibiotic stewardship; strengthen antibiotic resistance risk assessment, surveillance, and reporting capabilities; and drive research innovation in the human health and agricultural sectors.

Addressing Prescription Drug and Opioid Misuse and Abuse. The misuse and abuse of prescription drugs impacts the lives of millions of Americans across the country, and costs the American economy tens of billions of dollars in lost productivity and increased health care and criminal justice expenses. In 2009, total drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time. In 2012 alone, 259 million opioid prescriptions were written – enough for every American adult to have a bottle. Heroin use has increased, and so have heroin-related overdose deaths. Between 2002 and

2013, heroin-related overdose deaths nearly quadrupled. As part of a new, aggressive, multi-pronged initiative, the Budget includes more than $99 million in new funding this year in targeted efforts to reduce the prevalence and impact of opioid use disorders. The Budget also includes improvements in Medicare and Medicaid, including a proposal to require states to track high prescribers and utilizers of prescription drugs in Medicaid, which would save $710 million over 10 years and bolster other efforts to reduce abuse of prescription drugs.

Improving Access to Mental Health Services. Mental and medical condition comorbidity results in decreased length and quality of life, and increased functional impairment and cost. People with serious mental illnesses have been shown to die earlier than other Americans and also face important barriers to obtaining medical care. The Budget includes an increase of $35 million, a total of $151 million for the President's Now is the Time initiative to focus on prevention and treatment of mental health conditions among students and young adults. Aiming to reach 750,000 young people per year and training thousands of additional behavioral health professionals and paraprofessionals, this investment represents a substantial step toward reducing barriers for individuals seeking care. The additional funds will be used to increase workforce capacity across the nation by expanding an existing partnership between Substance Abuse and Mental Health Services Administration (SAMHSA) and Health Resources and Services Administration (HRSA) that addresses the number of licensed behavioral health professionals available and by creating a Peer Professionals program to provide training for individuals who have experienced their own behavioral health issues to help reach those in need of treatment. In addition, this increase will raise awareness about mental health and substance use disorders and increase Americans' willingness to seek help through a social media campaign and other

outreach efforts. The Budget also supports ongoing research at the National Institutes of Mental Health to prevent the first episode of serious mental illness and change the trajectory of these disorders and continues support for evidence-based treatment of serious mental illness at an early stage through a five percent set-aside within the SAMHSA Community Mental Health Services Block Grant. Finally, the Budget proposes the elimination of Medicare's 190-day lifetime limit on inpatient psychiatric facility services, removing one of the last obstacles to behavioral health parity in the Medicare benefit.

Leaving the Department Stronger

The FY 2016 Budget request positions the Department to most effectively fulfill our core mission by investing in a number of key management priorities that will strengthen our ability to combat fraud, waste, and abuse, strengthen program integrity, and enable ongoing cybersecurity efforts, among other areas.

Strengthening Program Integrity. The FY 2016 Budget continues to build on progress made by the Administration to eliminate improper payments and fraud. The Budget includes new investments in program integrity totaling $201 million in FY 2016 and $4.6 billion over ten years. This includes, for example, the continued funding of comprehensive efforts to combat health care fraud, waste, and abuse through prevention activities, improper payment reductions, provider education, audits and investigations, and enforcement through the full Health Care Fraud and Abuse Control (HCFAC) discretionary cap adjustment.The FY 2016 Budget again requests the full discretionary cap adjustment be provided. This investment builds on important gains over the course of the past several years: from 2009 to 2014, programs supported by

HCFAC have returned over $22.5 billion in health care fraud related payments. Together, the Department's proposed program integrity investments will yield $22 billion in gross savings for Medicare and Medicaid over 10 years.

Reforming the Medicare Appeals Process. Between FY 2009 and FY 2014, the number of appeals received by the Office of Medicare Hearings and Appeals has increased by more than 1300%, which has led to a backlog that is projected to reach 1 million appeals by the end of FY 2015. The Department has undertaken a three-pronged strategy to improve the Medicare Appeals process: 1) Take administrative actions to reduce the number of pending appeals and more efficiently handle new cases that are entering the appeals process; 2) Request new resources to invest at all levels of appeal to increase adjudication capacity and implement new strategies to alleviate the current backlog; and 3) Propose legislative reforms that provide additional funding and new authorities to address the appeals volume. The FY 2016 Budget includes a comprehensive legislative package of seven proposals aimed both at helping HHS process a greater number of appeals and more efficiently handle new cases that are entering the appeals process, and requests additional resources for CMS, OMHA, and the Departmental Appeals Board to enhance their capacity to process appeals.

Improving Federal Spending Transparency. A key Congressional priority is implementation of the Digital Accountability and Transparency Act of 2014 (DATA Act) which seeks to improve the transparency of Federal spending. HHS plays a critical, government-wide role in its implementation promoting transparency, facilitating better decision making, and improving operational efficiency. The HHS Budget request includes $10 million to begin implementing

new data standards, assessing impacts, facilitating long term policies, processes, and systems, and establishing the Section 5 grants pilot in coordination with OMB.

Enhancing the Departments' Cybersecurity. The HHS Budget makes a significant investment in the security of the Department's information technology systems. The FY 2016 Budget includes $73 million for Cybersecurity, an increase of $32 million over FY 2015 enacted. HHS operational divisions are responsible for securing millions of individuals' personal health information, conducting highly sensitive biodefense work, reviewing new drug applications and clinical trial data, and issuing more grants than any other federal entity. The Budget reflects a recognition that protection of these systems is key to safeguarding Americans' personally identifiable information and ensuring that sensitive data does not fall into the wrong hands. Specifically, these funds will enable HHS to enhance threat monitoring capabilities, strengthen end-user security tools, and increase the capacity of the Trusted Internet Connection to support Department-wide IT security.

Conclusion

Members of the Committee, thank you for the opportunity to testify today. The President's FY 2016 Budget request for HHS makes the investments critical for today while laying the foundation for a stronger economy for the middle class. I am looking forward to working closely with Congress and Members of this Committee on these priorities moving forward so that together we can best deliver impact for those we serve – the American people. I welcome any questions you may have.

Chairman KLINE. Seriously, I want to thank you, Madam Secretary, for your ongoing efforts to keep us informed about the Department's progress in implementing the *Child Care and Development Block Grant Act of 2014,* as well as the opportunity for committee staff to communicate directly with your staff.

Can you update us, briefly, on the timeline for the release of guidance in the proposed rules in accordance with the Act?

Secretary BURWELL. I think, our staff has had an opportunity to go back and forth, and I think that's helpful as we're producing the guidelines. And I'm hopeful—I'm not sure which particular piece you're referring to, and so I want to make sure, and we can follow up on that. But overall, we are making progress and hope to get them out.

One piece that I would like to recognize with regard to the implementation of the authorities that you all gave us, there's an important piece of the budget that is related to the implementation, and one of the things that we were told with regard to the authorities, improve the quality, improve the safety, and also, improve our ability to serve communities that sometimes aren't being served, such as parents that work in different hours.

And so there's funding in the budget that we are talking about today on the discretionary side that I think it is important to do that, and I do want to raise that as a part of this conversation. That as part of doing the implementation, there is some funding to do that.

Chairman KLINE. Okay. I'm not sure that's exactly what I was getting at, but that's good. Thank you very much.

Secretary BURWELL. And I will get back on the specifics of the timing of the guidelines.

Chairman KLINE. Just trying to get a better feel for the timeline.

Secretary BURWELL. I'm happy to get back on exactly the timetable.

Chairman KLINE. And again, I very much appreciate the exchange between staffs, very, very helpful.

I want to take the remainder of my time, no doubt, and I'll try to be brief, but there is an issue having to do with the *Patient Protection and Affordable Care Act* that's just sitting out there that really, really needs to be addressed, and that's the maximum amount of out-of-pocket limits for cost sharing that I'm sure that you've heard about. I've heard from several employers recently about this unilateral change the Department made to cost sharing, maximum out-of-pocket limits under PPACA.

We can't seem to determine where this is coming from. The statute is pretty clear. There are two separate and distinct types of coverage, self-only and other than self-only coverage, each with respective out-of-pocket limits. Before this new rule, any combination of family member's out-of-pocket costs has counted towards the maximum of these out-of-pocket family coverage limits. Now, the Department has declared that starting in 2016, the individual out-of-pocket limit applies first before the family limit applies. That means the cost of the employer coverage will increase because insurance will pay 100 percent of the out-of-pocket costs sooner.

I understand that you're aware; I have been led to believe that you're aware of these concerns. I'm sure that employers have raised

this issue directly with you and your staff probably many times. They certainly have with us.

We'd like to understand under what statutory authority you did that? And then I'd like to enter into the record letters from the ERISA Industry Committee, the American Benefits Council, and the National Coalition on Benefits, conveying their grave concerns to the Department's new embedded maximum out-of-pocket limit rule.

[The information follows:]

[Additional Submissions by Mr. Kline follow:]

June 18, 2015

The Honorable Orrin Hatch
Chairman
Senate Committee on Finance

The Honorable Ron Wyden
Ranking Member
Senate Committee on Finance

The Honorable Lamar Alexander
Chairman
Senate Committee on Health, Education, and Pensions

The Honorable Patty Murray
Ranking Member
Senate Committee on Health, Education, Labor, Labor, and Pensions

The Honorable Paul Ryan
Chair
House Committee on Ways and Means

The Honorable Sandy Levin
Ranking Member
House Committee on Ways and Means

The Honorable John Kline
Chair
House Committee on Education and the Workforce

The Honorable Robert Scott
Ranking Member
House Committee on Education and the Workforce

Dear Senators and Representatives:

On behalf of the members of the ERISA Industry Committee (ERIC), I write to ask for your support on a matter of significant and immediate importance to large employers.

ERIC is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers, and we support the ability of our members to tailor health, retirement, and compensation benefits for millions of employees, retirees, and their families.

Recently the three government agencies that issue regulations under the Affordable Care Act (ACA), the Departments of HHS, Labor, and Treasury, crafted a rule with no basis in the law and made this policy change effective almost immediately, i.e., as of January 1, 2016.

This new policy proposal basically forces large employers to add an individual cost-sharing limit to family coverage, even though there is no provision in the ACA requiring this treatment, and some of our members will be forced to spend millions of dollars to make this change.

In addition to the lack of statutory justification, we take issue with this policy change for two reasons. First, it is not possible for employers to make a change of this magnitude in time for the start of the 2016 plan year.

Second, the Administrative Procedure Act prescribes how government agencies are to promulgate new rules. In general, the responsible agency must propose a regulation, accept comments during a set period of one or two months, and then finalize the regulation after weighing the comments from stakeholders.

No part of this process was followed when the Departments issued this policy change. Instead, the change was buried in the preamble to a lengthy set of rules on the ACA Exchanges, and its applicability to large employers was not clarified for several months.

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Our attached letter asks for the immediate withdrawal of this rule, laying out the unjustified actions by the Departments in considerable detail.

We would appreciate the opportunity to meet with you and/or your staff to support efforts to nullify this governmental overreach. My colleague, Gretchen Young (202/627-1920), or I would be happy to discuss this in more detail.

Sincerely,

Annette Guarisco Fildes
President & CEO
The ERISA Industry Committee

cc:
Members of the Senate Finance Committee
Members of the Senate Committee on Health, Education, Labor, and Pensions
Members of the House Ways and Means Committee
Members of the House Committee on Education and the Workforce

June 16, 2015

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Re: Maximum Out-of-Pocket Limits in Group Health Plans

Ladies and Gentlemen:

We are writing on behalf of The ERISA Industry Committee ("ERIC") to urge the Departments of Labor, Treasury, and Health and Human Services (the "Departments") to immediately retract the recent "clarification" of the rules applicable to cost-sharing limits in large group health plans.

The assertion that these plans are subject to the self-only limit when they provide coverage *other than* self-only coverage is not supported by the statute. The manner in which the Departments have created this new requirement is not consistent with the Administrative Procedure Act or with the most basic principles of fairness and good government. We ask the Departments to recognize that the requirement is unenforceable and to announce that it has been withdrawn.

The ERISA Industry Committee is the only national trade association advocating solely for the employee benefit and compensation interests of the country's largest employers. ERIC supports the ability of its large employer members to tailor health, retirement and compensation benefits for millions of employees, retirees and their families.

ERIC's members, which sponsor some of the largest private group health plans in the country, are committed to, and known for, providing high-quality, affordable health care. Our members expend considerable resources to maintain plans that cover many disparate populations across a wide range of geographic areas and that operate in all states and territories. These plans provide health care to millions of workers and their families with a high standard of cost containment, quality, and effectiveness.

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The Creation of the New Cost-Sharing Limit

Health and Human Services ("HHS") publishes annual notices of benefit and payment parameters applicable to health coverage in the individual and small group markets. In late November of 2014, HHS suggested in the preamble of the proposed benefit and payment parameters for 2016 that HHS might "clarify" that the annual cost-sharing limitation for self-only coverage "applies to all individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only." 79 *Fed. Reg.* at 70723 (Nov. 26, 2014). HHS did not propose any new regulation, or any modification of an existing regulation, to reflect this new rule.

When HHS published the final notice of benefit and payment parameters for 2016, HHS stated in the preamble that it was finalizing the proposal to apply the self-only limit to all coverage. 80 *Fed. Reg.* at 10824-25 (Feb. 27, 2015). This statement, too, appeared only in the preamble; the statement was not accompanied by any change in HHS's regulation describing the cost-sharing limits. The preamble acknowledged that some commenters had "raised concerns about whether this clarification was within the Congressional intent of the statute," but HHS did not respond to these concerns. Instead, HHS stated, "We believe that this clarification is an important consumer protection," without explaining by what authority HHS had created this consumer protection.

Because this new rule appeared in the preamble of a 129-page *Federal Register* notice dealing almost entirely with technical issues inapplicable to large group health plans, several months passed before most plan sponsors became aware of the change in the cost-sharing limits. When plan sponsors did become aware of the change, many of them assumed that the new rule applied only to individual and small group plans and did not affect large group health plans. This view was reinforced by the fact that neither the Labor Department nor the Treasury Department had endorsed the new cost-sharing limit, whereas these two agencies normally join with HHS in issuing Affordable Care Act (ACA) regulations applicable to large group health plans. Finally, on May 26, 2015, the Departments collectively issued informal guidance announcing their consensus view that HHS's earlier "clarification" applied to large group health plans. *See* ACA FAQ Part XXVII.

The Departments' Rule is Contrary to the Statute

Public Health Service (PHS) Act section 2707(b), as added by the Affordable Care Act, requires a group health plan to ensure that any annual cost-sharing limit imposed under the plan does not exceed the limits of section 1302(c)(1) of ACA.

Section 1302(c)(1) of ACA applies these cost-sharing, or out-of-pocket (OOP), limits to essential health benefits in non-grandfathered plans as follows:

> (c) REQUIREMENTS RELATING TO COST-SHARING.—
>
> (1) ANNUAL LIMITATION ON COST-SHARING.—
>
> (A) 2014.—The cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage for a plan year beginning in 2014 shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 for self-only and family coverage, respectively, for taxable years beginning in 2014.
>
> (B) 2015 AND LATER.—In the case of any plan year beginning in a calendar year after 2014, the limitation under this paragraph shall—

> (i) in the case of self-only coverage, be equal to the dollar amount under subparagraph (A) for self-only coverage for plan years beginning in 2014, increased by an amount equal to the product of that amount and the premium adjustment percentage under paragraph (4) for the calendar year; and
>
> (ii) in the case of other coverage, twice the amount in effect under clause (i).
>
> If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

These limits are set at $6,850 for self-only coverage and $13,700 for family coverage in 2016. (Comparable limits are $6,600 for self-only coverage and $13,200 for family coverage in 2015.)

The statutory language states explicitly that the OOP limit for coverage other than self-only coverage (which we call "family" coverage for the sake of simplicity) is twice the limit applicable to self-only coverage. The statute does not impose any other OOP limit on family coverage. Nowhere does the statute suggest that family coverage is subject to two out-of-pocket limits: an umbrella limit for aggregate costs incurred by all family members, and an embedded individual limit, equal to the self-only limit, for costs incurred by any individual member of the family.

The Departments' Rule is Contrary to HHS's Own Regulation

HHS's regulation at 45 C.F.R. § 156.130 interprets the ACA cost-sharing limits. This regulation was published in 2013, and HHS has not changed it in any relevant respect since then. The regulation states:

> (a) *Annual limitation on cost sharing.*
>
> (1) For a plan year beginning in the calendar year 2014, cost sharing may not exceed the following:
>
> (i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that that is in effect for 2014; or
>
> (ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.
>
> (2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:
>
> (i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.
>
> (ii) For other than self-only coverage—twice the dollar limit for self- only coverage described in paragraph (a)(2)(i) of this section.

Like the statute, the regulation clearly states that the cost-sharing limit for coverage other than self-only coverage is twice the limit for self-only coverage. The regulation does not state, or even suggest, that any other limit applies to family coverage.

HHS confirmed in the preamble of the 2013 regulation that the cost-sharing limit for family coverage is twice the limit for self-only coverage:

> Proposed paragraph (a)(1)(i) would address the limitation for self-only coverage and proposed paragraph (a)(1)(ii) would address the limitation for coverage other than self-only coverage; *the practical effect for coverage other than self-only coverage would be that the annual limitation would be double the limitation applicable to self-only coverage.*

78 *Fed. Reg.* at 12847 (emphasis added).

HHS announced the new embedded self-only limit two years later, in the preamble of a different regulation. It is unfair to portray the new limit as a "clarification" of HHS's regulation setting forth the cost-sharing limit for family coverage. No one reading the statute or HHS's regulation would guess that family coverage is subject to an embedded self-only limit applicable to each family member.

Because HHS has never amended the regulation to set forth its new cost-sharing requirement, group health plan sponsors and other interested parties reading the regulation in the future will reach the same conclusion that they reached in the past, the only conclusion one *can* reach from the wording of the regulation: that the sole out-of-pocket limit for family coverage is an umbrella limit that is twice as high as the self-only limit. HHS cannot expect those who seek to understand the cost-sharing limits in the future to read the preamble of every rule HHS has issued since 2013 to discover whether HHS has created a new cost-sharing limit that is not reflected in its regulation. Announcing a new rule in the preamble of an unrelated regulation, and pretending that the new rule is a "clarification" of a regulation that clearly and unambiguously states a different rule, is not an appropriate exercise of HHS's rulemaking authority.

The Departments' Rule is Contrary to Treasury's Interpretation of IRC § 223

Both the statute and HHS's regulation incorporate by reference the OOP expense limits applicable to high-deductible health plans under section 223(c)(2) of the Internal Revenue Code (Code). Code section 223(c)(2)(A)(ii) specifies the dollar limit on OOP expenses for self-only coverage. Like the ACA cost-sharing statute, Code section 223(c)(2)(A)(ii) states that the limit for family coverage is *twice* the limit for self-only coverage.

In the twelve years since Code section 223 was enacted, the Treasury Department has never suggested that a high-deductible health plan must apply the self-only OOP limit to each individual with family coverage; nor could the Treasury Department plausibly adopt this interpretation of Code section 223(c)(2). We are at a loss to understand how the Departments can take the position that the OOP limit for family coverage in Code section 223(c)(2)(A)(ii) has one meaning when applied to high-deductible health plans, and has an entirely different meaning when incorporated in ACA's OOP limits. Congress clearly stated that the ACA limit for family coverage was to be *the same as* the limit under Code section 223(c)(2)(A)(ii).

The Departments' Rulemaking Procedure is Contrary to the Administrative Procedure Act

Thus, the Departments' new cost-sharing limit is not an interpretation—still less is it a clarification—of existing law. Instead, it is an entirely new rule, unsupported by the statute and existing regulations. We do not think HHS has authority to apply the self-only limit to family coverage when Congress has stated clearly that the only applicable limit is *twice* the limit for self-only coverage. Even if HHS did have authority to promulgate a new cost-sharing limit, however, it must follow federal rulemaking procedures in order to do so.

Under section 553 of the Administrative Procedure Act, 5 U.S.C. § 553, a federal agency that wishes to create a substantive rule must publish the proposed rule in the *Federal Register*; must refer to the legal authority under which the rule is proposed; must give interested persons an opportunity to comment on the proposed rule; and must publish the rule in final form at least 30 days before its effective date. HHS has done none of these things.

The embedded self-only cost-sharing limit for family coverage has never been published in proposed or final form. Neither the proposed nor the final version of this new rule appears anywhere in the Code of Federal Regulations: instead, the rule is mentioned exclusively in the preambles of regulations that primarily address technical payment parameters for the individual and small group markets. The preambles do not say whether the new rule applies to large group health plans. The preambles do not state what the effective date of the proposed "clarification" is intended to be. The preambles do not explain what legal authority empowers HHS to create a rule contrary to the statute. In these circumstances, interested parties have never had an opportunity to comment on the proposal: HHS adopted the proposed rule before the sponsors of large group health plans were aware that it even applied to their plans.

These are not mere technical deficiencies. The purpose of the notice-and-comment rulemaking procedure is to inform the agency concerning the consequences of substantive rules that it proposes to adopt. When a proposed rule would impose new and unanticipated costs on private parties, it is especially important that the parties have a full and fair opportunity to be heard. As we explain below, the Departments' new cost-sharing limit will have significant and adverse effects on large group health plans. Because the Departments did not follow the rulemaking procedure prescribed by the Administrative Procedure Act when they adopted this new substantive rule, the rule is unenforceable. *See, e.g., Chamber of Commerce v. Occupational Health and Safety Administration,* 636 F.2d 464, 471-72 (D.C. Cir. 1980) (Bazelon, J., concurring) (federal agency must comply with the Administrative Procedure Act when it "effectively enunciates a new requirement heretofore nonexistent"); *Credit Union National Ass'n v. National Credit Union Administration Board,* 573 F. Supp. 586, 591 (D.D.C. 1983) (a substantive rule's nature cannot be "disguised by the simple semantic maneuver of claiming it 'clarifies or explains'").

The Departments' New Cost-Sharing Limit Would Adversely Affect Group Health Plans

The embedded self-only cost-sharing limit would have a significant impact on large employers. For any alteration of this magnitude, plan sponsors need sufficient time to be able to understand and implement the necessary modifications within their companies and with their third-party administrators ("TPAs") and carriers as well as to prepare their employees for a significant departure from the current rules.

ERIC recently polled its members on the impact of the new cost-sharing limit for family coverage. More than half of our members completed the poll. Of those who responded, 70% said that they

would be moderately or significantly affected by this new rule. Almost 95% of respondents identified their high-deductible health plans as the plans that would be affected.

As we have explained, Code section 223(c)(2) currently requires employers to apply only an umbrella out-of-pocket limit to their high-deductible health plans: no separate limit applies to the expense incurred by individual family members. The Departments' new rule would require these plans also to apply a self-only limit to each individual with family coverage. The new cost-sharing limit shifts medical costs to employers for individuals who have not reached, and might never reach, the umbrella limit under Code section 223(c)(3). Many employers face a major plan design change or revision to the pricing structure to accommodate the additional cost.

Almost more important, though, is that the rule change in many cases would be extremely disruptive to the plan operations of ERIC members. Those affected would face a huge time commitment to determine what design revisions would be necessary and how they should be implemented; most ERIC members by this point in the year have already settled on at least a preliminary pricing structure, including employee contributions, for 2016.

Many ERIC members do not know if their TPAs or carriers are capable of complying with the new limits on cost-sharing, let alone how much it would cost and what change in the price structure would be necessary to accommodate the increase. For instance, some ERIC members use pharmacy benefit managers ("PBMs") for their self-insured plans, and it is not clear if these PBMs would be able to administer an "embedded" OOP limit for a high-deductible health plan that has a shared medical/drug deductible. Other ERIC members have heard that their current vendors may not be able to handle the new rules within their current platforms; some have said that they must change the deductible limits if the OOP limits are changed.

Once the plan design changes are decided upon, significant systems and operations modifications would be required to implement the new cost-sharing limits. After that, our members would face the considerable task of changing all of their open enrollment material for 2016 and, of course, communicating with their employees and their families would be both complicated and time-consuming.

ERIC's recommendation: The Departments' "clarification" of the ACA cost-sharing limits must be withdrawn immediately. We believe that the rule is unenforceable in any event, but the Departments' recent assertion in FAQ Part XXVII that they intend to enforce the rule starting in 2016 has created concern that employers will be targeted with enforcement activity that is expensive and disruptive even if it is ultimately unsuccessful.

Immediate withdrawal is imperative as plan sponsors are literally in the midst of finalizing their benefits for the 2016 plan year; it is essential that they know very, very quickly that they will be able to finalize their plan designs and operations for 2016 without having to accommodate this wholly unexpected and unjustified policy change.

If the Departments wish to promulgate a new substantive rule of this magnitude, they must follow the rulemaking procedure prescribed by the Administrative Procedure Act, and they must identify the source of their authority to create the rule. They must give employers and other affected parties

adequate notice and sufficient time to comment. Any substantive rule the Departments ultimately adopt must give employers time to understand and implement the new requirement.

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Thank you for your consideration of these comments. We would be pleased to discuss this letter with you if you have any questions.

Sincerely,

Annette Guarisco Fildes
President & CEO
The ERISA Industry Committee

AMERICAN BENEFITS COUNCIL

June 17, 2015

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Re: Requirements to "Embed" Maximum Out-of-Pocket Limits

Dear Assistant Secretary Borzi, Dep. Assistant Secretary Irwy and Director Counihan:

We write to express our serious concerns regarding recent agency Frequently Asked Questions ("FAQ") guidance requiring "embedded" individual out of pocket maximums for insured large group and self-funded group health plans for 2016 policy and plan years.

As discussed below, we believe the Departments' recent interpretation regarding the maximum out-of-pocket ("MOOP") limits under Public Health Service Act ("PHSA") 2707(b) is inconsistent with the plain language of the statute and Congressional intent.

The Council and its members are particularly concerned that the process used to

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impose this new requirement lacked prior and clear notice of the Departments' intent to apply the embedded MOOP interpretation to large group insured and self-funded plans. The timing of this guidance is highly problematic in that most large plan sponsors have finalized their plan designs for plan year 2016 and have insufficient time to comply with this new requirement.

Another significant concern is that this "embedded" MOOP requirement increases plan costs at a time when employers are faced with the challenge of lowering plan costs in order to avoid the 40 percent excise tax on health benefits effective 2018.[1]

In light of these concerns, we request that the FAQ guidance be rescinded and the Departments use notice and comment rulemaking for any future implementation of the PHSA 2707(b) cost-sharing limits. As a first step, we urge the Departments to issue an immediate clarification that the recent FAQ guidance will not apply to 2016 plan or policy years.

BACKGROUND

PHSA Section 2707(b), as added by the Affordable Care Act ("ACA"), provides that a non-grandfathered group health plan shall ensure that any annual cost sharing imposed under the plan does not exceed the limitations provided for under section 1302(c)(1) of the ACA. Under Section 1302(c)(1), an enrollee's out-of-pocket costs for essential health benefits are limited.[2]

In the Preamble to the final U.S. Department of Health and Human Services (HHS) Notice of Benefit and Payment Parameters for 2016 ("NBPP") (80 FR 10750) issued February 27, 2015, HHS stated that under Section 1302(c)(1) of the ACA, the self-only maximum annual limitation on cost sharing applies to each individual, regardless of whether the individual is enrolled in self-only coverage or in coverage other than self-only (for example, family coverage). The HHS interpretation effectively requires an "embedded" individual out-of-pocket maximum such that, even within a family plan, an individual's cost sharing for the essential health benefits ("EHB") may never exceed the self-only annual limitation on cost sharing.

The HHS guidance is specific to how insurers comply with the NBPP with respect to

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[1] Internal Revenue Code 4980I

[2] For plan or policy years beginning in 2016, the maximum annual limitation on cost sharing is $6,850 for self-only coverage and $13,700 for other than self-only coverage.

qualified health plans sold in the health exchange. The HHS guidance created uncertainty for employers as it did not address the applicability of HHS' embedded MOOP interpretation to large group insured and self-funded plans.

On May 12, 2015, the U.S. Department of Labor ("DOL") posted the previously issued HHS guidance on its website regarding the embedded individual out of pocket maximum, but still did not clarify whether the HHS guidance applied to all non-grandfathered plans, or only the small group and individual insurance market.

The Departments finally clarified that the new embedded MOOP requirement applied to all non-grandfathered plans, including self-funded and large insured group health plans in ACA FAQs Part XXVII issued on May 26, 2015.[3]

"EMBEDDED" MOOPS ARE NOT SUPPORTED BY STATUTE OR CONGRESSIONAL INTENT

We believe that the Departments' interpretation regarding the MOOP limits is not consistent with the plain language of the statute and is not what Congress intended.

ACA Section 1302(c) requires that the "cost-sharing incurred under a health plan with respect to self-only coverage or coverage other than self-only coverage...shall not exceed the dollar amounts in effect under section 223(c)(2)(A)(ii) of the Internal Revenue Code *for self-only and family coverage, respectively.*" HHS proposed and finalized an interpretation that for purposes of the cost-sharing requirements, the self-only coverage limit for the annual limitation on cost sharing applies to all individuals regardless of whether the individual has other than self-only coverage. Section 1302(c), however, states that the limits apply *respectively.* This would mean that cost-sharing under <u>self-only</u> coverage cannot exceed the 2014 <u>self-only</u> high deductible health plan ("HDHP") limit adjusted for ACA purposes as outlined under section 1302(c)(1)(B). Similarly, cost-sharing under <u>family</u> coverage cannot exceed the adjusted <u>family</u> HDHP limit.

Code Section 223 (the HDHP provision) is clear that the maximum out-of-pocket limits are separate—one limit for self-only coverage and another limit for family coverage (or coverage other than self-only)—and there is nothing in Code Section 223 which would require an embedded limit on self-only cost-sharing under a family plan. Since Code Section 223 does not require a separate, embedded limit on self-only cost-sharing (in fact, the HDHP rules set specific and *separate* self-only and family cost-

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[3] FAQs About Affordable Care Act Implementation (Part XXVII) May 26, 2015

sharing limits) it strongly implies that, in Section 1302(c), Congress intended one limit for self-only coverage and a separate limit for family coverage.

IMPACT ON LARGE GROUP HEALTH PLANS

Applying the embedded MOOP interpretation to the large group insured and self-funded plans will result in unanticipated costs for 2016 policy and plan years. With 2016 fast approaching, most large plan sponsors have finalized or are very near finalizing their plan designs for the 2016 plan year. To require these sponsors to make plan changes at this late date to implement an embedded MOOP requirement would entail significant time and expense (for example, consulting actuaries to determine premium rates for the modified coverage, implementing programming changes, amending enrollment materials and communicating plan benefit changes to employees and beneficiaries).

Applying the embedded MOOP to the large group insured and self-funded plans is especially problematic given the looming threat of the 40 percent tax on employee benefits, which is effective 2018. Employers are currently making changes to their plans to avoid triggering the 40 percent tax. The embedded MOOP interpretation will make avoiding the tax even more difficult for large group and self-funded plans.

Implementation of the 40 percent tax and benefit mandates --including the embedded MOOP interpretation - are at odds with each other and put employers in an untenable position. On the one hand, the 40 percent tax is forcing employers to decrease benefits and increase employee cost-sharing - on the other hand, mandates such as the MOOP interpretation require employers to increase benefit levels. This is not a sustainable path for employer-sponsored coverage.

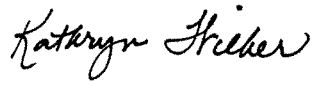
FUTURE INTERPRETATIONS OF ACA COST SHARING LIMITS

To the extent the Departments intend for the embedded MOOP interpretation to apply to large group insured and self-funded plans, sound public policy strongly advocates in favor of the Departments only doing so through a proposed rulemaking with a public comment period. In fact, the Departments had stated an intent to do so in the Preamble to the 2013 EHB final rule in which HHS explained that the Departments interpret the out of pocket maximum in Section 1302(c)(1) to apply to all markets, including self-insured and large group insured plans, and further stated that the Departments *intend to engage in future rulemaking to implement Section 2707(b) of the PHSA* and noted that Section 45 CFR Section 147.150(b), the regulation section that would apply to insured group health plans, would be reserved (i.e., no applicable regulations were issued). This intent to engage in future rulemaking to implement PHSA 2707(b) was reiterated in FAQs issued simultaneously with the 2013 EBH final rule.

* * * * *

Thank you for your consideration. We look forward to working with you to resolve these important concerns.

Sincerely,



Kathryn Wilber

C: Amy Turner, EBSA, U.S. Department of Labor
Christin Young, CMS, HHS

National Coalition on **BENEFITS**

June 22, 2015

The Honorable Thomas E. Perez
Secretary
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

The Honorable Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

The Honorable Jacob J. Lew
Secretary
U.S. Department of Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

Dear Secretaries Perez, Burwell and Lew:

The National Coalition on Benefits ("NCB") would like to express serious concern over a recent policy change that fundamentally alters the application of out-of-pocket (OOP) limits to large, non-grandfathered group health plans. This action was initiated by the Department of Health and Human Services ("HHS") as a note in the Preamble of a rule, and then applied to the large group market through FAQs.

The new policy will have a significant impact on our health plans at a time when plans have generally completed their benefit and compliance reviews. In addition, many employers are struggling to comply with the complex administrative and financial challenges imposed by the Affordable Care Act ("ACA"). We request that this policy change be withdrawn immediately.

The NCB is a coalition of national businesses and employer associations established to support the employer-sponsored health care system and ensure that companies can continue to provide health benefits in a uniform manner nationwide. NCB works with Congress and the Administration to ensure that federal and state health reform initiatives preserve, rather than

erode, protections guaranteed by the Employee Retirement Income Security Act ("ERISA"). More than 150 million Americans obtain coverage through employer-sponsored health plans and, increasingly, a core component of the services that these plans are expected to deliver relates to quality improvement, patient safety and wellness.

Core issue and chronology: The ACA imposes annual cost-sharing limits on essential health benefits in non-grandfathered group health plans for self-only and family coverage. These OOP limits will be $6850 for self-only coverage and $13,700 for family coverage in 2016. The statute provides for one OOP limit for ***self-only*** coverage, and one OOP limit for ***family*** coverage. The statute does *not* provide a *third limit* applicable to individuals in family coverage.

In February of 2015, in the preamble to the final HHS Notice of Benefit and Payment Parameters for 2016, HHS announced that the annual limitation on cost sharing for self-only coverage would apply to all individuals, regardless of whether the individual is covered by a self-only plan or by family coverage. This policy "clarification" does not appear in the regulatory text of the final rule, and does not address its application to large employers.

On May 8, 2015, HHS published an FAQ stating that the OOP limits would also be applicable to high-deductible health plans ("HDHPs"). On May 26, 2015, the Departments of HHS, Labor, and Treasury collectively issued "ACA FAQ Part XXVII," which takes the position that the "clarification" of the OOP limits announced in the preamble to the 2016 Notice would also apply to large non-grandfathered group health plans, whether insured or self-funded, including HDHPs. The FAQ went on to provide that the clarification would apply for plan or policy years that begin in or after 2016.

Impact on plans: Most large employers have nearly completed their preparations for the 2016 plan year, including any benefit design modifications, systems accommodations, operational implementations, and employee communications related to their existing plans. Compliance with this policy clarification will increase the cost of coverage, with estimates ranging from 2% to 7% of plan expenses.

The policy "clarification" should be withdrawn immediately: While the statute does not contemplate this change, it is still clear that under the Administrative Procedure Act ("APA") the change should have been promulgated as a proposed rule.

NCB encourages the Agencies to withdraw this policy change, which was not completed through rulemaking.

The NCB believes that employers' ability to voluntarily offer and maintain benefit plans is an integral part of our health care system. This system cannot continue, however, if employers are not provided with the regulatory consistency, simplicity and predictability they need to continue to provide high-quality, cost-effective benefits to their workers and their families.

Thank you for considering our comments on this important issue. We look forward to meeting with you to discuss these concerns.

Sincerely,

The National Coalition on Benefits

cc:

Phyllis C. Borzi
Assistant Secretary of Labor
Employee Benefits Security Administration
U. S. Department of Labor

Kevin Counihan
Director & Marketplace Chief Executive Officer
Center for Consumer Information and
Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services

Mark Iwry
Senior Advisor to the Secretary and Deputy Assistant Secretary for Retirement and Health Policy
U. S. Treasury Department

Chairman KLINE. The letters also convey that compliance will not be possible by 2016 given that employers' plans are already set for next year. It wasn't until May, when additional guidance was issued, that most large employers knew this change applied to them. So there's real confusion out there, Madam Secretary. And, again, I'm fairly confident that you are hearing some of this directly, but I want to make sure you heard from me.

Can you commit to at least delay the impact of this, really, significant rule change for at least a year, and if not, why not?

Secretary BURWELL. So with regard to the issue of the question of delay, we are now hearing and receiving feedback. We want to take and incorporate that and determine what we should do to move forward. I think it's important to note why the change was put in place. And the change was actually put in place about the consumer and the fact that when one consumer in a family hits that individual limit and the question of should they hit that family limit and whether you should aggregate or the individual. Because, I think actually when consumers purchase and how the consumer thinks about this issue, I hear and understand, and we are hearing from the companies in terms of how they think about the question of the maximum out-of-pocket limit.

But if you are an individual in a family, do you think that limit is your individual limit, and then there's a broader family limit for all. And so once you've hit your individual limit, what would happen is you would keep going. And so you would not have those things paid for, and you signed up in a place where you thought your individual limit was your individual limit and your family limit was for all members of the family. And so that's how the consumer has tended to think about it and at least what we've heard from the consumer side of it.

And so that is why we have gone forward. We are hearing comments and want to incorporate those comments and understand if it is implementable.

Chairman KLINE. Well, I understand the point of view of the consumer here, and I'm not making light of that. But the statute we think is pretty clear. And because there is so much confusion out there, and there is the uncertainty and arguably the inability to comply, we are hopeful that you will commit sooner rather than later to a delay of this rule change.

And I'm going to try to—it's already too late. The light has turned red for me.

But, Mr. Scott, you're recognized.

Mr. SCOTT. Thank you, Mr. Chairman.

Thank you, Secretary Burwell, for being with us today. I wanted to ask you a few questions about the *Affordable Care Act,* but, first, I want to thank you for your Department's outreach efforts, particularly Joanne Grossi, who is the regional director in my area has just been outstanding in outreach into the community, making sure that people know about it, and during the signup period was all over my district. So I'm sure she was all over the region.

Can you say a word about what the *Affordable Care Act* does for people with insurance in terms of preexisting conditions and job lock?

Secretary BURWELL. So two different things that I think it does. With regard to preexisting conditions, it creates a situation where anyone with a preexisting condition is able to get insurance. And so whether it's the people that I've met as I traveled across the country that are concerned for their children as their children get older, if it's child that has asthma or other conditions or someone who has actually gotten cancer and is now well and their ability to know that they won't be locked out. So preexisting conditions are something that are no longer something that creates both health and financial worry for people in the system.

And with regard to the question of lock out and job lock, there are many people who wouldn't make changes because of their fear of losing coverage. And that is a part of the numbers that the chairman stated in terms of the changes that occur. Because with regard to the employer-based market, we have not, in the two years that the *Affordable Care Act* has been up, seen that shift from employer-based coverage in terms of the reduction and percentage of employees that are in employer-based coverage. We haven't seen that shift.

And some of the estimates are about people, though, who will choose to make a decision to go do something entrepreneurial if they want to start a business or make other changes in their lives. And so the lock that was created because they were fearful of losing coverage doesn't exist because they have an option, and that option is through the marketplace.

Mr. SCOTT. And what has happened to the growth in healthcare costs since the passage of ACA?

Secretary BURWELL. With regard to the growth of healthcare costs, thinking about it in terms of we've had some of the lowest price growth per capita that we have seen in 50 years in terms of slowing of that growth. I think when discussing the question of growth and cost growth, while it's a hard thing to do and recognize, one needs to look at historical growth and then what growth is.

And so if we look at what was released recently in the Medicare trustee's report, which is let's reflect on the public sector costs of this growth, what we saw is growth of 1.2 percent over the period of the last four years. What we saw in that period before then was 3.6 percent growth. And so what we've seen is a slowing in a lot of different places, both the public and the private, of that growth.

Mr. SCOTT. And the programs under your jurisdiction, can you say a word about the effect of the sequestration if we don't do something about the sequestration?

Secretary BURWELL. So as we look at this issue of being funded at the lowest level in a decade when one accounts for inflation, it is across the entire Department, and whether that's an issue of Head Start or child care that we'll focus on in this committee, it also is in places like the NIH and our research or the CDC, who has been so active this year in so many ways, whether that's Ebola or measles, and also in places like the FDA, who are doing things like making sure our food is safe and that we are watching and taking care and that our drugs and diagnostics are safe.

So it's across the entire Department. Another place that this particular committee is interested in, I know, is the older Americans

and the programs that we have there to support those older Americans around food and transportation as well as elder justice.

Mr. SCOTT. Thank you. Head Start is not in the Department of Education. It's in the Department of Health and Human Services. Can you explain why it's important—what the services to low-income children get remaining in Health and Human Services that it would not be available in just an educational program and why Head Start is so important?

Secretary BURWELL. So I think that the program of Head Start, we have it as part of our continuum at HHS that starts with home visiting. And thank you to all of you all who supported the sustainable growth rate bill that had the extension of the home visiting an evidence -based program that starts with that care in the home, visiting the home, and helping start children on the right track. And we believe that continuum as well as the changes in the authorizations in Head Start that you all have done to push to improve quality that is all part of a continuum, and the continuum is related to the issues that we work on broadly at HHS.

And whether that's starting the mother on the right trajectory with regard to her maternal health so the child is born in a certain environment that has been taken care for 9 months and then continuing that early care, starting that learning early and that brain development. The science that we know, and having a 5 and 7-year-old, of how quickly that neurodevelopment is occurring and how fast they are learning, sometimes it surprises me.

But it is what we believe is a continuum of both health and the building block of healthy productive lives that we use at HHS.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Dr. Foxx.

Ms. FOXX. Thank you, Mr. Chairman.

And Madam Secretary, welcome to our hearing. Madam Secretary, I appreciate you bringing up the *Older Americans Act*. We're looking at—the Committee is looking at ways to promote best practices to combat elder abuse. And I wonder if you could talk a little bit about how the Department is working with other agencies to protect vulnerable elders?

Secretary BURWELL. So working across the Department and obviously, the Department of Justice is a partner with some of the work we do. But most recently, whether it's with our Departments and States, as well as other stakeholders.

The White House Conference on Aging, we took an approach this year, where we actually went out to communities across the country, and this was one of the pillars and issues that we focused on and used that as an opportunity to bring in the engagement and involvement of both ideas as well as how we can implement better as a Department in terms of the issue of elder abuse. So we're seeking that input to improve what we are doing both within the U.S. Government, but also with a number of the players that implement and those are stakeholders on the ground and States. Because many of the programs are actually delivered and implemented at that level.

Ms. FOXX. And would you discuss a little bit those delivery models of the *Older Americans Act* and what makes them work well?

Working with other agencies, I'm sure, is the right thing to be doing, but are there ways to implement these similar delivery models across other programs across the country, and how is the Department providing leadership to do that?

Secretary BURWELL. So I think two—there are many things, but I'll just focus in a short time on two things that I think are important in this space.

One is actually the awareness of the issue. Elder abuse is something that is not an issue that many focus on and whether these providers and the organizations in the community are a part of recognizing the issue. It is a little like the issue with victims in trafficking, creating a greater awareness of it is an important thing to do.

I think the other thing that we think is important to do, is that when these acts occur that justice is served, so people know that when they are taking advantage of the elderly, and that's a place where we need to continue to work with State and local officials on that as well as Federal.

And I think one very specific example of that is the recent takedown that was done on Medicare. You all probably know that our most recent takedown, which was a joint effort with us, DOJ, the FBI, HHS, OIG, and CMS. It was over $700 million in false billing. And many of those examples were around elder justice issues where patients were being told they were being treated for dementia and were simply being moved from one location to another being charged for that and Medicare was therefore charged. So I think it is the combination of those kinds of things that we trying to bring together.

Ms. FOXX. Thank you very much for that.

Congressman Scott brought up Head Start performance standards. We know that Head Start is the largest program we have working with young children. But we're concerned about the impact of the new regulations that you're putting out there.

Our reauthorization in 2007 required you to have regulatory revisions not result in the elimination of or reduction in quality and scope of services, but you are talking about a reduction of 126,000 children's slots, elimination of 10,000 teachers' jobs. How can you ensure that the revisions that you are proposing are in compliance with the 2007 law?

Secretary BURWELL. We have done three issuances of regulations with regard to implement the law, and this is the third of those. One of the things we did was make sure they are serving low-income communities, the other was making sure that there were reviews and people had to reapply for the money, the grantees. And so we set standards there, this is the third part. And in this part, we are using evidence-based studies to improve the quality and safety, which we believe that the authorization is what it told us to do.

One of the things that the Chairman mentioned, that I think is important to mention, is we got rid of one-third of the guidelines in terms of simplifying and making it easier. With regard to some of the things that you are referring to, I think you are referring to the extension of the day and the year. And the evidence that we have seen, all the scientific evidence shows, that moving from three

and a half hours to six hours is an important effort to provide the quality that we need to provide and the summers, having two children right now going through their summer, what they lose if they do not have that kind of continued education.

We propose the amount of money that it would take in our budget. We're hopeful that we can move forward on that. And the other thing is if grantees can't meet that and have reason not to, there is waiver ability.

Ms. FOXX. Thank you.

Chairman KLINE. The gentlelady's time has expired.

Mr. Hinojosa.

Mr. HINOJOSA. Thank you, Chairman Kline and Ranking Member Scott. I strongly support the Health and Human Services budget request and ask that we work together to forge a consensus on how to ensure that our families continue to have access to quality healthcare coverage and adequate funding for Head Start.

We can invest in our preschool programs today or in juvenile detention tomorrow. We have heard Pope Francis deliver a very strong message all over the world urging leaders like us. The Pope says, we must make the right amount of investments to address poverty found in older senior persons and children in low-income families.

Madam Secretary, thank you for your testimony on the Department's enormous progress we have made since the enactment of ACA. It's a pleasure to have you testify before this committee.

Today, in my congressional district, because of the *Affordable Care Act* there are over 100,000 individuals who now have health insurance and 88,000 seniors who are now eligible for Medicare preventive services without paying any copays, co-insurance, or deductible. We know that another program, Head Start, is a crucial developmental program in my congressional district known as the lower Rio Grande Valley. This program serves between 15,000 to 20,000 children and families. Head Start has made a significant impact on improving the opportunities for eligible children, especially our Nation's Latino and African American youth. Thank you for your strong budget support for this program.

My first question, what is at stake for our Nation if we ignore the ever-growing body of research, and we fail to sufficiently invest in quality early learning for our Nation's minority children?

Secretary BURWELL. So I think this is why this area in our budget, and we discussed the Head Start portion of it, but there's also the child care proposal. And part of the child care proposal on the discretionary side comes to part of the chairman's question in terms of implementing the authorization. That's on the discretionary side. The broader proposal that we have, which is a larger mandatory proposal, is about making sure that there's access on this continuum.

And so what we do is we take care of that child from the moment of that home visiting and the pregnancy through those early years of education, and that we do that both for those at the lowest level of income, and Head Start is focused on that. But child care, and that's a part of what we're proposing is child care for working families, that there is supplement so that they can afford that, up through that school age. And so what we are trying to do is create

a continuum, which we think was a part of the authorization and some of the concepts of the authorization.

This budget funds it fully. We think it's one of the most important priorities. And as we reviewed the budget and put it together, it is a place where we made choices that we would prioritize and put a lot of our dollars because we think it is so important to the long-term health of those children and the well-being of our society.

Mr. HINOJOSA. I agree with you, and I recommend that you consider adding more emphasis on early reading and writing for children from cradle through the fourth year so that they can love books and improve their vocabulary and be able to stay at grade level and do well.

In my district, the majority of the uninsured population falls under the Medicare—excuse me, falls under the Medicaid coverage gap and does not qualify for assistance in healthcare marketplace. According to the Kaiser Family Foundation, up to 950,000 uninsured people would gain healthcare coverage if the State of Texas decided to expand Medicaid. What justifications, if any, have you heard or received, and how has HHS responded to discussions that you've had with the governors like Abbott in Texas?

Secretary BURWELL. So with regard to the conversations with governors, I spent the weekend at the National Governors Association, and the year before that I did as well. In terms of any concerns that governors have, what I want them to know is we want to expand the program, we want to expand the program in a way that implements the statute, which is about expanding access and doing it for low income populations so it's affordable. But we want to do that in ways that works for States.

And so I think in terms of answering concerns and questions, whether it's the negotiations that we did with Governor Pence, and I personally participated in a number of other governors so that we can make sure that we do this in a way that serves the citizens, the States, that may have different needs. And so that's, in terms of one of the issues that comes up. I want to clearly articulate – I want to work with governors and their states.

Mr. HINOJOSA. Thank you. I yield back.

Chairman KLINE. The gentleman yields back.

I'm going to yield to Dr. Roe, but I want to give members a heads-up here. We're looking at a clock and time. I'll be recognizing Dr. Roe for five minutes and probably Ms. Davis, maybe Mr. Walberg and Mr. Grijalva. After that we are going to have to start dropping down. So just start tailoring your questions we are going to go to four minutes and see if that will make it. I am trying not to go to three or two, but I want to give everybody a chance to be involved in this conversation.

Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here. Just some QFRs, some questions I want to bring up to begin with and then we'll get to the questions. These are things I want your shop to answer.

One is the Medicare wage index or area wage indexes. If you look at those around the country, it was never intended to be like that. The 20 of the highest are in California and Massachusetts, and 14 of the lowest are in Alabama and Tennessee. For instance, what

you get paid in Santa Cruz, California, is 1.7 with the Medicare area wage index and it is 0.73 where I live. It's putting us out of business. And that needs to desperately be looked at.

The second thing I want to bring up, and I want to know what your solution for that is, the second thing I want to know are the RAC audits. The RAC audits, certainly, we are all against fraud and abuse. But in my State, the Medicare comes in, does these audits, withholds the payments, and we win 72 percent of them. And now, the backlog is so long, you can't get in front of anybody to get your money back that you've earned, and that's unfair. And I think you absolutely need to redo the RAC audits.

And thirdly, this is a much deeper one, and it may take some time, but Medicare is on an unsustainable course, as you well know. Last year, in 2014, Medicare spent $613 billion, and we took in $304 billion in premiums. That's unsustainable. And since its inception, $3.6 trillion, negative, of premiums over what we spent on the program. I'd like to know what your recommendations are to put this on a more sustainable course. Yes, through our reform we did save $2.9 trillion over the budget window. That's a start. But I would like to know what those other issues are.

And regrettably, I've got to ask some questions now that I don't like asking, but I think are extremely important to ask. And also one last thing, question was for the QFR on IPAB. Do you think one person, that would be you now currently, sitting in that seat, should have the power to determine how Medicare dollars are spent if it goes over this formula? I'd like to know that, because there's nobody on that 15-panel board right now.

Recently, we've seen two videos that showed Planned Parenthood physicians basically having wine and eating a salad bargaining over the harvesting and sale of dismembered baby parts. I found this incredibly offensive to me as a physician and as an obstetrician. Have you seen those videos?

Secretary BURWELL. I have not seen the videos. I've read the articles about them.

Mr. ROE. Well, last week in the Wall Street Journal, it reported that you couldn't comment because you haven't seen it, but you need to see those, Secretary Burwell, as quickly as you can. And it's only eight or ten minutes, but you need to look at those videos to see what the rest of us have looked at.

And given Planned Parenthood's, which I think is horrific conduct, Americans may be troubled to realize that Planned Parenthood gets over $500 million a year, much of it through your shop, through Medicaid and Title X funding. Having said that with a significant financial relationship, could you tell us what you've done to investigate these activities?

Secretary BURWELL. So, first, because it's so related to the budget issues we're discussing today, the RAC issues and the backlogs, we have put together a strategy that includes, it is just because it is such an important issue and appeal, so I just want to make sure there is a budget issue in terms of extending the number of people that we can have to review the appeals because there are legal judges that we have to bring in.

Second, there are statutory changes. And on the Senate side a bill is moving to make changes that will help us, and third, admin-

istrative actions, including settlement. So, I just want to raise that because it is important.

I want to go on to the broader issue that you've raised. With regard to the issue, I want to start by saying this is an important issue that people have passion deeply on both sides of the issue and whether that's the issues of research that are important for eyes, degenerative diseases, Down's syndrome, Autism, or the issue of belief. And I want to start there. With regard to the question of—

Mr. ROE. Let me stop you, because my time is about up. Have you had any contact with Planned Parenthood yet? On this issue.

Secretary BURWELL. I'm sorry?

Mr. ROE. With regard to this issue, this sale of the . . .

Secretary BURWELL. No. Planned Parenthood's funding, the $500 million, I think you mention I think is a number that is a State number. And with regard to Medicaid and States those are issues where—

Mr. ROE. 41 percent of their funding comes through the Federal taxpayers. And let me just say before my time runs out, because we are limited in time. I found it absolutely amazing that Planned Parenthood could complain about a woman having an ultrasound before she terminates her pregnancy, and then uses an ultrasound so they can harvest body parts to be sold for fetal tissue. I found that absolutely astonishing.

Mr. Chairman, I yield back.

Chairman KLINE. The gentleman yields back.

Ms. Davis, you are recognized.

Mrs. DAVIS. Thank you, Mr. Chairman. And I'm sure there will be plenty of investigations on that by my colleagues.

But I wanted to go on and just ask Mr. Chairman for unanimous consent that the CBO's score showing that a repeal of the *Affordable Care Act,* which would add $137 billion to the deficit in the next decade, that this report be entered into the record.

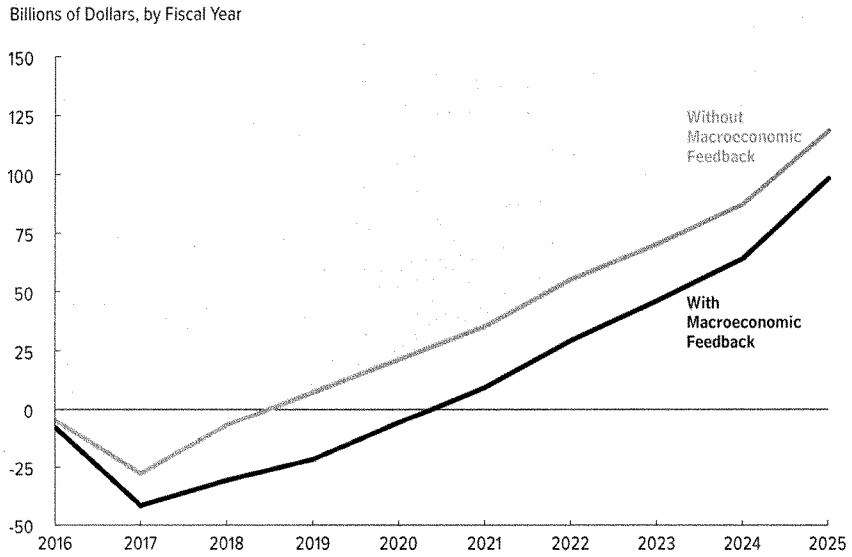
Chairman KLINE. Without objection.

[The information follows:]

CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

CBO

Budgetary and Economic Effects of Repealing the Affordable Care Act



Annual Effects on Deficits of Repealing the ACA

JUNE 2015

Notes

Unless otherwise indicated, all years are federal fiscal years, which run from October 1 to September 30 and are designated by the calendar year in which they end.

Numbers in the text and tables may not add up to totals because of rounding.

As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, administrative actions, and certain statutory changes. Some statutory changes that have been made subsequently have superseded provisions of the ACA and thus affect the estimated impact of repealing the ACA.

Estimates of insurance coverage reflect average enrollment over the course of a calendar year and include spouses and dependents covered under family policies; people with multiple sources of coverage are assigned to a single category on the basis of their primary coverage.

Additional data—specifically, those underlying the figures in this report—are posted along with the report on CBO's website (www.cbo.gov/publication/50252).

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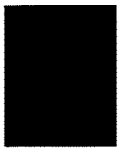


Budgetary and Economic Effects of Repealing the Affordable Care Act

Summary

Over the past several years, a number of proposals have been advanced for repealing the Affordable Care Act (ACA), which became law in March 2010. In this report, the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) analyze the main budgetary and economic consequences that would arise from repealing that law.

To conduct the analysis, CBO and JCT first considered the effects of the ACA's repeal on health insurance coverage and on the federal budget over the next 10 years, holding gross domestic product (GDP) and other macroeconomic variables (such as interest rates) constant—assumptions that underlie most cost estimates used in the Congressional budget process. The agencies then examined the macroeconomic effects of repealing the ACA and estimated the consequences of the resulting feedback for the federal budget over the next decade (involving changes in tax revenue, for example, that stem from changes in GDP). Finally, CBO and JCT considered the budgetary and economic effects of repealing the ACA for the period beyond 2025.

As has been the practice for past analyses of the ACA, CBO and JCT estimated the budgetary implications of a repeal in two broad categories: the effects of repealing the act's provisions concerning insurance coverage—including subsidies provided through the insurance exchanges, added costs for Medicaid, revenues from certain penalties and taxes, and related effects—and the effects of repealing other provisions of the act, which would mostly be related to Medicare spending and tax revenues. For the purposes of this analysis, CBO and JCT assumed that a repeal would take effect on January 1, 2016, and would not change federal law retroactively. As discussed below, all of the resulting estimates are subject to substantial uncertainty.

What Would Be the Major Effects of Repealing the ACA?

CBO and JCT estimate that repealing the ACA would have several major effects, relative to the projections under current law:

- Including the budgetary effects of macroeconomic feedback, repealing the ACA would increase federal budget deficits by $137 billion over the 2016–2025 period (see Table 1). That estimate takes into account the proposal's impact on federal revenues and direct (or mandatory) spending, incorporating the net effects of two components:
  - Excluding the effects of macroeconomic feedback—as has been done for previous estimates related to the ACA (and most other CBO cost estimates)—CBO and JCT estimate that federal deficits would increase by $353 billion over the 2016–2025 period if the ACA was repealed.
  - Repeal of the ACA would raise economic output, mainly by boosting the supply of labor; the resulting increase in GDP is projected to average about 0.7 percent over the 2021–2025 period. Alone, those effects would reduce federal deficits by $216 billion over the 2016–2025 period, CBO and JCT estimate, mostly because of increased federal revenues.
- For many reasons, the budgetary and economic effects of repealing the ACA could differ substantially in either direction from the central estimates presented in this report. The uncertainty is sufficiently great that repealing the ACA could reduce deficits over the 2016–2025 period—or could increase deficits by a substantially larger margin than the agencies have estimated. However, CBO and JCT's best estimate is that repealing the ACA would increase federal budget deficits by $137 billion over that 10-year period.

Table 1.

Summary of Estimated Effects on Direct Spending and Revenues of Repealing the Affordable Care Act

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2016-2020	Total, 2016-2025
Estimated Changes Without Macroeconomic Feedback												
Effects on Outlays	-71	-107	-106	-100	-93	-88	-77	-71	-65	-43	-477	-821
Effects on Revenues	-66	-79	-99	-107	-115	-123	-132	-142	-152	-161	-466	-1,174
Effects on the Deficit[a]	-5	-28	-7	7	21	35	55	70	87	118	-12	353
Estimated Budgetary Impact of Macroeconomic Feedback												
Effects on Outlays	*	-2	-3	-2	-1	1	2	4	5	6	-8	9
Effects on Revenues	3	11	21	26	27	27	28	28	27	26	88	225
Effects on the Deficit[a]	-4	-13	-24	-29	-28	-26	-26	-24	-23	-20	-97	-216
Estimated Changes With Macroeconomic Feedback												
Effects on Outlays	-71	-109	-109	-103	-94	-87	-75	-68	-60	-37	-486	-812
Effects on Revenues	-63	-67	-78	-81	-88	-96	-104	-114	-124	-135	-377	-949
Effects on the Deficit[a]	-8	-42	-31	-22	-6	9	29	46	64	98	-108	137

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Repealing the Affordable Care Act (ACA) would reduce the amounts of future appropriations needed by the agencies responsible for implementing the ACA and would eliminate the authorizations of certain other appropriations; such effects on discretionary spending are not included in this table and would depend on future legislative action. In addition, the results shown here do not include effects on discretionary spending that stem from macroeconomic feedback, which are estimated to be minimal.

Direct spending is the budget authority provided by laws other than appropriations acts and the outlays that result from that budget authority.

* = between zero and -$0.5 billion.

a. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

- Repealing the ACA would cause federal budget deficits to increase by growing amounts after 2025, whether or not the budgetary effects of macroeconomic feedback are included. That would occur because the net savings attributable to a repeal of the law's insurance coverage provisions would grow more slowly than would the estimated costs of repealing the ACA's other provisions—in particular, those provisions that reduce updates to Medicare's payments. The estimated effects on deficits of repealing the ACA are so large in the decade after 2025 as to make it unlikely that a repeal would reduce deficits during that period, even after considering the great uncertainties involved.

- Repealing the ACA also would affect the number of people with health insurance and their sources of coverage. CBO and JCT estimate that the number of nonelderly people who are uninsured would increase by about 19 million in 2016; by 22 million or 23 million in 2017, 2018, and 2019; and by about 24 million in all subsequent years through 2025, compared with the number who are projected to be uninsured under the ACA. In most of those years, the number of people with employment-based coverage would increase by about 8 million, and the number with coverage purchased individually or obtained through Medicaid would decrease by between 30 million and 32 million.

How Would a Repeal Affect the Budget and the Economy Over the Next 10 Years?

CBO and JCT's estimate that repealing the ACA would increase deficits by $353 billion over the 2016–2025 period, excluding the budgetary impact of macroeconomic feedback, has four major components (see Table 2):

- An end to the ACA's subsidies for health insurance coverage would generate gross savings for the government of $1,658 billion over the 2016–2025 period, CBO and JCT estimate. Those savings would stem primarily from eliminating federal subsidies for insurance purchased through exchanges and from reducing outlays for Medicaid.

Table 2.

Estimate of the Direct Spending and Revenue Effects of Repealing the Affordable Care Act, Without Macroeconomic Feedback

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2016-2020	Total, 2016-2025
	Net Changes in the Deficit From Repealing Insurance Coverage Provisions											
Exchange Subsidies[a]	-41	-69	-78	-82	-83	-86	-91	-94	-98	-101	-353	-822
Medicaid and CHIP Outlays	-44	-66	-71	-75	-82	-88	-93	-97	-102	-106	-339	-824
Small-Employer Tax Credits[b]	-1	-1	-1	-1	-1	-1	-1	-1	-1	-1	-5	-11
Subtotal	-86	-136	-150	-158	-166	-175	-184	-193	-201	-208	-697	-1,658
Penalty Payments by Uninsured People	4	4	4	4	4	4	5	5	5	5	19	43
Penalty Payments by Employers[b]	9	13	15	16	16	17	18	20	21	22	69	167
Excise Tax on High-Premium Insurance Plans[b]	0	0	3	6	7	9	11	14	17	21	16	87
Other Effects on Revenues and Outlays[c]	7	15	19	20	21	22	23	25	26	27	81	204
Subtotal	19	32	40	45	48	52	58	63	69	75	185	502
Net Decrease in the Deficit From Repealing Coverage Provisions	**-67**	**-104**	**-110**	**-113**	**-118**	**-123**	**-127**	**-130**	**-132**	**-133**	**-512**	**-1,156**
	Net Increase in the Deficit From Repealing Other Provisions Affecting Direct Spending and Revenues											
Increase in the Deficit From Changes in Outlays[d]	**24**	**35**	**46**	**61**	**77**	**91**	**111**	**125**	**140**	**168**	**243**	**879**
Increase in the Deficit From Changes in Revenues	**39**	**40**	**57**	**59**	**62**	**66**	**70**	**75**	**79**	**83**	**258**	**631**
	Net Increase or Decrease (-) in the Deficit											
Net Effect on the Deficit	**-5**	**-28**	**-7**	**7**	**21**	**35**	**55**	**70**	**87**	**118**	**-12**	**353**
On-budget	-8	-34	-14	-1	13	26	45	59	75	104	-44	265
Off-budget[e]	3	6	7	7	8	9	10	11	12	14	32	88

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

CHIP = Children's Health Insurance Program.

a. Includes spending for exchange grants to states and net spending and revenues for risk adjustment and reinsurance.

b. Includes the associated effects on revenues of changes in taxable compensation.

c. Consists mainly of the effects on revenues of changes in taxable compensation. CBO estimates that repealing the coverage provisions would reduce outlays for Social Security benefits by about $9 billion over the 2016–2025 period and would have negligible effects on outlays for other federal programs.

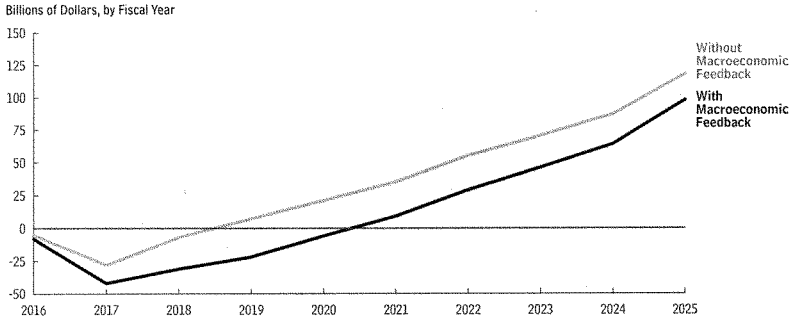
d. These estimates reflect the effects of provisions affecting Medicare, Medicaid, and other federal health programs, and they include the effects of interactions between insurance coverage provisions and those programs.

e. Off-budget effects include changes in Social Security spending and revenues as well as in spending by the U.S. Postal Service.

- Those gross savings would be partially offset by the effects of eliminating several ACA provisions related to insurance coverage that are projected to reduce federal deficits—including the provisions that impose penalties on some employers and uninsured people and that impose an excise tax on certain high-premium insurance plans. In addition, increases in employment-based coverage stemming from a repeal would reduce revenues because most payments for that coverage are exempt from income and payroll taxes. In sum, those effects of repealing the ACA would increase federal deficits by $502 billion over the 2016–2025 period, CBO and JCT estimate, and the net savings from repealing the ACA's coverage provisions would thus be $1,156 billion.

Figure 1.

Estimated Effects on Deficits of Repealing the Affordable Care Act



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Note: The term "macroeconomic feedback" refers to the estimated effects on the federal budget that would arise from changes in economic output or other macroeconomic variables—such as changes in the number of hours that people work and in their aggregate compensation, which would change revenues, or changes in interest rates, which would change interest payments.

- The ACA also includes many other provisions related to health care that are estimated to reduce net federal outlays, primarily for Medicare. The provisions with the largest effects reduced payments to hospitals, to other providers of care, and to private insurance plans delivering Medicare's benefits, relative to what they would have been under prior law. Repealing all of those provisions would increase direct spending in the next decade by $879 billion, CBO estimates.

- The ACA also includes many provisions that are estimated to increase federal revenues (apart from the effect of the provisions related to insurance coverage). Those with the most significant budgetary effects increased the Hospital Insurance payroll tax rate for high-income taxpayers, added a surtax on those taxpayers' net investment income, and imposed annual fees on health insurers. JCT estimates that repealing all of those provisions would reduce revenues by a $631 billion over the 2016–2025 period.

CBO and JCT also analyzed the macroeconomic effects of repealing the ACA and then estimated the impact of their feedback to the federal budget. According to the agencies' estimates, repealing the ACA would increase GDP by about 0.7 percent in the 2021–2025 period, mostly because provisions of the law that are expected to reduce the supply of labor would be repealed. Over the next few years, however, repealing the ACA would have smaller estimated effects on output—partly because responses to a repeal would be expected to occur gradually and partly because the effects would be muted while the economy is operating below its potential (maximum sustainable) output. Over the 2016–2025 period, that macroeconomic feedback would reduce federal deficits by $216 billion, CBO and JCT estimate, largely because of the additional revenues attributable to the increases in the supply of labor (which would in turn increase employment and taxable income).

All told, CBO and JCT estimate that repealing the ACA would raise federal deficits by $137 billion over the 2016–2025 period through its impact on direct spending and on revenues. A repeal would *reduce* deficits during the first half of the decade but would *increase* them by steadily rising amounts from 2021 through 2025. Including the effects of macroeconomic feedback, a repeal of the ACA would increase the federal budget deficit by $9 billion in 2021, rising to $98 billion in 2025 (see Figure 1).

That growth in projected increases in deficits from repealing the ACA reflects the agencies' estimates that, toward the end of the 10-year budget window, the net savings from repealing the law's coverage provisions would increase more slowly than the net costs of repealing the act's other provisions. Although many factors would affect the rate of growth of the savings from repealing the coverage provisions, one reason they would grow slowly is that the annual updates to exchange subsidies are structured in a way that slows their growth, which limits the savings from eliminating them; another is that the revenue loss from repealing the excise tax on certain high-premium insurance plans would grow very rapidly as more plans were affected each year. However, the revenue losses and spending increases that would result from repealing the act's other provisions would grow more rapidly than the net savings from repealing the coverage provisions. Most significantly, the costs of repealing the ACA's reductions in updates to Medicare's payment rates would compound over the next decade because those reductions lower the growth rate of Medicare's costs.

How Would a Repeal Affect the Budget and the Economy Beyond 2025?

CBO and JCT expect that the trend projected for the latter part of the coming decade would probably continue after 2025, whether or not the effects of macroeconomic feedback are incorporated into the analysis. To generate rough estimates for the decade beyond 2025, CBO and JCT extrapolated the budgetary effects that a repeal of the ACA would have in the years before 2025. According to that analysis, and excluding the budgetary effects of macroeconomic feedback, a repeal would increase annual deficits over the 2026–2035 period by amounts that lie within a broad range around one percent of GDP. Although the macroeconomic feedback stemming from a repeal would continue to reduce deficits after 2025, the effects would shrink over time because the increase in government borrowing resulting from the larger budget deficits would reduce private investment and thus would partially offset the other positive effects that a repeal would have on economic growth. Consequently, taking that feedback into account would not substantially alter the increases estimated for federal deficits that would occur over that period. A repeal of the ACA would probably increase deficits in subsequent decades as well, whether or not the effects of macroeconomic feedback are included.

Why Are These Estimates Uncertain?

Estimates of the effects of repealing the ACA are subject to substantial uncertainty, which stems at least in part from the difficulty in projecting the effects of the ACA itself. Although initial data are available about some particular effects, the ways in which individuals, employers, states, insurers, doctors, hospitals, and other affected parties will respond to the changes made by the ACA—and the ways in which those same people and organizations would respond to its repeal—are all difficult to predict, and the responses could deviate in either direction from CBO and JCT's estimates. It also is a difficult task—and one subject to considerable uncertainty—to predict how repealing a law as complex as the ACA would be interpreted and implemented by executive branch agencies without some specific statutory guidance.

The Supreme Court's forthcoming ruling about subsidies provided through insurance exchanges constitutes another major source of uncertainty. CBO and JCT's baseline projections and the estimates in this report reflect the way the law is currently being implemented, with subsidies available through all exchanges, but the Court could rule that the law does not authorize subsidies in some states. If that happened, CBO and JCT would reduce their projections of spending on those subsidies under current law and would reduce their estimates of the savings generated by repealing the ACA's coverage provisions—although the magnitude of those reductions is uncertain and would depend in part on the specific details of the Court's opinion.

Over the longer term, there is particular uncertainty about the ways that providers of health care will respond to the ACA's reductions in the updates to Medicare's payment rates and about whether repealing the ACA would weaken pressures for cost control that may have contributed to a broad slowdown in spending growth for health care. The effects on labor markets, GDP, and other macroeconomic variables—and the resulting budgetary feedback—also could be smaller or larger than the agencies have estimated.

On balance, CBO and JCT estimate that the most likely outcome of repealing the ACA would be to increase budget deficits over the 2016–2025 period, but that estimate is designed to represent the middle of a broad range of possible outcomes. In light of the myriad uncertainties involved, it is possible that repealing the ACA could

reduce deficits over that period or could increase them by substantially more than the agencies have estimated.

Estimating the Effects of Repeal Legislation

Implementing a repeal of the ACA would present major challenges. In the five years since its enactment, nearly every key provision of the law has taken effect and has been incorporated into final rules and other administrative actions. Undoing the ACA would thus be quite complicated. As a result, CBO and JCT's budgetary and economic analyses have had to incorporate many assumptions about the ways in which legislation to repeal the ACA would be interpreted and implemented. For several reasons, the budgetary effects of a repeal would not simply be the opposite of the budgetary effects of the ACA itself.

Factors Affecting Implementation

Although the proposals for repealing the ACA have varied slightly, they have shared many key elements. Generally, they have specified that the provisions of prior law would be "restored or revised as if such Act had not been enacted," but they have not detailed how that would be accomplished.[1] As a result, executive branch agencies would have considerable discretion in determining how to implement a repeal. Some proposals have specified that the repeal would be effective as of the original enactment date of the ACA, indicating that the revisions would be applied retroactively.[2] Others have set effective dates in the future. For purposes of this analysis, CBO and JCT assumed that the repeal of the ACA would take effect on January 1, 2016, and that it would not affect federal spending incurred or federal revenues collected in prior years.

CBO and JCT cannot anticipate with any certainty what choices federal agencies would make to implement such legislation to repeal the ACA. Medicare, for example, would be affected in several fairly complicated ways. In many cases, the program's payment rates reflect base payment amounts that are increased or updated each year according to formulas specified in law. The ACA reduced those updates, and repealing the relevant provisions would clearly cancel the reductions that are currently scheduled to take place in future years. The complication that arises is that the base payment amounts to which the updates will apply are currently lower than they would have been had the ACA never been enacted. If the ACA was repealed, it is unclear whether those base amounts would be adjusted upward so that future payments would not be affected by past update reductions. In other cases, repealing the ACA would require payment mechanisms for Medicare to revert to those used under prior law, but the Department of Health and Human Services (HHS) would need to decide how to calculate those payments once the law was repealed. (Legislation to repeal the ACA could reduce the scope of such discretion, however, by specifying the manner of restoration or revival of the provisions of prior law.)

How CBO and JCT Developed the Estimates

The analysis presented in this report is based on the spending and revenue projections contained in CBO's March 2015 baseline, as adjusted for subsequently enacted legislation (in particular, Public Law 114-10, the Medicare Access and CHIP Reauthorization Act of 2015).[3] The estimates thus reflect all of the previous administrative actions, judicial decisions, and enacted legislation modifying the ACA's provisions or affecting its implementation that were incorporated into that baseline.

In some cases, provisions of the ACA have been superseded by subsequent legislation, so repealing those provisions would not have a budgetary impact. For example, the ACA extended funding for the Children's Health Insurance Program (CHIP) through 2015. However, P.L. 114-10 extended that funding through 2017, so repealing the ACA would not reverse the extension of CHIP that was enacted as part of the ACA. Similarly, P.L. 114-10 modified provisions governing the premiums that enrollees with higher income must pay for Part B of Medicare, superseding changes to those premiums made by the ACA. Several tax provisions that were enacted as

1. For example, see H.R. 596, a bill to repeal the Patient Protection and Affordable Care Act and health care-related provisions in the Health Care and Education Reconciliation Act of 2010, and for other purposes, 114th Cong. (2015), www.congress.gov/bill/114th-congress/house-bill/596.

2. For example, see H.R. 6079, Repeal of Obamacare Act, 112th Cong. (2012), www.congress.gov/bill/112th-congress/house-bill/6079. For a discussion of the challenges involved in repealing the ACA retroactively, see Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

3. See Congressional Budget Office, *Updated Budget Projections: 2015 to 2025* (March 2015), www.cbo.gov/publication/49973, and cost estimate for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015 (March 25, 2015), www.cbo.gov/publication/50053.

part of the ACA also have been repealed or modified, thus reducing some of the revenue consequences of repealing the ACA.

Furthermore, CBO and JCT anticipate that some changes induced by the ACA would be sustained in the event of its repeal, at least for some period. For example, the ACA established deadlines that accelerated implementation of Medicare's bidding program for durable medical equipment, and CBO expects that if the ACA was repealed, that program would not revert to the slower schedule anticipated under prior law. Similarly, some of the people projected to enroll in Medicaid as a result of the ACA were eligible for the program under prior law and thus would remain eligible in the event of a repeal; CBO and JCT estimate that rates of enrollment among those previously eligible people would remain elevated for a few years. Whether a repeal of the ACA would have broader effects on the rate of cost growth in health care—beyond the effects already captured in CBO and JCT's estimates—is discussed further below.

Because the ACA was a large, complex piece of legislation, estimating the effects of its repeal also is complicated, although the degree of difficulty varies somewhat depending on the provision. For example, estimating the effects of repealing the ACA's insurance coverage provisions is simplified by the fact that those provisions created many new flows of funds that CBO and JCT can distinguish and estimate separately from one another—in particular, the subsidies for insurance purchased through exchanges and federal payments for Medicaid beneficiaries made newly eligible by the law—in constructing baseline budget projections. In those cases, the effect of repeal can be readily estimated by reversing the signs of those amounts as projected in CBO's baseline (with some adjustments, described elsewhere in this report).

However, some of those provisions and many others in the ACA modified existing programs or existing tax law or affected other spending or revenues indirectly. Those budgetary effects are not projected separately in CBO's baseline and must be newly estimated for each repeal proposal, relative to current baseline projections of spending and revenues. For example, Medicare's total payments to hospitals change from year to year for various reasons, and there is no identifiable stream of payments or savings that is specifically attributable to the ACA's provisions—so those savings must be estimated anew. The ACA includes dozens of such provisions that affect payments to different types of providers. Likewise, various provisions of the ACA governing revenues affect the ways that households and businesses arrange their finances and thus alter income or payroll tax revenues. However, the effects of the ACA on those continuing revenue streams cannot be easily identified and are not projected separately, so they must be newly estimated in any analysis of repeal legislation.

Differences From an Estimate of the ACA's Effects Since Its Enactment

A related question that sometimes arises is whether CBO and JCT could provide an updated estimate of the ACA's budgetary impact from its inception that would be similar to the analyses that the agencies provided when the law was enacted. A retrospective analysis of the effects of a current law is quite different from a cost estimate for proposed legislation because such an analysis requires the formulation of a counterfactual benchmark to represent what would have happened over the past few years if the law had not been enacted; that would be a challenging undertaking that is beyond the scope of CBO and JCT's usual analytic methods. The agencies therefore cannot readily provide a retrospective analysis of the ACA that is analogous to the cost estimate that was provided in 2010. That problem is not unique to the ACA—it is common to most legislation that affects preexisting federal programs and taxes.[4]

Effects of a Repeal Over the Next 10 Years, Excluding Macroeconomic Feedback

To estimate the budgetary effects of the ACA's repeal, CBO and JCT first examined the impact on health insurance coverage and on the federal budget over the next decade, holding GDP and other macroeconomic variables constant—which is the only approach that the agencies take for most cost estimates. As with past analyses of the ACA, the current budgetary analysis involved grouping the ACA's provisions into two broad categories: The provisions concerning insurance coverage, including subsidies provided through the insurance exchanges, increased outlays for Medicaid, revenues from certain penalties and taxes, and related budgetary effects; and the various noncoverage provisions, mostly affecting direct

4. For additional discussion, see Congressional Budget Office, answers to questions for the record following a hearing on the budget and economic outlook for 2014 to 2024 conducted by the Senate Committee on the Budget (June 10, 2014), pp. 14–19, www.cbo.gov/publication/45396.

spending for Medicare and making changes in the tax code that are not directly related to insurance coverage.

Taking into account the effects on federal revenues and direct spending but *excluding* the budgetary effects of macroeconomic feedback, CBO and JCT estimate that a repeal of the ACA would increase federal deficits by $353 billion over the 2016–2025 period.[5] That figure reflects an estimated reduction in outlays of $821 billion that is more than offset by an estimated reduction in revenues of $1,174 billion. The resulting estimate of the effects on deficits is substantially larger than the one CBO and JCT issued in July 2012 for a similar proposal to repeal the ACA—a difference that mostly reflects a shift in the budget window to encompass later years in which repealing the ACA would increase budget deficits sharply. As with past analyses of the ACA, the estimates in this report do not include any savings or costs associated with changes in discretionary spending—even though future appropriations to administer the ACA's provisions would no longer be needed if that law was repealed.[6]

Effects on Insurance Coverage

A repeal of the ACA would include a repeal of various provisions that, under current law, are projected to increase the number of nonelderly people who have health insurance. Those provisions include an expansion of eligibility for Medicaid, subsidies for nongroup coverage purchased through health insurance exchanges, a requirement that most U.S. residents obtain insurance coverage or pay a penalty, and a penalty on certain employers that do not offer their full-time workers health insurance that meets specified standards for coverage and affordability. In addition, an excise tax on certain employment-based health plans with relatively high premiums will take effect starting in 2018. The ACA also contains a range of provisions that affect the types and prices of insurance policies that can be sold. Those—and many other provisions affecting insurance coverage—also would be repealed.

If the ACA was repealed, many people would obtain their coverage from a source that differs from current projections, and many others who are projected to retain or gain insurance coverage in the future would instead be uninsured (see Table 3). On average, over the 2021–2025 period, the following changes would occur, relative to CBO and JCT's current-law projections:

- About 14 million fewer people would be enrolled in Medicaid.
- About 18 million fewer people would have nongroup coverage. That reduction is the net effect of a projected decline of about 22 million in nongroup coverage purchased through exchanges (which would no longer serve as a conduit for federal subsidies and might not exist at all) and a projected increase of about 4 million enrollees in nongroup coverage purchased directly from insurers.
- About 8 million more people, on net, would have employment-based coverage—roughly mirroring the agencies' estimate of the extent to which the ACA will reduce employment-based coverage in future years.
- About 24 million more nonelderly U.S. residents would be uninsured.[7]

The effects on sources of insurance coverage in earlier years would generally be similar or slightly smaller, but the effects of repealing the ACA are estimated to be noticeably smaller in 2016—partly because the ACA is not projected to increase insurance coverage as much in that year. For reasons that are discussed below, the effects of repealing the ACA on people's sources of insurance coverage differ slightly from the estimated effects of implementing the coverage provisions that are shown in the agencies' most recent baseline projections.

Effects on Direct Spending and Revenues Related to Insurance Coverage

CBO and JCT estimate that repealing the provisions of the ACA affecting health insurance coverage would yield a net decrease in federal deficits of $1,156 billion over

5. Direct, or mandatory, spending is the budget authority provided by laws other than appropriation acts and the outlays that result from that budget authority. CBO and JCT estimate that on-budget deficits would increase by $265 billion over the 2016–2025 period and that off-budget deficits would increase by $88 billion over that period. Off-budget effects include changes in Social Security spending and revenues as well as spending by the U.S. Postal Service.

6. Discretionary spending is the budget authority provided and controlled by appropriation acts and the outlays that result from that budget authority.

7. As a result, the overall share of the nonelderly population with health insurance would drop from about 90 percent under current law to about 82 percent if the ACA was repealed.

Table 3.

Estimate of the Effects on Health Insurance Coverage of Repealing the Affordable Care Act

Millions of Nonelderly People, by Calendar Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025
Insurance Coverage Under Current Law[a]										
Insurance exchanges	20	23	23	23	23	23	23	22	22	22
Medicaid and CHIP	51	52	52	52	53	53	54	54	54	55
Employment-based coverage	149	149	150	151	152	153	153	153	154	155
Nongroup and other coverage[b]	22	22	22	23	23	23	23	23	24	24
Uninsured	29	27	27	26	26	26	26	27	27	27
Total	271	272	274	275	276	277	278	280	281	282
Change in Insurance Coverage With Repeal of the ACA										
Insurance exchanges	-20	-23	-23	-23	-23	-23	-23	-22	-22	-22
Medicaid and CHIP	-8	-11	-11	-12	-14	-14	-14	-14	-14	-14
Employment-based coverage[c]	6	8	8	8	8	8	8	8	8	8
Nongroup and other coverage[b]	4	4	4	4	4	5	4	5	4	4
Uninsured	19	22	22	23	24	24	24	24	24	24
Number of Uninsured Nonelderly People With Repeal of the ACA	48	49	49	49	50	50	50	50	50	50

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Estimates of the nonelderly population include residents of the 50 states and the District of Columbia who are younger than 65.

ACA = Affordable Care Act; CHIP = Children's Health Insurance Program.

a. Amounts reflect average annual enrollment over the course of a year and include spouses and dependents covered under family policies; people reporting multiple sources of coverage are assigned a primary source. Amounts represent CBO's March 2015 baseline, adjusted for enactment of Public Law 114-10, the Medicare Access and CHIP Reauthorization Act of 2015.

b. "Other coverage" includes Medicare; the changes from repealing the ACA would be almost entirely for nongroup coverage.

c. The change in employment-based coverage is the net result of projected increases and decreases in offers of health insurance from employers and changes in enrollment by workers and their families.

fiscal years 2016 through 2025 because of those provisions' effects on direct spending and revenues (see Table 2 on page 3). That amount includes the following:

- A total of $822 billion in savings resulting from eliminating exchange subsidies,
- A net reduction of $824 billion in federal outlays for Medicaid and CHIP, and
- Additional savings totaling $11 billion from the repeal of a tax credit for certain small employers that provide health insurance to their employees.[8]

Those gross savings of $1,658 billion over the 2016–2025 period would be partly offset by costs totaling $502 billion stemming from four sources related to insurance coverage:

- A reduction in revenues of $43 billion from eliminating penalty payments by uninsured people,
- A decline in revenues of $167 billion from eliminating penalty payments by employers,
- A reduction in revenues of $87 billion from eliminating the excise tax on certain high-premium insurance plans, and

8. The ACA's premium subsidies for health insurance purchased through exchanges are structured as refundable tax credits; CBO and JCT treat the portions of such credits that exceed taxpayers' other income tax liabilities as outlays and the portions that reduce tax payments as reductions in revenues—just as other refundable tax credits are treated. Subsidies to reduce enrollees' cost-sharing liabilities are classified as outlays. A small portion of the cost of the tax credit for certain small employers (and the savings that would arise from its repeal) reflects its effects on outlays.

- Other budgetary effects, mostly involving revenues, associated with shifts in the mix of taxable and nontaxable compensation resulting from net increases in employment-based health insurance coverage—which would, on net, increase deficits by $204 billion.[9]

Those figures differ by about $51 billion from the estimated effects of the ACA's coverage provisions that are reflected in CBO's March 2015 baseline, for three main reasons.[10] First, the costs for exchange subsidies and additional Medicaid payments over the first three months of fiscal year 2016 will be incurred during calendar year 2015 and thus would not be eliminated by a repeal (which, for the purposes of this analysis, is assumed to take effect on January 1, 2016). Second, for the next few years, some proportion of the people who have enrolled or are expected to enroll in Medicaid as a result of the ACA—and who would have been eligible even if the ACA had never been enacted—probably would still enroll in Medicaid if the ACA was repealed, and the savings attributable to the repeal would be reduced as a result. Third, enactment of P.L. 114-10 increased the projections of enrollment in Medicaid and CHIP, relative to the March 2015 baseline, and correspondingly reduced the costs of coverage obtained through exchanges and employment-based plans. On net, those changes also reduced the savings that would be generated by repealing the ACA. (Those factors largely explain why the estimated effects that a repeal would have on the number of people with various types of insurance coverage differ slightly in magnitude from CBO and JCT's baseline projections of the ACA's effects.)

Effects on Direct Spending for Medicare, Medicaid, and Other Programs

The ACA made numerous changes to payment rules and rates for Medicare and Medicaid, and it made other changes to certain other federal health programs as well. On net, CBO estimates, repealing those provisions would increase direct federal spending by $879 billion over the 2016–2025 period, mostly because of changes in spending for Medicare, which would rise by an estimated $802 billion (see Table 4). Repealing the provisions of the ACA that are not related to insurance coverage would increase federal spending for Medicaid by about $66 billion over that period, mostly because of increases in payments for prescription drugs and payments to hospitals that treat a disproportionate share of uninsured or low-income patients.[11] On net, direct spending for other health programs would increase by about $10 billion, CBO estimates.

Nearly all of the net increase estimated for direct spending for Medicare—about $715 billion of the estimated $802 billion—would stem from repealing provisions of the ACA that imposed reductions in payment rates or slowed increases in payment rates (relative to prior law) for services covered under Parts A and B of Medicare; those benefits are provided either through the traditional fee-for-service sector of the Medicare program or through private insurance plans.[12] (Those private plans are generally known as Medicare Advantage plans; they receive payments under Medicare's Part C.) Roughly one-half of that net increase in spending would stem from repealing provisions that changed payment rates in the fee-for-service sector; the other half would be attributable to repealing provisions that changed the rules for setting payment rates for Medicare Advantage plans.[13] Because the ACA reduced the rate at which many payments are updated annually, the effects of those provisions on

9. Changes in the extent of employment-based health insurance affect federal revenues because most payments for that coverage are exempt from income and payroll taxes. If employers increase or decrease the amount of nontaxable compensation they provide in the form of health insurance (relative to current-law projections), CBO and JCT estimate that offsetting changes will occur in wages and other forms of compensation—which generally are taxable—to hold total compensation roughly the same. Such effects also arise with respect to other provisions of law (such as the excise tax on certain high-premium insurance plans), and those effects are included in the estimates for those elements.

10. See Congressional Budget Office, "Effects of the Affordable Care Act on Health Insurance Coverage—Baseline Projections" (March 2015), www.cbo.gov/publication/43900.

11. In total, federal spending for Medicaid and CHIP would be reduced by $758 billion over the 2016–2025 period, combining the effects of repealing the provisions related to and those not related to insurance coverage.

12. Medicare Part A covers inpatient services provided by hospitals, care in skilled nursing facilities, home health care, and hospice care. Part B mainly covers services provided by physicians, other practitioners, and hospitals' outpatient departments.

13. Payments in the fee-for-service sector affect payments to Medicare Advantage plans, and changes in either of those types of payments affect the premiums that enrollees pay for Part B of Medicare. In previous estimates, CBO calculated the aggregate effects of those interactions separately, but now the agency incorporates those interactions into the estimates for each provision. As a result, the current estimates for the effects of repealing specific provisions of the ACA affecting Medicare are not comparable to previous estimates.

Table 4.

Estimated Changes in Direct Spending and Revenues That Would Result From Repealing the Affordable Care Act, Without Macroeconomic Feedback

Billions of Dollars, by Fiscal Year

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	Total, 2016-2020	Total, 2016-2025
						Changes in Outlays						
Coverage Provisions												
Exchange subsidies and state exchange grants	-35	-59	-67	-71	-71	-74	-78	-82	-85	-89	-303	-712
Payments for risk adjustment and reinsurance	-15	-17	-13	-15	-16	-16	-17	-17	-17	-16	-75	-158
Medicaid and CHIP	-44	-66	-71	-75	-82	-88	-93	-97	-102	-106	-339	-824
Other changes in direct spending[a]	*	*	*	-1	-1	-1	-1	-1	-1	-1	-2	-6
Subtotal	-94	-142	-152	-161	-170	-179	-189	-197	-205	-211	-720	-1,700
Other Provisions												
Medicare provisions	23	34	44	58	69	82	100	113	126	153	228	802
Other Medicaid provisions	2	2	3	4	7	8	9	10	11	11	17	66
Other changes in direct spending	-1	-1	-1	-1	1	2	2	3	3	4	-3	10
Subtotal	24	35	46	61	77	91	111	125	140	168	243	879
Total Outlays	**-71**	**-107**	**-106**	**-100**	**-93**	**-88**	**-77**	**-71**	**-65**	**-43**	**-477**	**-821**
On-budget	-70	-106	-105	-100	-92	-87	-76	-70	-64	-42	-474	-813
Off-budget[b]	*	-1	-1	-1	-1	-1	-1	-1	-1	-1	-4	-9
						Changes in Revenues						
Coverage Provisions												
Exchange premium credits	6	10	11	11	11	12	12	12	12	13	48	109
Collections for risk adjustment and reinsurance	-14	-16	-13	-15	-16	-16	-17	-17	-17	-16	-74	-157
Small-employer tax credits	1	1	1	1	1	1	1	1	1	1	4	10
Penalty payments by uninsured people	-4	-4	-4	-4	-4	-4	-5	-5	-5	-5	-19	-43
Penalty payments by employers	-9	-13	-15	-16	-16	-17	-18	-20	-21	-22	-69	-167
Excise tax on high-premium insurance plans	0	0	-3	-6	-7	-9	-11	-14	-17	-21	-16	-87
Other changes in revenues	-7	-16	-19	-20	-21	-22	-24	-25	-27	-28	-83	-209
Subtotal	-27	-38	-42	-48	-52	-56	-62	-67	-73	-78	-208	-544
Other Provisions												
High-income surtaxes	-22	-17	-31	-33	-35	-37	-39	-42	-44	-47	-136	-346
Fees on certain manufacturers and insurers[c]	-14	-18	-19	-18	-19	-20	-21	-22	-23	-23	-87	-196
Other revenue provisions	-3	-6	-8	-8	-9	-10	-10	-11	-12	-13	-34	-89
Subtotal	-39	-40	-57	-59	-62	-66	-70	-75	-79	-83	-258	-631
Total Revenues	**-66**	**-79**	**-99**	**-107**	**-115**	**-123**	**-132**	**-142**	**-152**	**-161**	**-466**	**-1,174**
On-budget	-62	-72	-91	-99	-106	-113	-121	-130	-138	-146	-430	-1,078
Off-budget[b]	-4	-7	-8	-8	-9	-10	-11	-12	-13	-15	-36	-96
						Net Increase or Decrease (-) in the Deficit[d]						
Net Effect on the Deficit	**-5**	**-28**	**-7**	**7**	**21**	**35**	**55**	**70**	**87**	**118**	**-12**	**353**
On-budget	-8	-34	-14	-1	13	26	45	59	75	104	-44	265
Off-budget[b]	3	6	7	7	8	9	10	11	12	14	32	88

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Note: CHIP = Children's Health Insurance Program; * = between $0 and -$0.5 billion.

a. Represents the outlay portion of several coverage-related provisions, including small-employer tax credits, and associated effects of coverage provisions on outlays for Social Security benefits.

b. Off-budget effects include changes in Social Security spending and revenues as well as in spending by the U. S. Postal Service.

c. Amounts reflect repeal of fees on manufacturers and importers of branded drugs and on health insurance providers and repeal of an excise tax on manufacturers and importers of certain medical devices.

d. Positive numbers indicate increases in the deficit, and negative numbers indicate reductions in the deficit.

federal spending will compound over the next decade; as a consequence, the costs of repealing them would grow relatively rapidly.

The ways in which HHS would implement a repeal of the ACA's Medicare provisions governing payment updates are uncertain, however. For this analysis, CBO assumed that repealing the provisions that reduced payment updates in the fee-for-service sector would increase the payment updates in 2016 and beyond—but it also assumed that HHS would not adjust the current base payment amounts to remove the effects of past update reductions implemented under the ACA. If instead HHS also adjusted those base payment amounts upward for the purposes of determining future payments, the cost of repealing the ACA's provisions would be roughly $160 billion higher over the 2016–2025 period than is estimated above.

Effects on Discretionary Spending

The estimates discussed elsewhere in this report do not include any savings or costs associated with changes in discretionary spending. CBO's original cost estimate for the ACA, issued in March 2010, focused on direct spending and revenues because those effects are relevant for budgetary procedures affecting Congressional debate and occur without any additional legislative action (as contrasted with discretionary spending, which is subject to future appropriation action). However, that estimate noted that additional funding would be necessary for agencies to carry out the responsibilities required of them by the legislation and that the legislation also included explicit authorizations for a variety of grants and other programs.[14]

Repealing the ACA would reduce the amounts of future appropriations that are needed for implementation or that are specifically authorized in the act for other purposes. (Some funds would be needed in 2016 to implement a repeal.)[15] However, the impact of a repeal on total discretionary appropriations over the next several years would depend on future legislative actions. Moreover, the potential impact of such legislation on future appropriations is affected by the caps on annual appropriations that were established by the Budget Control Act of 2011. Eliminating the need to implement the ACA might lead to reductions in total discretionary spending, on net, or it might create some room under those caps for additional spending for other discretionary programs.

Effects on Revenues Not Related to Coverage

The ACA made many changes to the Internal Revenue Code that were not directly related to the law's insurance coverage provisions. JCT estimates that repeal of those noncoverage revenue provisions would reduce revenues by a total of $631 billion over the 2016–2025 period (see Table 4). The largest components of those revenue effects include the following:

- The ACA increased the Hospital Insurance payroll tax for certain high-income taxpayers and applied a surtax to their net investment income. Repeal of those provisions is projected to reduce revenues by $346 billion.
- Repeal of an annual fee on health insurance providers is estimated to reduce revenues, on net, by $142 billion (reflecting both the loss of fee collections and the indirect effects of those fees on health insurance premiums that are either tax-preferred or subsidized).
- The repeal of an annual fee on manufacturers and importers of branded drugs is projected to reduce revenues by $30 billion, and the repeal of an excise tax on manufacturers and importers of certain medical devices is projected to reduce revenues by $24 billion.

Comparison With a Prior Estimate

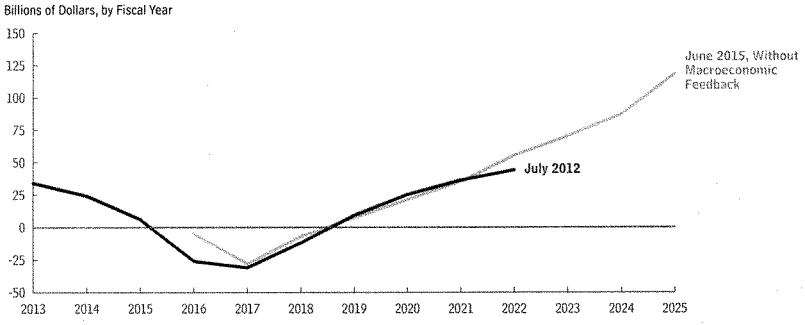
CBO and JCT's current estimate that repealing the ACA would increase deficits by $353 billion over 10 years (excluding the effects of macroeconomic feedback) differs from the estimate that the agencies released in July 2012 for H.R. 6079—the last time they analyzed a proposal to

14. For more information, see Congressional Budget Office, cost estimate for H.R. 4872, the Reconciliation Act of 2010 (final health care legislation) (March 20, 2010), pp. 10–11, www.cbo.gov/publication/21351, letter to the Honorable Jerry Lewis about potential effects of H.R. 3590, the Patient Protection and Affordable Care Act, on discretionary spending (May 11, 2010), www.cbo.gov/publication/21457, and "H.R. 3590, Patient Protection and Affordable Care Act, Additional Information on the Potential Discretionary Costs of Implementing PPACA" (May 12, 2010), www.cbo.gov/publication/21460.

15. In 2012, CBO estimated that, over the 2013–2022 period, repealing the ACA would reduce the need for appropriations to the Internal Revenue Service by between $5 billion and $10 billion and would reduce the need for appropriations to HHS by between $5 billion and $10 billion. CBO has not updated those estimates.

Figure 2.

Comparison of Estimated Effects on Deficits of Repealing the Affordable Care Act



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: The term "macroeconomic feedback" refers to the estimated effects on the federal budget that would arise from changes in economic output or other macroeconomic variables—such as changes in the number of hours that people work and in their aggregate compensation, which would change revenues, or changes in interest rates, which would change interest payments.

June 2015 estimates were developed for this report; 2012 estimates are from Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

repeal all of the ACA's provisions.[16] At that time, CBO and JCT estimated that changes in direct spending and revenues would increase deficits by $109 billion over the period from 2013 through 2022.

Most of the difference between that earlier estimate and the current one stems from a shift in the budget window to encompass later years—in which repealing the ACA is estimated to increase budget deficits sharply. In fact, over the 2016–2022 period, which is encompassed by both estimates, the estimated budgetary effects of repeal are quite similar (see Figure 2): In 2012, CBO and JCT estimated that repealing the ACA would increase budget deficits by a total of $46 billion from 2016 through 2022; the agencies now estimate that repeal would boost deficits by $78 billion over that period (excluding the effects of macroeconomic feedback). In 2012, CBO and JCT estimated that repealing the ACA would increase the deficit substantially in the decade after 2022, but they did not quantify the annual effects. CBO and JCT now estimate that repealing the ACA would increase deficits by $275 billion over the 2023–2025 period.

It is difficult to identify all of the specific reasons for the differences between the two estimates for the 2016–2022 period because CBO and JCT have made many changes in their baseline projections since 2012 to account for such factors as changes in economic conditions and projections, technical changes and improvements in the agencies' models, administrative actions, judicial decisions, and statutory changes. One item of significance is that, since 2012, the agencies have substantially lowered their projections of per capita spending on health care. That change in particular has contributed importantly to substantial but offsetting changes in the estimated effects of repealing various components of the ACA:

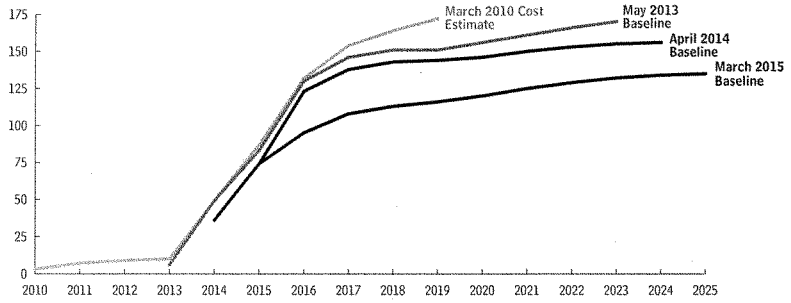
- Holding other factors equal, the changes in projections of per capita spending on health care have lowered the total cost for any given year of subsidizing coverage through the exchanges or Medicaid; correspondingly, the gross and net savings estimated to

16. The 2012 estimate was issued shortly after the Supreme Court ruling that made the ACA's Medicaid expansion optional for states. See Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

Figure 3.

Evolution of CBO and JCT's Estimates of the Net Budgetary Effects of the Insurance Coverage Provisions of the Affordable Care Act

Billions of Dollars, by Fiscal Year



Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

Notes: Effects on the deficit of provisions of the Affordable Care Act that are not related to insurance coverage and effects on discretionary spending are not shown.

Estimates for the various years are from Congressional Budget Office, "Effects of the Affordable Care Act on Health Insurance Coverage—Baseline Projections" (March 2015), "Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline" (April 2014), "May 2013 Baseline" (May 2013) www.cbo.gov/publication/43900, and cost estimate for H.R. 4872, the Reconciliation Act of 2010 (final health care legislation) (March 20, 2010), www.cbo.gov/publication/21351.

result from repealing the ACA's insurance coverage provisions are smaller. Many other factors also have affected the agencies' projections since 2012, including reductions in the number of people projected to purchase coverage through exchanges and increases in the number of people projected to obtain coverage through Medicaid—but the net effect has been a reduction in the projected costs of the coverage provisions (see Figure 3). Taking into account all of those factors, the net savings from repealing the coverage provisions are now projected to total $762 billion over the 2016–2022 period, as compared with $1,027 billion in the previous estimate (a 26 percent reduction).

- At the same time, lower projections of spending on health care are reflected in lower projections of outlays for Medicare, Medicaid, and other federal health care programs—and thus in lower estimated costs in any given year from repealing the ACA provisions that reduced those outlays. Taking into account those and other factors, and again focusing on the 2016–2022 period covered by both estimates, the net costs of repealing those provisions are now projected to total $445 billion, as compared with $623 billion in the previous estimate (a 28 percent reduction).

- The increase in deficits that stems from repealing the noncoverage revenue provisions is now projected to total $394 billion over the 2016–2022 period, as compared with $450 billion in the previous estimate (a 12 percent reduction). Changes to the overall macroeconomic forecast, additional data, and changes to the tax code that have occurred since 2012 have resulted in revisions to estimates of the effects of repealing several of those revenue provisions. The projections of an overall reduction in health spending also have affected the estimates for several of those provisions, thus contributing to a smaller estimate for costs that would be attributable to a repeal.

In sum, CBO and JCT now estimate that repealing the insurance coverage provisions of the ACA would generate $762 billion in net savings over the 2016–2022 period, an amount that would be offset by $840 billion in estimated costs from repealing the other provisions, to yield a

net increase in deficits of $78 billion over that period. In 2012, the estimate of $1,027 billion in net savings from repealing the ACA's coverage provisions was offset by $1,073 billion in estimated costs from repealing the other provisions—yielding an estimated net increase in deficits of $46 billion for the 2016–2022 period.

The Macroeconomic Feedback Effects of a Repeal and Their Impact on the Federal Budget

CBO and JCT also have analyzed the effects that repealing the ACA would have on the U.S. economy and estimated the budgetary impact—or feedback effects—of those macroeconomic changes. CBO and JCT estimate that the net effect on the economy's output would be negligible in 2016 but would grow after that. According to the agencies' estimates, from 2021 through 2025, a repeal would increase GDP by about 0.7 percent, on average—mostly by repealing provisions that, under current law, are expected to reduce the supply of labor.

The macroeconomic feedback effects of repealing the ACA would lower federal deficits by $216 billion over the 2016–2025 period, CBO and JCT estimate (see Table 1 on page 2). The largest effect would be an increase in revenues arising from the increased supply of labor, which in turn would boost employment and taxable income. After accounting for the feedback effects, CBO and JCT estimate that the total impact on direct spending and revenues of repealing the ACA would be to increase federal deficits by $137 billion over the 2016–2025 period. The estimates of the macroeconomic effects and of their consequences for the federal budget are highly uncertain, however, and actual results could be substantially different.

In general, CBO and JCT analyze the macroeconomic effects of changes in fiscal policy by examining similar policies that have been implemented previously and by using results from a variety of economic models. Both agencies also distinguish between longer- and shorter-term effects. Changes in fiscal policy affect output over the longer term by altering people's incentives to work and save and by changing businesses' incentives to invest, thereby changing potential output over the longer term. In the shorter term, changes in fiscal policies also can affect the economy by influencing the demand for goods and services, leading to changes in actual output relative to potential output (the maximum sustainable output of the economy).

For this report, CBO and JCT collaborated to examine the macroeconomic effects of repealing the ACA and those effects' feedback to the federal budget, with each agency focusing on different components of the analysis. JCT primarily analyzed the macroeconomic effects and feedback to federal revenues stemming from the revenue provisions not related to insurance coverage and from the excise tax on certain high-premium insurance plans.[17] CBO primarily analyzed the macroeconomic effects and feedback to federal revenues arising from the other changes in fiscal policy that would stem from repealing the ACA, as well as the feedback effects to federal outlays stemming from a repeal.[18] The estimates of macroeconomic effects and of their feedback to the federal budget presented in this report constitute a synthesis of those analyses.

Macroeconomic Effects from 2021 Through 2025

The largest macroeconomic effects of repealing the ACA would take several years to arise. CBO and JCT estimate that, over the final five years of the current budget window—the period from 2021 to 2025—repealing the ACA would boost GDP by about 0.7 percent, on average, relative to current-law projections. During that period, the estimated effects on output stem from two main sources:

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17. JCT used its macroeconomic equilibrium growth (MEG) model, in which economic output in the longer run is determined by the supply of labor and capital, which in turn respond to the rates of taxation on wages and capital income. In the shorter run, output may be influenced by changes in consumer demand stemming from changes in after-tax income. For a description, see Joint Committee on Taxation, *Overview of the Work of the Staff of the Joint Committee on Taxation to Model the Macroeconomic Effects of Proposed Tax Legislation to Comply with House Rule XIII.3.(b)(2)*, JCX-105-03 (December 2003), http://go.usa.gov/3XS2R. For a discussion of the values currently used in the MEG model, see Joint Committee on Taxation, *Macroeconomic Analysis of the "Tax Reform Act of 2014,"* JCX-22-14 (February 2014), http://go.usa.gov/3XSTJ.

18. To estimate the effects of repealing the ACA over the longer term, CBO employed a version of a widely used Solow-type growth model in which economic output is determined by the number of hours of labor that workers supply, the size and composition of the capital stock (such as factories and equipment), and the combined productivity of labor and capital (known as total factor productivity). In the short term, changes in fiscal policies also can affect the economy by influencing the demand for goods and services by consumers, businesses, and governments, which leads to changes in actual output relative to potential output. For a description see Congressional Budget Office, *How CBO Analyzes the Effects of Changes in Federal Fiscal Policies on the Economy* (November 2014), www.cbo.gov/publication/49494.

- The ACA's largest effects on output are projected to result from several provisions that reduce the supply of labor by decreasing some people's incentives to work; repealing those provisions would thus increase the supply of labor and increase output relative to baseline projections.

- Implementation of the ACA is also expected to shrink the capital stock, on net, over the next decade, so a repeal would increase the capital stock and output over that period. In particular, repealing the ACA would increase incentives for capital investment, both by increasing labor supply (which makes capital more productive) and by reducing tax rates on capital income. However, the net increase in deficits that would be caused by a repeal—even after accounting for macroeconomic feedback—would increase government borrowing and thus would reduce capital investment somewhat in the longer term.

Labor Supply. CBO and JCT estimate that repealing the ACA would increase the supply of labor and thus increase aggregate compensation (wages, salaries, and fringe benefits) by an amount between 0.8 percent and 0.9 percent over the 2021–2025 period. Those effects would be the result of repealing various provisions of the ACA that are estimated to reduce the amount of labor that people choose to supply. In particular, the subsidies and tax credits for health insurance that the ACA provides to some people are phased out as their income rises—creating an implicit tax on additional earnings—and those subsidies, along with expanded eligibility for Medicaid, generally make it easier for some people to work less or to stop working without losing health insurance coverage.[19] For other people, the act directly imposes higher taxes on labor income, thus discouraging work. Repealing the ACA would reverse those effects. In percentage terms, the increase in total hours worked is estimated to be larger than the increase in aggregate compensation because the largest increases in labor supply would occur among the lower-wage workers whose incentives would be most strongly affected. Specifically, repealing the ACA would increase the aggregate number of hours worked by about 1.5 percent over the 2021–2025 period, CBO and JCT estimate.

CBO previously estimated that implementation of the ACA will have larger effects on hours worked and compensation.[20] To update that analysis for this estimate, CBO and JCT first considered the agencies' most recent baseline projections of the number of people affected by the ACA's provisions—including projections of enrollment in subsidized exchange plans and in Medicaid. The agencies also considered more recent evidence about the ACA's likely effects on labor markets and extended that analysis to 2025. As a result, the estimated effects of the ACA on total hours worked and compensation in the second half of the 10-year budget window were reduced by about 15 percent, mostly because fewer people are now projected to receive subsidies through exchanges under current law.

Capital Stock. CBO and JCT estimate that repealing the ACA would increase the capital stock over the 2021–2025 period, on net, for two main reasons. First, the projected reduction in labor supply stemming from the ACA is expected to cause a gradual reduction in the capital stock as businesses adjust the amount of capital available for workers to use—so repealing the ACA would undo that effect. Second, repealing the ACA also would eliminate several taxes that reduce people's incentives to save and invest—most notably the 3.8 percent tax on various forms of investment income for higher-income individuals and families. The resulting increase in the incentive to save and invest—relative to current law—thus would gradually boost the capital stock; consequently, output would be higher.

CBO and JCT also considered the extent to which repealing the ACA would affect output through its effects on federal deficits. As discussed in more detail below, the agencies estimate that repealing the act ultimately would increase federal deficits—even after accounting for other macroeconomic feedback. Larger deficits would leave less money for private investment (a process sometimes called crowding out), which reduces output. Over the 2021–2025 period, however, that effect would not be large enough to offset the effects of repealing the ACA that would boost investment.

19. Because such people would still be insured, CBO and JCT estimate that the changes in labor supply stemming from repeal of the ACA would not significantly affect the *number* of people who had health insurance, although the changes would affect the *sources* of health insurance for some people.

20. CBO had estimated that the ACA will cause a reduction of roughly 1 percent in aggregate labor compensation over the 2017–2024 period and will reduce the total number of hours worked, on net, by 1.5 percent to 2.0 percent during that period. See Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024* (February 2014), Appendix C, www.cbo.gov/publication/45010.

CBO and JCT thus estimate that, on balance, repealing the ACA would yield a larger capital stock, which would boost output over that period. The effects on output of those changes in the capital stock would be smaller than the increases in output stemming from changes in the supply of labor.

Macroeconomic Effects From 2016 Through 2020

CBO and JCT estimate that repealing the ACA would have smaller effects on output in the next few years than would occur later in the coming decade, in part because the ACA's adverse effects on output are projected to be smaller as the responses to its provisions phase in. Correspondingly, repealing the law would have smaller effects over the 2016–2020 period. The macroeconomic effects of implementing or repealing the ACA also are different when the economy operates below its potential, as is projected for the next two years or so. CBO and JCT estimate that a repeal would have a negligible effect on output in 2016 and would increase output by about 0.1 percent in 2017, rising to about 0.6 percent in 2020.

Labor Supply. One reason that the effects of repealing the ACA would be smaller over the next few years is that the law's influence on labor supply will probably be smaller over that period. That conclusion reflects an expectation that the number of people who will receive exchange subsidies under the ACA will be somewhat smaller next year than in later years. The number of additional Medicaid enrollees also is projected to rise over the next several years under current law. Moreover, people will probably adjust gradually to the incentives under current law, and CBO and JCT estimate that affected people would probably adjust gradually to a repeal of the ACA as well. Consequently, the estimated effects on labor supply over the shorter term—both for current law and for a repeal of the ACA—are smaller.

A second consideration is that the reductions in labor supply stemming from the ACA are expected to have a somewhat muted effect on total hours worked over the next two years or so, when there will still be some slack in the labor market. Thus, if some workers reduce the number of hours they work or leave the labor force altogether, some underemployed workers or people who are not actively looking for employment but are willing to work will probably be available to take their place. As a result, the ACA's effects on labor markets are projected to be smaller in the near term—so the effects of repealing the ACA also would be smaller.

Aggregate Demand. CBO and JCT estimate that repealing the ACA would decrease aggregate demand for goods and services in the short-term—reversing the projected effects of the ACA and slightly dampening output over the next two years or so. On balance, implementation of the ACA is expected to boost overall demand because the people who will benefit from the expansion of Medicaid or from access to the exchange subsidies are predominantly in lower-income households and thus are likely to spend a large fraction of their additional resources on goods and services—whereas the people who will pay higher taxes are predominantly in higher-income households and are likely to change their spending to a lesser degree. Similarly, reduced Medicare payments to hospitals and other providers under the provisions of the ACA will reduce income and profits, but those changes are likely to decrease demand by a relatively small amount. Given the projected effects of the ACA in spurring demand and output to a small degree over the next few years, CBO and JCT estimate, repealing the ACA would have the opposite effect.

Combined Short-Term Effects on Output. On balance, CBO and JCT estimate, the reduction in aggregate demand in 2016 that would stem from repeal of the ACA would roughly offset the rise in output caused by increases in labor supply and by the other factors described above, so projected output would be about the same in 2016 whether or not the law was repealed. Output would be higher, on net, in later years because the dampening effect on aggregate demand would wane and the other effects of repealing the ACA that boost output would strengthen—particularly the effects on labor supply.

Budgetary Feedback From Macroeconomic Effects

Taking into account the factors described above, CBO and JCT estimate that the macroeconomic effects of repealing the ACA would lower federal deficits by $216 billion over the 2016–2025 period. Most of that reduction would stem from an increase in revenues resulting from higher employment and taxable income, relative to projections under current law. Combined with the estimated effects of a repeal on federal deficits excluding macroeconomic feedback, the total result of changes in direct spending and revenues would amount to an increase in federal deficits of $137 billion over 10 years.

CBO and JCT's estimates of those macroeconomic feedback effects and the methods used to generate them depend in part on the types of provisions and categories

of feedback being analyzed. In estimating the feedback effects on revenues of repealing the noncoverage revenue provisions and the excise tax on certain high-premium insurance plans, JCT projected macroeconomic effects and net effective tax rates for several different types of taxable income (including wages, interest, dividends, capital gains, and business income). In analyzing the coverage provisions—which affect the economy primarily through their impact on labor supply—CBO estimated that the resulting increases in GDP would raise revenues in a roughly proportional way, primarily because income and payroll taxes would rise with higher compensation and income.

To estimate the effects of macroeconomic feedback on federal spending, CBO generally uses a simplified method that accounts for changes in GDP and interest rates, among other factors, but does not involve the sort of detailed program-by-program analysis that the agency uses for official cost estimates. As a rule, increases in GDP would have much smaller effects on federal spending than on revenues. CBO's estimates for discretionary programs incorporate the assumption that spending generally remains at the amounts projected in its budgetary baseline even if output changes.[21] For mandatory programs, CBO estimates, aggregate spending would be affected only slightly by a change in the rate of economic growth.[22]

The agencies' analysis of macroeconomic effects on the federal budget includes effects on interest payments caused by changes in interest rates. In 2016 and 2017, the reduction in overall demand estimated in the event of a repeal of the ACA would slightly reduce interest rates and, as a result, federal interest payments. Over the longer term, however, repealing the ACA would be expected to increase interest rates slightly—by roughly 5 basis points, or five one-hundredths of a percent—because of the resulting increase in federal borrowing. Under current law, federal debt held by the public (on which interest payments are made) is projected to be about $14 trillion in 2016 and about $21 trillion in 2025, so even small changes in interest rates can have a noticeable effect on interest payments as that debt is refinanced.[23]

Overall, CBO and JCT estimate, the macroeconomic effects of repealing the ACA would increase federal revenues much more than they would affect federal outlays. Specifically, the increase in output that would result from repealing the ACA would boost revenues by $225 billion over the 2016–2025 period.[24] By 2021, when the increase in output attributable to the legislation is estimated to reach 0.7 percent, the macroeconomic effects would boost federal revenues by nearly the same percentage—or by about $27 billion. (Under current law, federal revenues are projected to total about $4.2 trillion in 2021.) In subsequent years, however, the feedback to federal revenues would shrink slightly as a share of total revenues because of the macroeconomic effects of the projected increases in federal borrowing. Outlays would primarily be affected by the estimated changes in interest rates, falling initially and then rising slightly in later years. On net, CBO estimates, the macroeconomic effects of repealing the ACA would increase outlays by $9 billion over the 2016–2025 period.

Other Potential Effects on Output

Implementation of the ACA—and consequently, its repeal—could affect GDP and other aspects of the economy in several other ways. In CBO and JCT's judgment, however, those other effects generally would be small and probably would offset one another. For example, increases in insurance coverage stemming from the ACA could improve workers' health or their job matches, which could in turn make them more productive. In that case, repealing the law would have the opposite effect. The evidence about such effects is limited, however. One recent study also found that past extensions of Medicaid

21. Changes in projected prices and rates of inflation affect CBO's projections of discretionary spending. CBO estimates that if the ACA was repealed, those macroeconomic effects would be small, resulting in an estimated reduction in discretionary spending of less than a billion dollars over the next decade.

22. For GDP growth, CBO recently estimated that a reduction in the real (inflation-adjusted) growth rate of 0.1 percentage point per year over the next decade—which would reduce GDP by about 1 percent in 2025—would reduce mandatory spending only by $4 billion over that period. According to that rule of thumb, a corresponding increase in the rate of GDP growth over the next decade would be expected to increase mandatory spending by roughly the same amount. See Congressional Budget Office, *The Budget and Economic Outlook: 2015 to 2025* (January 2015), Appendix C, www.cbo.gov/publication/49892.

23. Reflecting a long-standing convention, CBO does not include in cost estimates the budgetary effects of changes in interest payments stemming from changes in the amount of debt incurred. However, the macroeconomic effects of those changes in interest payments are incorporated into the agency's macroeconomic analysis.

24. A portion of the $225 billion increase in revenues would come from increases in payments of Social Security payroll taxes, which are off-budget, but CBO cannot provide an estimate of that portion at this time.

eligibility for children increased their earnings and tax payments as adults.[25] However, the ACA did not substantially change the number of children eligible for Medicaid, so that finding is not directly relevant to an analysis of the ACA or its repeal.

At the same time, repealing the ACA could increase productivity through other channels. For example, productivity could fall, under current law, if businesses hired more part-time workers and fewer full-time workers as a way to avoid paying the penalties that the ACA imposes on larger businesses that do not offer health insurance to their full-time employees. In addition, businesses might invest less in their workers' training because workers will find it easier than they did under prior law to change jobs without losing health insurance, and the resulting higher turnover reduces the return on such investments. Repealing the ACA could thus reverse those effects, but in any event such effects would probably be small.

A repeal of the ACA also could affect saving rates by encouraging people to save more of their income to cover the expected costs of health care, which would in turn lower interest rates and boost output. Such effects would probably be small, however, and could be offset by the reinstatement of certain prior-law tests for Medicaid eligibility. Those tests limited the amount of assets that certain people could hold and still qualify for Medicaid, and reinstating those limits would, to a small degree, discourage savings.

Impact on the Economy and the Federal Budget Beyond 2025

Detailed, year-by-year projections of the effects of a repeal in years beyond 2025 would not be meaningful because the uncertainties involved are simply too great. Instead, CBO and JCT have made a rough assessment of the likely budgetary consequences in the decade after 2025 of repealing the ACA, with and without the effects of macroeconomic feedback. Both types of analysis indicate that repealing the act would increase deficits over the 2026–2035 period, and it seems likely that such legislation would result in higher budget deficits in later years as well.

25. David W. Brown, Amanda E. Kowalski, and Ithai Z. Lurie, *Medicaid as an Investment in Children: What is the Long-Term Impact on Tax Receipts?* Working Paper 20835 (National Bureau of Economic Research, January 2015), www.nber.org/papers/w20835.

Effects Excluding Macroeconomic Feedback

To assess budgetary effects in the decade after 2025, CBO and JCT grouped the elements of the estimate into broad categories, examining their rates of growth towards the end of the 10-year budget window, and projecting the rate at which the budgetary impact of each category would increase over time—as the agencies did during consideration of the ACA and similar legislation in 2009 and 2010, and when preparing their 2012 estimate of the effects of a repeal. Overall, CBO and JCT estimate that the direct spending and revenue effects of repealing the ACA would increase the federal deficit by $55 billion in 2022 and by amounts that would rise to $118 billion in 2025 (excluding the effects of macroeconomic feedback). For this analysis, the effects were grouped as follows:

- Net savings from repealing the ACA's coverage provisions would total $133 billion in 2025, and CBO and JCT estimate that the savings would be growing by about 2 percent per year toward the end of the 10-year budget window. That estimate of slow growth reflects several factors, but one reason those savings would grow relatively slowly in that period (and in later years) is that the annual updates to exchange subsidies are structured in a way that will tend to slow their growth—which would limit the savings from a repeal.[26] Another reason is that the revenues stemming from the excise tax on certain high-premium insurance plans will grow rapidly as more plans are affected by that tax, and the loss of those revenues would reduce the net savings from repealing the coverage provisions.

- Repealing changes that the ACA made to Medicare, Medicaid, and other federal health programs—other than those associated directly with expanded insurance coverage—would cost a total of $168 billion in 2025, and CBO estimates that those costs would be growing by about 15 percent per year toward the end of the 10-year budget window. That rapid growth would occur because repealing the ACA's reductions in updates to Medicare's payment rates would increase the growth rate of that program's spending, and thus the costs of repealing those provisions would compound over the next decade.

26. For additional discussion of the provisions that govern the annual updates for exchange subsidies, see Congressional Budget Office, *The 2015 Long-Term Budget Outlook* (June 2015), pp. 33–34, www.cbo.gov/publication/50250.

- Repealing the ACA's revenue provisions that are not related to insurance coverage would result in revenue losses totaling $83 billion in 2025, and JCT estimates that those losses would be growing by about 6 percent per year toward the end of the 10-year budget window.

Extrapolating the budgetary effects for each category using the growth rates described above yields an estimate that repealing the ACA would continue to increase federal deficits substantially in subsequent years. In particular, CBO and JCT conclude that repealing the ACA would increase federal budget deficits over the 2026–2035 period, relative to the deficits that would occur under current law, by amounts that lie within a broad range around one percent of GDP. The imprecision of that calculation reflects the greater degree of uncertainty surrounding it relative to CBO and JCT's 10-year estimates.

Effects Including Macroeconomic Feedback

The same macroeconomic effects that would generate budgetary feedback over the 2016–2025 period also would operate farther into the future. However, the net savings stemming from those effects would start to decline after 2019, CBO and JCT estimate, and would continue to shrink after 2025. Although the increase in labor supply would continue to boost output and revenues in a roughly proportional way, the growing increases in federal deficits that are projected to occur if the ACA was repealed would increasingly crowd out private investment and boost interest rates. Both of those developments would reduce private investment and thus would dampen economic growth and revenues; the increase in interest rates also would increase federal interest payments.

On balance, output would probably be higher over the 2026–2035 period as a result of repeal, but incorporating the budgetary effects of macroeconomic feedback would not substantially alter the estimated increase in federal deficits over that period—which would remain within a broad range around one percent of GDP. Including the effects of macroeconomic feedback, a repeal of the ACA would probably increase deficits in subsequent years as well.

Uncertainty Surrounding the Estimates

Although CBO and JCT have endeavored to develop estimates that are in the middle of the distribution of potential outcomes, that distribution spans a wide range. Estimates of the budgetary impact of repealing the ACA are based in large part on projections of the law's effects, which are themselves highly uncertain. Assessing the effects of broad changes made by the ACA in the nation's health care and health insurance systems requires estimates of a broad array of technical, behavioral, and economic factors that are difficult to predict. For example, the effects of the ACA on insurance coverage depend on how individuals, employers, and insurers respond to the subsidies and penalties and related changes instituted by the act. Uncertainty about those factors translates into still more uncertainty regarding the budgetary effects of repealing the act's insurance coverage provisions.[27]

As for the other provisions of the ACA, separating their incremental effects on outlays for continuing programs and existing revenue streams from other factors that affect those outlays and revenues can become more difficult and uncertain over time because more of those other factors may arise. The substantial discretion that would be given to executive branch agencies to determine how to implement a repeal of the ACA is yet another source of uncertainty.

Several other sources of uncertainty stand out: the Supreme Court's forthcoming ruling on exchange subsidies; the responses of providers over the longer term to the ACA's reductions in Medicare's payment updates; the degree to which the recent slowdown in overall spending on health care will persist, and the nature of the ACA's role in that slowdown; and the law's macroeconomic effects, particularly concerning labor markets.

The Supreme Court's Ruling

Currently, a particular source of uncertainty involves the outcome of litigation regarding whether people may receive subsidies for coverage purchased through exchanges that are operated by the federal government rather than by a state government. The Supreme Court is expected to rule on that case later in June 2015. Until that

27. One area of uncertainty involves the extent to which employers will continue to offer health insurance coverage to their workers under current law. However, CBO and JCT's analysis found that even if the changes in employment-based health insurance differed substantially from those projected, they would have limited effects on the budgetary impact of the ACA because changes in the availability and take-up of such insurance affect the federal budget in several ways that are partly offsetting. See Congressional Budget Office, "The Effects of the Affordable Care Act on Employment-Based Health Insurance," *CBO Blog* (March 15, 2012), www.cbo.gov/publication/43090.

ruling is issued, CBO and JCT's baseline projections reflect the way the ACA is currently implemented, which involves people in many states receiving subsidies through what are known as federally facilitated marketplaces or through exchanges established in partnership between the federal government and a state government. In the event that the Supreme Court ruled that those subsidies must cease, CBO and JCT would reduce their projections of spending under current law and would reduce their estimates of the savings generated by repealing the ACA's coverage provisions. The magnitude of such changes would depend on the specifics of the Court's ruling. If instead the Court ruled that the exchange subsidies are being issued properly, CBO and JCT's baseline projections—and the estimates contained in this report—would not be affected by the Court's ruling.

Providers' Responses to Changes in Payment Rates

An important source of uncertainty in projecting health care spending under current law for the long term involves the way that providers will respond to scheduled restraint in annual updates to Medicare's payment rates—and whether those responses will lead to offsetting increases or further reductions in spending for Medicare and other health care programs. The scheduled updates in the payment rates would generally fall below increases in the prices of inputs (namely, labor and supplies) used to deliver care. To keep the growth of their costs in line with the growth in those payment rates, providers could use fewer inputs per patient over time—that is, they could raise their productivity—or seek to control costs in other ways. If providers cannot achieve significant gains in productivity, they might reduce the quality of care offered to Medicare enrollees, reduce enrollees' access to care (which might reduce spending), or seek to increase revenues by other means (which might increase spending).[28] The nature of such responses, if any, under current law would also affect the budgetary consequences of repealing the ACA.

Trends in Health Care Spending

Substantial uncertainty also surrounds the question of whether repealing the ACA would affect spending for health care in ways that are not captured directly in the estimates presented above. Health care spending has grown more slowly in recent years than it has historically, both in absolute terms and relative to the pace of economic growth. But that slow growth might not persist under current law. Although many analysts attribute at least a portion of the slowdown to the effects of the recent recession and slow recovery, there is debate about the role of structural or other changes in the health sector and whether and how enactment of the ACA has encouraged those changes. Some considerations suggest that the effect of the ACA's enactment may be limited:

- CBO's own analyses and other studies have shown that Medicare spending began to slow before the enactment of the ACA—and before the recession—and CBO also found that the direct effects of the recession explained very little of that slowdown, suggesting that other factors were at work.[29]

- The overall slowdown in the growth of spending occurred when very few of the ACA's provisions had been implemented in any substantial way, making it difficult to attribute much of the slowdown to the effects of specific provisions of that law.

- At a more qualitative level, the last time health care spending grew at roughly the same rate as the economy for an extended period was in the mid- to late-1990s—after an unsuccessful attempt to enact major health care legislation—which suggests that attention to the issue rather than enactment of legislation could be an important factor.

Nevertheless, it is difficult to dismiss the argument that implementation of the ACA's provisions has in some way fostered a focus on cost control that has encouraged slower growth in spending. As one analysis concluded recently, however, "it is impossible to quantify how much the ACA has truly contributed to the reduced spending projections over time"—at least until more extensive data and analyses are available.[30] Reflecting that view, CBO

28. For additional discussion, see Congressional Budget Office, *The 2015 Long-Term Budget Outlook* (June 2015), pp. 38–40, www.cbo.gov/publication/50250.

29. See Michael Levine and Melinda Buntin, *Why Has Growth in Spending for Fee-for-Service Medicare Slowed?* Working Paper 2013-06 (Congressional Budget Office, August 2013), www.cbo.gov/publication/44513; and Chapin White and Paul Ginsburg, "Slower Growth in Medicare Spending—Is This the New Normal?" *New England Journal of Medicine*, vol. 366, no. 12 (March 22, 2012), pp. 1073–1075, www.nejm.org/doi/full/10.1056/NEJMp1201853.

30. See John Holahan and Stacey McMorrow, *The Widespread Slowdown in Health Spending Growth: Implications for Future Spending Projections and the Cost of the Affordable Care Act* (Robert Wood Johnson Foundation and Urban Institute, April 2015), p. 11, http://tinyurl.com/q7j6kkc.

and JCT have not incorporated such an effect into this estimate. But to the extent that such an effect has occurred and would continue under current law, repealing the ACA would generate a larger increase in federal deficits than is estimated here. Specifically, repealing the ACA would cause spending on Medicare and Medicaid to grow more rapidly—and the substantial costs of the tax preference for employment-based health insurance to grow more quickly—than is reflected in this estimate.

Responses in Labor Markets

Finally, there is considerable uncertainty surrounding CBO and JCT's estimates of the macroeconomic effects of repealing the ACA, largely because of the uncertainty concerning the consequences of that law for labor markets. That uncertainty arises in part because many of the ACA's provisions have been in place for less than two years and in part because estimates of how workers and businesses might respond vary considerably. CBO and JCT seek to provide estimates of macroeconomic effects that lie in the middle of the distribution of potential outcomes, but the actual effects of the ACA could differ notably from their estimates. For example, if fewer people obtain subsidized insurance coverage through exchanges under the ACA than CBO and JCT expect—or if those people respond less strongly to incentives regarding work than the agencies have estimated—then the effects of the ACA on employment and output would be smaller than estimated in this report (the same would be true for the cost of those subsidies). Alternatively, if more people obtain subsidized coverage through exchanges, or if the subsidy system affects their labor supply more strongly, then the ACA's impact on the labor market and the economy (and the cost of subsidies) would be larger. The effects of repealing the ACA could thus be smaller or larger as well.

Overall Magnitude of the Uncertainty

Quantifying the variation in budgetary effects that might stem from any source of uncertainty is difficult, and trying to capture the likely effects for all of them simultaneously would be harder still. As a qualitative matter, however, the range of important uncertainties and the large flows of funds that are affected by the ACA suggest that the variation in budgetary effects of repealing that law could be substantial. Although CBO and JCT's best estimate is that repealing the ACA would increase federal budget deficits by $137 billion over the 2016–2025 period through its effects on direct spending and revenues, the effects on federal deficits of repealing the ACA could differ, in either direction, from the central estimates presented in this report by a sum that exceeds that amount. Thus, the uncertainty is sufficiently great that repealing the ACA could in fact reduce deficits over that period—or could increase deficits by a substantially larger margin than the agencies have estimated.

For the decade after 2025, the estimated effects on deficits of repealing the ACA are so large as to make it substantially less likely that a repeal could reduce deficits. The range of uncertainty grows wider over time, however, because it becomes more and more difficult to project health care spending—a key driver of both the costs and the savings generated by the ACA. Over a long horizon, a wide range of changes could occur in people's health, in the sources and extent of their insurance coverage, and in the delivery of medical care (reflecting factors such as advances in medical research, developments in technology, and changes in patterns of medical practice) that are likely to be significant but that are very difficult to predict, both under current law and under any proposal to repeal the ACA.

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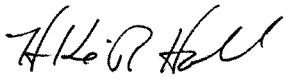
About This Document

This Congressional Budget Office report was prepared at the request of the Chairman of the Senate Budget Committee. In keeping with CBO's mandate to provide objective, impartial analysis, this report makes no recommendations.

Philip Ellis wrote the report and contributed to the analysis with significant input from Benjamin Page. Thomas Bradley, Lori Housman, Paul Masi, Kevin McNellis, Jamease Miles, Lara Robillard, Erica Socker (formerly of CBO), Zoe Williams, and Rebecca Yip prepared the analysis of effects on Medicare. Chad Chirico, Julia Christensen, Kate Fritzsche, Daniel Hoople, Sarah Masi, Andrea Noda, Lisa Ramirez-Branum, Robert Stewart, and Ellen Werble prepared the analysis of effects on Medicaid, exchange subsidies, and other federal health programs. Jessica Banthin, Sean Lyons, Alexandra Minicozzi, Eamon Molloy, Romain Parsad, Allison Percy, Sam Trachtman (formerly of CBO), and Christopher Zogby contributed to the analysis of effects on Medicaid and exchange subsidies. The staff of the Joint Committee on Taxation contributed to the analysis of effects on exchange subsidies and revenue changes associated with employment-based health insurance and prepared the analysis involving revenue provisions. Paul Burnham, Devrim Demirel, Ed Harris, Janet Holtzblatt, Jonathan Huntley, Leah Loversky, Shannon Mok, Frank Russek, and the staff of the Joint Committee on Taxation prepared the analysis of the macroeconomic feedback. Linda Bilheimer, Wendy Edelberg, Theresa Gullo, Mark Hadley, Holly Harvey, and David Weiner provided guidance and helpful comments.

Jeffrey Kling and Robert Sunshine reviewed the report, Kate Kelly edited it, and Maureen Costantino and Jeanine Rees prepared it for publication. An electronic version is available on CBO's website (www.cbo.gov/publication/50252).



Keith Hall
Director

June 2015

Mrs. DAVIS. Thank you, Mr. Chairman.

Thank you very much, Madam Secretary, for being here, for your service, and for joining us today.

You mentioned NIH earlier. I know that you care deeply that we continue to fund this at higher rates. We absolutely cannot fall behind the global community in how we address science and innovation. And so I think that's very, very important. And I'm pleased that the President has increased that funding.

But I also wanted to talk about not just the innovation piece of it, but really the access piece and affordability, and particularly focus on the changes that you have recommended in reforming Medicare Part D.

And specifically in ways that you call for in the budget request in terms of reducing Medicare costs both for the government and the consumer and looking at the question of giving authority to you and to the Department to negotiate drug prices in Medicare Part D. So can you talk a little bit about that and why that is part of the budget and why you think that this is so important?

Secretary BURWELL. I think that we believe that the ability, as we look and address the issue, one of the issues that was brought up—the question of the long-term health of Medicare and how we work on that, is that we look at some of the issues that will be driving costs in the out year. We believe that drug costs are a part of that, and we see that happening. We see that both in terms of the numbers we see now, but in the out-year projections we also hear it from the private sector.

So the belief is, and, you know, having come from the private sector and actually having come from a company that is known for its negotiating on price, Wal-Mart, the idea that we use market mechanisms to try and put downward pressure on price is something that we think is important. And so that's why we've asked for those authorities so that we can try and work with the pharmaceuticals and negotiate to keep downward pressure on that price. That's what we hope we can do, and we see it as part of the overall issues that we're being asked about, how we transform the system for the long term. We believe there are things that we need to do and pressure we need to put.

Mrs. DAVIS. What do you see as some of the key problems that you're going to be having as you try to move forward with this?

Secretary BURWELL. So I think with regard to this particular issue, it's not one, you know, it is a legislative and a statutory issue. And so it will take a statutory change to grant the authorities to be able to negotiate. That's not something that administratively we can do. So it is something where the action will sit with the Congress.

Mrs. DAVIS. Uh-huh, yeah. Well, thank you for working on that. I know it's not a simple way of moving forward, but it does seem to make a difference. And there have been so many stories lately about how the high costs have, really, not just bankrupted families, but made it very difficult for people to access important lifesaving drugs.

I wanted to just for a moment also talk about the increasing access for folks here at home. And we know that the ACA really has been a huge success in helping to reduce the number of the unin-

sured. I actually have a constituent in my district who was going regularly down to Tijuana to get the medications that she needs, and this now means, as a result of her being insured, that she doesn't have to do that any longer, and it has been a big difference in her life.

So I wondered if you could just talk a little bit about how dramatic the increase in the uninsured population has been since the implementation of the ACA and what this additional coverage has meant in terms of increasing patient outcomes.

Secretary BURWELL. So with regard to that, I will try and be brief, and just in terms of numerically the number I think you know is over 16 million is the number of reduction in the insured. With regard, I think what tells the story better are the individuals, and whether that's Anne Ha, a woman who was 26, uninsured, her mother told her to sign up; she needed insurance, she didn't, but in the end she listened to her mom. A month later she discovered she has stomach cancer and had the coverage that she needed. And that coverage both helped her for her health and actually, recently married, and in addition to that, though, the financial security in terms of her business and her availability to continue on in that way as well.

So I think it's the individual stories combined with the numbers in terms of what we're seeing of what the extended coverage means.

Mrs. DAVIS. Right, yeah. I particularly have heard about that when it comes to type 2 diabetes and the prevention that's made a real difference for those folks. So thank you very much for your service.

Thank you, Mr. Chairman.

Chairman KLINE. The gentlelady's time has expired.

Mr. Walberg, you are recognized for five minutes.

Mr. WALBERG. Thank you, Mr. Chairman.

And thank you, Madam Secretary, for being here. Thank you for reaching out to us before this as well.

I want to ask you the first question, how many fictitious claims have been paid since enactment of ObamaCare, and how much has been lost due to this fraud? But to just bring it into context here, earlier this month, GAO released a report that investigated Healthcare.gov through various undercover tests performed throughout the 2014 coverage year. The report revealed some stunning things, that the marketplace approved subsidized coverage for 11 out of 12 fictitious applicants created by GAO resulting in a payment, they state, of about $30,000 to insurers on behalf of these fake enrollees.

For seven of the 11 successful fictitious applicants, GAO intentionally did not submit all the required verification documents to the marketplace, and the marketplace even then did not cancel subsidized coverage for these applicants despite the inconsistent and incomplete information.

And so subsequent to that, how many fictitious claims have been paid since the enactment of ObamaCare, and how much has been lost due to the fraud?

Secretary BURWELL. So with regard to the example, we take very seriously the issue of program integrity and want to continue to

improve it. We look forward to the GAO's recommendations out of that study. We haven't seen those yet. We look forward to understanding what they are, because we welcome the opportunity.

With regard to the question of answering the number, because GAO didn't find actually that there were fictitious claims, they did, when they had individuals who came through the system—first, they came to Healthcare.gov, the marketplace in terms of electronically, couldn't get through. Then they actually came through, through the phones, and that's where they got through. At that point, because they are GAO, they were able to do things that for everyone else would be perjury; that would have up to a $250,000 fine affiliated with it.

Mr. WALBERG. And they were successful?

Secretary BURWELL. And were successful in breaking the law in terms of what they were doing to go through.

With regard to the next step, and there are a number of gates. There's the gate at Healthcare.gov, in terms of that was where it was caught. Got through at the point, you know the question of confirmation of information. Then because they did not file taxes, what will happen to these individuals is in this year, as per statute, they will no longer be able to get subsidies in the next year, because at that point the IRS will let us know that they have not filed taxes.

Mr. WALBERG. So, we don't know how many fictitious complaints may have been filed already other than GAO?

Secretary BURWELL. No, we don't. We know of the 11 examples of GAO—

Mr. WALBERG. We know that.

Secretary BURWELL.—with regard to those that have committed—

Mr. WALBERG. Twelve examples, 11 got through.

Secretary BURWELL. With regard to those are the only examples we know of because as GAO said in the report, they didn't know of other examples other than those that they had created.

Mr. WALBERG. They don't, yes. But you don't know either?

Secretary BURWELL. So, with regard to the things we have in place, what we do know is we have a number of steps in place. And within 90 to 95 days, we go through data matching. And this year already, 117,000 people who have not—we don't know that they are fictitious, we know that they have not provided the right documentation—and the first quarter of this year, 117,000 people came off.

Several other hundred thousand people, over close to 200,000 people, received information saying we did not have enough justification for their income and, therefore, their APTC, their tax credit, would be adjusted downward.

Mr. WALBERG. What—

Secretary BURWELL. So we are on a constant path of making sure we have the information that aligns with what we have been told, and if not, we are taking action.

Mr. WALBERG. Without getting into specifics of these cases that were successful, again, which shows that there should be concern, can you explain to the committee what process has likely failed to allow these fictitious applicants to gain subsidies?

Secretary BURWELL. So, there are a series of processes that occur. And in terms of the gates, when people have lied about their information – it's something that can happen in the system. It can happen in all of our systems. The way we catch that is in the data matching and information. So it depends on whether they've lied about which part and that could have to do with—

Mr. WALBERG. But which ones failed?

Secretary BURWELL. Pardon me?

Mr. WALBERG. Do we know which ones failed that allowed.

Secretary BURWELL. No, because we have not seen the GAO examples. One of the things that would be very helpful to us is to actually see the example. Because all we know is what you've said. And if we have the information, then we can find where the system may not be working. Right now in terms of the system, as the examples I gave you—

Mr. WALBERG. What's keeping you from getting the examples, then, if that's the case? This came out earlier in July.

Secretary BURWELL. At this point, the GAO has neither given us recommendations or—

Mr. WALBERG. Have you asked for it?

Secretary BURWELL. We have asked the GAO in terms of can we understand how you did this. They believe they are protecting their sources and methods.

Chairman KLINE. The gentleman's time has expired.

Mr. Grijalva, you are recognized for five minutes.

Mr. GRIJALVA. Thank you.

Thank you, Mr. Chairman, and thank you, Madam Secretary. With regard to the GAO question you just received, the gaming of the system and the process, is this such a rampant phenomenon that it is undercutting the very pinning's of the *Affordable Care Act* or are we dealing with an issue in which as you get more information, you deal with it?

Secretary BURWELL. At this point, there are a number of gates and efforts on program integrity in place, and that's the initial information gathering, which we check at the hub at that point, when that goes through, we also—when we don't have data matching, as I said, within 90 to 95 days, we review those cases, we take action.

At the point of the filing of taxes and in the examples that we are given, folks didn't file their taxes, that is the next place where that would occur, and the next gate will occur in terms of that people choose not to file their taxes for some reason, that is the point at which subsidies will go away.

We have a number of gates in place. We are implementing those. If we can understand places where people think those aren't working, we do want to understand that so that we can work to improve. We have improved the timetable.

Mr. GRIJALVA. But GAO shares the methodology with you and those examples. We are waiting—you are waiting for that, correct?

Secretary BURWELL. We are looking forward to GAO coming out with recommendations, which is the part that has not yet occurred.

Mr. GRIJALVA. Thank you. The President's commitment to early childhood education, it is reflected in the budget proposal, $1.5 billion extra for early head start and for head start itself. Briefly, if

you could tell us, you know, the budget levels of spending caps established by the majority, what is that going to do to the fact that you are trying to build capacity, you are trying to stress quality and accountability for providers for these children, and what does that do to capacity?

Secretary BURWELL. So with regard to the levels, I think that if you are going to meet those levels and you want to fully fund head start, what it will mean are dramatic cuts to things like NIH or CDC in terms of other places. I think we believe we put together a budget that is a budget that as I mention, you know, there is savings in terms of deficit reduction that comes from the HHS budget as a whole, that we put together a plan and an approach that affords us the opportunity to fund all of those things.

But at the current cap levels, you would not be able to do that, and so you would not be able to implement the changes in head start or you would have to make dramatic choices in other places. One of the largest budget areas for HHS is NIH.

Mr. GRIJALVA. Yeah. And I think the last point, community health centers, that was mentioned briefly in your testimony. At least in my community, it is an essential network for health delivery, an essential part of the *Affordable Care Act* delivery system. If you could talk to the committee as to that role and how the budget that you are talking about is reflecting an—continuing that commitment that the President made to the health centers at the inception of the *Affordable Care Act* discussion?

Secretary BURWELL. And we appreciate the work that was done also in the sustainable growth rate bill in terms of these issues. The community health centers serve approximately one in 15 Americans actually are served by community health centers. We think they are an integral part of care. They are an integral part of primary care, a very important part of making sure as we expand access that we have an ability to serve.

That is a part of why they were extended as part of the original *Affordable Care Act* and are extended now, as we have seen in the number of uninsured drops so that there are places for people to go as part of that. We believe they are a successful part of coverage, especially in communities that don't always have as much, and whether that is rural, minority, or other communities, that these are an important part of that.

They are also an important part of integrating behavioral health and primary health together so that we can get to the place where that type of coverage is one.

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

Chairman KLINE. The gentleman yields back.

We are going to move members to four minutes because we are watching the clock. I can't seem to get it to slow down, so Mr. Guthrie, you are recognized for four minutes.

Mr. GUTHRIE. Thank you.

Thank you, Madam Secretary. Thank you for being here again, and I appreciate it. I want to talk about the employers' sponsored health insurance, the small market group definition. The *Affordable Care Act* in Section 1304 expands the small market group definition to 100 employees, so of particular concern are employers

from 51 to 100, because if you are below 50, you are not mandated to provide.

Once you are, maybe 100, 102, I don't know what the number is, but once you start growing, then you are able to self-insure when you get a bigger pool because a lot of bigger businesses aren't having the same issues.

So the trap seems to be, and I have heard from a lot of employers' insurers and actually, a lot of colleagues on both sides of the aisle have been working to try to fix this problem. And I have seen estimates of a 30 percent increase from different studies. But the issue is, you know, employers from 51 to 100, if they go into this small market group definition, will have expensive mandated benefits, and there is a big concern, as I said. It is bipartisan over here in the Capitol, and so I just wondered if you have looked at this issue and what actions are you looking at taking?

Secretary BURWELL. So looking at the issue right now, one of the things I would ask, if we could follow up with you and your staff to make sure that we are getting the comments that you are hearing directly from either employers or other groups. It would be very helpful. There is, you know, another side in terms of expanding the other market that people argue, but we would love to hear directly if you have those comments—

Mr. GUTHRIE. Absolutely.

Secretary BURWELL.—as we are reviewing that. It would very helpful to hear the specifics of why people assume it will work the way that you described it working. There are others that argue the other side of this issue, so it would be helpful if you could follow up on that evidence.

And so, I want to understand in terms of a policy perspective and then the question is would we have authorities, and so those are the two questions we are examining right now. It is a timely conversation, so if I could ask that we follow up with your team or you directly to—

Mr. GUTHRIE. Absolutely.

Secretary BURWELL.—make sure we have those comments. I would appreciate having the facts from the field to inform our conversation.

Mr. GUTHRIE. Okay. We will make sure that happens. There is a bill, it is H.R. 1624, and it has 158 cosponsors and is bipartisan. It is not just—I mean, it is a very bipartisan, look at what is going on, and having said that, Mr. Chairman, I have a letter actually—and I do have a letter, we will share it with you, from 19 employer groups regarding this, and I would like to enter into the record, unanimous consent to enter into the record.

Chairman KLINE. Without objection.

[The information follows:]

April 3, 2015

Dear Representatives Guthrie, Cárdenas, Mullin and Sinema,

The undersigned organizations represent the interests of millions of businesses of every size, sector, and region. As employer organizations, we applaud your introduction of legislation (H.R. 1624) maintaining the current definition of a small group market as 1-50 employees, and giving states the flexibility to expand the group size if the market conditions in their state necessitate the change. It is in the best interest of employers and their employees that states determine the definition of their small group market. Repealing the ACA mandated expansion and returning the historical role of state determination will allow flexibility and ensure a broad array of coverage options and mitigate dramatic premium increases.

Expanding the small group market to include groups up to 100 at this time would reduce choice for this segment of the market. While national insurers are in virtually every state's large group market, they are only in a portion of the small group markets – which have numerous administrative requirements for entry. As a result, many groups size 51-100 will find that they cannot keep the insurer they currently have once they are required to buy coverage in the small group market. Your legislation will help these small businesses keep their plans.

Further, expanding the small group market to include all groups with up to 100 employees would have an immediate impact on premiums due to new rating rules, required Essential Health Benefits, and minimum actuarial value and cost sharing requirements. As rates increase, more mid-sized groups may drop coverage or self-insure, resulting in additional rate increases for the small group market – including for those employers with less than 50 employees. Your legislation allowing states to maintain the existing small group market size will mitigate premium increases and allow employees to keep their existing plans.

We thank you for your leadership on this issue. We urge you to continue to work toward its swift passage to give states the flexibility to help protect small employers and their employees.

Sincerely,

American Hotel & Lodging Association
American Rental Association
American Supply Association
Associated Builders and Contractors, Inc.
Auto Care Association
Council for Affordable Health Coverage

Healthcare Leadership Council
International Franchise Association
National Association of Health Underwriters
National Association of Home Builders
National Association of Manufacturers
National Association of Wholesaler-Distributors
National Club Association
National Federation of Independent Business
National Restaurant Association
National Retail Federation
Society of American Florists
The Society for Human Resource Management
U.S. Chamber of Commerce

Mr. GUTHRIE. Thank you, Madam Secretary, and I yield back.

Chairman KLINE. The gentleman yields back.

Mr. Courtney, you recognized for four minutes.

Mr. COURTNEY. Thank you, Mr. Chairman, and thank you, Madam Secretary, again for your accessibility since taking over, and it's much appreciated. For the record, I just want to note we had a great conversation to talk about the observation coding issue, which still is a very, I think, widespread problem out there for folks who are discharging from hospital, and unbeknownst to them, find themselves in this sort of coverage gap for Medicare to cover medically prescribed services.

Since we spoke about the two-day midnight rule, I have already got a sheath of input from folks who, again, I will share with you about why that by itself is just not a solution to this problem. So but we will move on.

The chairman mentioned earlier about the insurance rate increases that were reported a while ago in the press. I would just point out, coming from Connecticut, a State which embraced this law, is now in year three of its exchange.

Just a couple of days ago, some of the insurers who participate in the exchange revised downward their initial rate request, so for example, Anthem came in at 6.7. They revised downward to 4.7. This is prior to insurance department rate review. The Co-op, which last year cut its rates by 8 percent, came in with a 13 percent rate increase. They revised downward to 3.4 percent. And the largest insurer on the exchange, ConnectiCare, which is a private health insurance company, they came in with a whopping two percent increase earlier. They have now revised downward to .7 percent.

And I point this out because this is a cohort that actually has claims experience under its belt now, so that the fear amongst the actuaries, that the walking wounded, in the exchanges were going to spike up, you know, in the initial years. I mean, we are actually seeing incredible stability in terms of the rates.

We also are seeing new insurers come into the marketplace. Harvard Pilgrim is now knocking on the door and is coming in to sell their product in Connecticut. So again, your Department has been boosting the insurance department rate review piece of this, and I am just wondering, you know, if you could share, you know, from a global standpoint, you know, whether or not some of these fears are really overstated?

Secretary BURWELL. So with regard to the rate issue, it is—I think what you were pointing to is one of the things about the Act that is important is about adding transparency and the light of day to things in the marketplace to make a market work so that individuals have information and that there is pressure in the market to make it work, and that was one of the ideas.

And so when people saw the rates, the rates that were reported are only the rates really, in most States, that are above 10 percent because that is required. If a company is going to raise the rates above 10 percent, part of the law is they have to—it has to be posted. We have to report it while the State insurance commissioners review it. That is the other part of this, is that it needs to be reviewed. It doesn't just happen that they propose it.

If they are going to propose above 10 percent, they need to justify it, and so that is a part of the process at work. And what you see in terms of Connecticut and what just happened is, that creates downward pressure, both in terms of the public pressure and the requirement that you have to justify any rate increases.

And so we think, overall, what we have seen last year is that the rates come in here and then that there is downward pressure. We also see in States like Connecticut and actually California just came through yesterday, and their rates were at 4 percent, which is lower than their increase of last year.

And so that is what we will continue to watch and monitor. The reason we recently had a conversation with the State insurers to make sure they know and are using that tool of rate review, to put that downward pressure, which we believe is an important thing to do, making the market work.

Mr. COURTNEY. I mean, as a former small employer who double digit requests were—you know, or increases were just a matter of course, I mean, to see a 2 percent or .7 percent, or—really that is eye popping in terms of—

Secretary BURWELL. The difference.

Mr. COURTNEY.—the stability.

I yield back, Mr. Chairman.

Chairman KLINE. The gentleman yields back.

Mr. Barletta, you are recognized for four minutes.

Mr. BARLETTA. Thank you, Mr. Chairman.

Secretary Burwell, my district is home to a number of small family run businesses that sell premium cigars to adult consumers. These job creators have expressed to me concerns about the impact of an expansion of FDA's regulatory authority under the *Tobacco Control Act* on their businesses.

Their shops serve a distinctly adult clientele, and I do not believe this category was the intent of Congress in 2009 when the law was passed. Can you tell the committee what steps you are taking to ensure that such businesses, which are a staple of Main Street America, are not regulated out of existence?

Secretary BURWELL. With regard to right now, as we are in the middle of a rulemaking process, I think you probably know that we actually proposed two different alternatives as part of the rule. To gather the evidence and information with regard to the question of premium cigars and how they are or are not sold to children, you know, that was a part of what we are trying to do, and we are reviewing that and we are in the middle of that process now.

Having said that, as we are in that process, a part of your question was the recognition of small employers, and that is something that will be taken into consideration, no matter where the rule ends. It is something, I think, is very important that we do as we think about implementation, and so wherever the rulemaking comes out, as we are in the process, but I do want to recognize the point that you have made, which is making implementation for small employers and small institutions possible, whatever it is.

It is something we consider a real priority and something we believe, no matter where you are we can work on as part of implementation.

Mr. BARLETTA. The proposed deeming rule has been under consideration for more than a year. Regulatory uncertainty is exceptionally challenging for small businesses, who are trying to plan for the future, as you know, open new stores, hire more workers, and serve their customers. When do you anticipate this rulemaking to be finalized?

Secretary BURWELL. I am hopeful that we will do it as quickly as possible. I think the issue you have raised is one of many complex issues that we received, I think you know, a number of comments on. We are trying to work through how we get to a balanced answer is what we are doing and trying to do that as quickly as possible. We appreciate the point that you made about uncertainty, again, in terms of recognition of what this means for the business community, especially small players.

Mr. BARLETTA. Okay. Thank you. I yield back, Mr. Chairman.

Chairman KLINE. The gentleman yields back.

Ms. Bonamici, you are recognized for four minutes.

Ms. BONAMICI. Thank you, Mr. Chairman, and thank you, Secretary Burwell, for your testimony, and thanks to you and the Department for all your work on so many issues, healthcare, precision medicine, I am interested in that, mental health services, thank you for your work on early childhood education, community and family support programs.

I want to spend my short time talking about the *Older Americans Act,* which recently celebrated its 50th anniversary, and I want to thank Chairman Kline and Ranking Member Scott, I know they are committed to working together with my colleagues and me to successfully reauthorize the OAA. Thank you to Dr. Foxx for calling out the issue of elder abuse, and I want to emphasize that elder abuse includes both physical abuse, but also financial abuse.

So I have three questions, and I think what I will do is tell you what the three are to save time. First, as we know, the population of older Americans is changing rapidly, so can you talk about what steps you are taking to modernize the administration for community living programs, as our older population is becoming increasingly diverse.

Secondly, when I talk to people about the *Older Americans Act,* they know about the nutrition programs, especially programs like Meals on Wheels. We know that the population of seniors is expected to double by about 2050, so we all support investments that will yield greater efficiency. So can you talk about how the Department is promoting evidence-based practices among nutrition providers and how you plan to spur innovation in those essential nutrition services? We know that oftentimes that is the only social contact seniors have as well is with that meal.

And then my third question has to do with the family caregiving. Seventy-seven percent of caregivers say that family caregiver support services make it possible for them to continue to care for their loved ones, it keeps seniors at home, but of course, it is hard work, and training in respite care services for caregivers are very important. Many of these caregivers are in the sandwich generation where they are taking care of parents and children at the same time. So what is the Department doing to prepare and support a large diverse community of caregivers?

Secretary BURWELL. So we will quickly try and work through each of these. In terms of the modernization, a part of the modernization, as I discussed, how we actually went about doing the White House conference on aging.

Ms. BONAMICI. Right, right.

Secretary BURWELL. And getting that input because it was a very different approach in terms of being out in the community, using technology, including the fact that the White House Conference on Aging, actually people could participate through technological approaches, and so changing the way we think about our work in terms of technology and the fundamental idea of people's engagement in our programs and their feedback, being more customer friendly and doing it in ways that use technology are two things in terms of the modernization.

In terms of the evidence-based practices around nutrition and meals, and I think that is part of a broader category of what I would consider prevention and preventative care and making sure that we are doing that correctly. And that, I think, is actually centered a little less than ACL and a little more with CMS, and it is also a part of the *Affordable Care Act* in terms of people knowing that they can do preventative and wellness visits without copays.

Those numbers are increasing. We need to increase them more, so the people accessing those services are not at the level—they are improving, but it is a place where we need to send more time. Nutrition and wellness comes into that as well in terms of how it fits into this broader thing that I think changes that but changes a larger piece.

The last piece is the family caregiving and encouraging that staying in community at home. And you probably have seen our most recent rulemaking at CMS, which is an important part of reforming the overall system of delivery of our healthcare and paying in ways that encourage that kind of care at home. And so the rulemaking and the demonstration we are doing there are probably our most effective tools because those are the ones that scale broadly and because payment is an important part of how people are making these decisions about staying in a community versus making a change.

Ms. BONAMICI. Thank you so much. I see my time has expired. Thank you, Mr. Chairman.

Chairman KLINE. Thank the gentlelady.

Mr. Carter, you are recognized for three minutes.

Mr. CARTER. Thank you, Mr. Chairman.

Ms. Burwell, earlier this year you received a letter, along with Secretary Lew, from a group of employers with workforces who have variable hours, and it was specifically to address the employer notice and appeals process, because it is very important for employers to get notification about employees who have received subsidies; otherwise, those employees are going to be facing tax penalties if they declined a more affordable employer plan and accepted the subsidies, so this is very important.

It is my understanding that, as of yet, none of those employers have received anything from HHS. Can you give me an idea, just a date of when you expect to give notification to employers?

Secretary BURWELL. Mr. Carter, this issue is one I am not specifically familiar with, but my understanding of what you are talking about is it is a Treasury issue because what you are talking about is tax information on the individuals in terms of they received an APTC, and that is a matter of—

Mr. CARTER. Okay. Can you just get back with me and let me know a date when we can expect for that to be resolved and start—

Secretary BURWELL. I am happy to raise with Secretary Lew the question that you have raised.

Mr. CARTER. Fair enough. Fair enough. Okay. Notification to the employers. You would agree that those employers who have multistate locations, it would be better if they got one notification as opposed from every State? That is also something I am very concerned about, and I hope you look into at that as well.

You do agree, obviously, that it is a burden on these employees when they have a tax penalty at the end because they didn't accept the employer's more affordable plan. So that is what we are trying to get at now, right?

Secretary BURWELL. What we want to do is make sure that where employers should cover, as appropriately, that they are providing coverage, and if the employee makes a choice to not accept the coverage by an employer, that they don't receive subsidies they shouldn't in terms of—

Mr. CARTER. Right, right, but it would have helped if the employers had gotten notification, so that is what we are trying to achieve here.

Also, right now you are using a paper system. Do you have any idea when you will be going to a computer system?

Secretary BURWELL. A paper system, I am not sure with regard to what you are referring to. I am sorry.

Mr. CARTER. Okay. Well, I will get clarification on that and send you a letter later.

Secretary BURWELL. Okay. Okay.

Mr. CARTER. In your opening statement, you said that over $100 million would be given to states and used for prescription drug abuse.

Secretary Burwell, I am a pharmacist, the only pharmacist currently serving in Congress. I have witnessed firsthand people's careers, people's lives, people's families being ruined, and people actually losing their life as a result of prescription drug abuse. And one of the limitations on that for pharmacists is that Medicare limits pharmacists as to what they can do with this in the way of compensation.

There is a bill, H.R. 592. I hope that you will look at that closely. This is something that needs to be addressed. This is an epidemic. This is one of the biggest drug problems that we have in this country, prescription drug abuse, one that has really gotten out of control. As a member of the State Senate in Georgia, I sponsored the prescription drug monitoring program that is now law. This is something that we really need to work on, and we can help you in our profession, and we want to help you, but please look at that bill, H.R. 592.

And Mr. Chairman, I yield back.

Chairman KLINE. The gentleman yields back.

Mr. Pocan, you are recognized for three minutes.

Mr. POCAN. Three minutes. Thank you, Mr. Chairman. I will go really quick. Thank you for being here, Secretary Burwell.

First, I am glad to see that NIH increase in the budget. The funding, as you know, with the sequester, it has been especially hard. I have the University of Wisconsin in my district, which has a lot of research going on. One of the things that we have noticed because of this cutback of funding is that now the age of the average first time grant recipient is 42, and it used to be 36 in 1980. A lot of young researchers are looking at a lot of other areas to go into, and we want to keep the talent there.

Senator Baldwin and myself and others have introduced a bill called the *Next Generation Research Act* trying to address some of those concerns. I am just wondering if you could very briefly just address how we can try to help those younger researchers as we move forward in NIH funding.

Secretary BURWELL. I think it is about creating a certainty in terms of the years that we have been through recently with regard to everything from sequester to shutdown, the ability to create the certainty. It is just like the certainty we need to create for those small businesses that were referred to.

People having certainty in knowing how things are going to run in regular order and assurance of the funding is how people are going to make their decisions. If you are making a decision to get a Ph.D. in a particular area, that is a long period of time you are making a financial commitment, and you want to know there is certainty at the other end.

So I think the thing that we can do is create certainty around funding streams, that the funding for this type of research, basic research and other research that NIH does, is going to be there, and so that is one of the things we want to work to do, which is why we have in this budget a billion dollar increase.

Mr. POCAN. If you could take a look at that *Next Generation Research Act,* too, working with a lot of those younger scientists, we have had some ideas, too, we would like to propose, at least while the sequester is still out there.

Secondly, and I am going to piggyback a little bit on Representative Hinojosa's question around the States that haven't done the Medicaid expansion. Unfortunately, States like my State, Wisconsin, where Governor Walker is, you know, in the increasingly smaller number of States that hasn't done this, we would save about $400 million over the next two years in our State. Almost 85,000 people would have additional healthcare.

You know, as you look in—and I am glad you just met with governors about this, but you know, as a Member of Congress, this is very frustrating. I actually do everything I can to get resources back to my State, and then I see something like this. You know, what can we do for the States like Wisconsin that are just really caught in this bad spot because we have governors that refuse to expand this?

Secretary BURWELL. So with regard to, you know, that is where the decision, as know, sits with the governors and State legislatures, not all States. Some States, it is just the governor, and so continuing to work. But I think one of the most important things

is articulation of the benefit, both the economic, job creation, and what it means in terms of State budgets as well as the individual. Obviously, that is the place where we focus our most attention.

Mr. POCAN. I am just going to wrap this thing. If you also need names of people who have told us they benefitted from the *Affordable Care Act,* you know, I go into little towns in my district, Spring Green in rural Wisconsin, small business, you know, they come and they grab their husband from upstairs, the wife had to tell me this is the first time they have had healthcare. I have had caregivers stop me in the grocery store crying because it is the first time in her adult life she has been able to have healthcare. If you also want those kind of things, we are more than glad to share those through our office.

Secretary BURWELL. Thank you.

Chairman KLINE. The gentleman's time has expired.

Mr. Russell, you are recognized.

Mr. RUSSELL. Thank you, Mr. Chairman.

I would like to thank you, Madam Secretary, for your distinguished service both to the Nation and also, to your charitable work.

As a small business owner that has a small workforce well under the 50 threshold, I have seen a 68 percent increase in health insurance that I provide my employees over a two-year period. Do you believe increasing the cost of insurance will encourage or discourage small businesses providing insurance?

Secretary BURWELL. With regard to the 68 percent increase, is it people taking it up, or is it the cost itself?

Mr. RUSSELL. It is the cost itself. We are part of a pool, being a light manufacturer, and so, you know, we can't do the groups on our own, but we can pool with others. And we have seen a 68 percent increase in two years.

Secretary BURWELL. Is it particularly incident-driven, having, you know, worked as a small employer at one point in time, when we would have, you know, we had a couple of very large cancer cases or we had a number of pregnancies at one time, was it those kinds of things? Because what we want to do is get to the issue.

What you are describing is a case that is not the experience that we have seen for most, and what I want to do is understand it.

Mr. RUSSELL. Sure.

Secretary BURWELL. So we can understand why—

Mr. RUSSELL. We have not even filed claims. We have been in business for five years.

And my second question is, in the HHS' 2011 report entitled "Drug Abuse Warning Network," it cited that 455,000 emergency room visits were directly associated with marijuana use. Further, supporting documentation shows multiple adverse health effects.

Do you believe the President's policies in not enforcing Federal law on illegal marijuana States that violate the law promote or prohibit HHS' goals on emergency care reduction and drug abuse prevention?

Secretary BURWELL. So, with regard to the HHS role in this space of marijuana, we are the research, the regulator, the educator, and the treatment. And with regard to the issue that you have raised in terms of the question of the health impacts of this, it is

something that we are spending time on. You may know we recently actually changed a rule that will lead to increased research that we hope will afford us the opportunity to do more and better education in the space of the damage.

Mr. RUSSELL. And then my final question and you certainly don't have to comment on the ongoing investigations that will be necessary and that sort of thing, but given that HHS provides significant Title X funding to Planned Parenthood, do you believe personally that the harvesting of infant body parts to be moral?

Secretary BURWELL. So as I said, this is an issue, an important issue, that has strong passion and strong beliefs about the importance of the research and other beliefs, and what I think is important is that our HHS funding is focused on the issues of preventative care for women, things like mammograms and cancer prevention screenings with regard to our relationship there.

With regard to the other issues, the attorney general, I think, has right now, is under review to make determinations on what is the appropriate next step.

Mr. RUSSELL. I yield back my time. Thank you, Mr. Chairman.

Chairman KLINE. The gentleman yields back.

Ms. Adams, you are recognized.

Ms. ADAMS. Thank you, Mr. Chairman. Thank you, Ranking Member Scott. Madam Secretary, thank you for being here, and some of my questions have already been answered.

But let me first of all say that I have, over the years, appreciated Planned Parenthood's good work in promoting healthcare for men and for women, and I am a little bit disheartened by all the attacks to undermine the good work that they do. But having said that, let me move on to Affordable Care.

My State of North Carolina is one of those 24 that did not expand Medicaid. We are looking specifically at—with all of the great benefits, I am still perplexed why our governor and our legislature decided not to do that, 317,000 more North Carolinians would have had it. I know you met with the governors.

My question is when we look at North Carolina having one of the highest rates of uninsured adults in the country, standing at 24 percent, it is critical that we take a serious look. And what are the options? Are there options for folk in my State and other States that have not expanded Medicaid that—who may want to consider it in the future, are there options that they have?

Secretary BURWELL. So with regard to the options for the individuals, I think, you know, that is why community health centers are going to continue to be extremely important in terms of ensuring that people who don't have coverage have care. They are an important part of that.

With regard to the options in terms of States making those decisions to do that expansion, we want to work with States, we want to provide them with different options and opportunities. That is what the 1115 waivers are about. We have done that. We have done that with Governor Pence in Indiana, and that program is up and fully running. There are other governors that we're having those conversations with, and we look forward to the opportunity to understand what are the core considerations of the State in terms of moving to reduce that coverage gap that you describe in

North Carolina, which is one of the largest states in the Nation now.

Ms. ADAMS. Thank you very much. For somebody in my position, I did serve in the legislature for 20 years. I am still at odds with the governor and the State legislature about it, so can you give me any suggestions about how to kind of push them along and to get closer to ensuring the low income people in North Carolina who it will—

Secretary BURWELL. I would certainly defer to you on how to work with your own State governor and legislature.

The only thing I will say is when you look at Kentucky and the analysis that's been done, in the State of Kentucky—and this is by, you know, an accounting firm in the University of Louisville, 40,000 more jobs and 30 billion flowing into the State by 2021, and so that, from an economic perspective, just seems to be an anchor of a place to talk about.

Ms. ADAMS. Yes, ma'am. That makes great economic sense for us to do it. I'll certainly continue to push those folk in North Carolina. Thank you, Madam Chair—Mr. Chair. I yield back.

Chairman KLINE. I thank the gentlelady.

Mr. Allen.

Mr. ALLEN. Yes, thank you.

Thank you, Mr. Chairman, and thank you, Madam Secretary. You've got a tough job. It's hard to deal with some of the issues that are coming out of this process, but I can tell you in Georgia, ObamaCare is not real popular. We are having major problems down there.

In fact, most physicians I meet with say that nothing's changed. Emergency rooms: people show up still without health insurance. They see very few patients. You might check with some of the hospitals. You know, their elective surgeries are off something like 80 percent because of the high deductibles, so just, you know, one problem after the other. But what I want to zero in on is this Planned Parenthood thing.

And I would like some commitment from you here today on when your Department will conduct an investigation on this very, very serious matter. Not only is it unconscionable, but they are breaking the law, and it's a big issue with the people of this country. I mean, it's what I hear about every day, what are we going to do about this? Can you tell me when we going to do something about that?

Secretary BURWELL. I do want to—just one moment on your *Affordable Care Act*—

Mr. ALLEN. Yeah.

Secretary BURWELL.—and that issue. And the question of expansion in a State like yours, and what we see in Arkansas is we've seen as a percentage drop the number of uninsured that are coming in emergency rooms, we've seen actually a dramatic drop, and so, as a part of the issue there and how we think about rural hospitals, which I know are an important issue in your State as they are in my home State.

With regard to the Planned Parenthood issue, as I've said, this is an important issue and one that there is passion and emotion and belief on many sides of the issue, and I want to respect that.

With regard to our funding, I think you know we do not fund abortions as the Federal Government except for the Hyde exceptions, which have been in place for many years. Our funding for Planned Parenthood is in another issue space. With regard to the issue you raised, which is a question of whether it's a legal issue, and there are laws and there are statutes that guide the use of fetal tissue that are in place and should be enforced.

With regard to investigating or looking into those issues, as I said, because it is a statutory legal issue, the Department of Justice and the attorney general has said she has taken those issues under review and will determine what the appropriate next step is.

Mr. ALLEN. And that would include your investigation? I mean, it should be like all hands on deck on this thing.

Secretary BURWELL. With regard to the question of a legal matter, and you know, I defer to our colleagues at the Justice Department, we will support them in anything they need or want from us, and we always do that, but with regard to making those decisions of the question of an investigation of a legal matter—

Mr. ALLEN. So you don't have personnel that can look into this?

Secretary BURWELL. With regard to what we do we have at the Department of HHS is, this is not an issue in terms of us funding this specific issue. When we do have issue—

Mr. ALLEN. You deal with Medicare fraud.

Chairman KLINE. The gentleman's time has expired.

Mr. DeSaulnier.

Mr. DESAULNIER. Thank you, Mr. Chairman. Thank you, Madam Secretary. Briefly, on the issue of Planned Parenthood, as I understand it, there are multiple investigations in California. The State attorney general is investigating the issues, including if the people who actually took the film violated the law.

But I have two areas for questions for you. One is your work on prescription drug abuse. As my colleague from Georgia mentioned, it's a very large issue, 45 Americans die a day, according to the Center for Disease Control. The U.S. has less than 5 percent of the world's population, but we consume over 80 percent of the opioids in the world. It's a huge cost issue both financially and from the human side.

So in California, we are switching to an electronic monitoring system. It's been getting up, and even people who question it are starting to support it. So my question is, what are things that you might think—and I'll ask both questions and let you go, given the time constraints, that we might be able to do on a Federal level to help States like California, New York, and Georgia.

And then secondarily, coming from a high cost State where we're very proud of the ACA in California, sort of the opposite side of what one of my colleagues brought up being from the Bay area, provider rates and attracting primary care physicians, so if you could address those two things quickly, I would appreciate it.

Secretary BURWELL. I'm sorry, the second issue?

Mr. DESAULNIER. The second question was the opposite side of high cost States and reimbursements rates, and then because of that, we're having a difficult time attracting primary care physicians in California, particularly young people to go into that field.

Secretary BURWELL. On the primary care, let's just start there, in terms of how we are structuring our graduate medical education proposal in this budget, it is actually to focus funding for GME on places like primary care and rural districts where we have shortages and other specialties. So what we're trying to do is use our tools at hand to encourage people to go into those specialties and create more of a pipeline to go to places.

With regard to the issue of prescription drug abuse, 250 million prescriptions in one year in the United States. That is enough for every adult in the country. This is an acute problem. One, prescribing it. I think that number itself tells you something about we got to go after prescribing. The congressman's comments about PDMPs, prescription drug monitoring program, essential, get those up, get those working in the States.

That's a lot of what I'm spending my time in conversations with governors, whether Governor Baker in Massachusetts or Hickenlooper, in Colorado, been to visit both.

Second is access to Naloxone. Naloxone is the drug that when someone is in overdose, actually saves their life, and so the question of how that's accessed is a very important thing in creating in a State-by-State basis.

The third is medicated assisted treatment, and for all those who are addicted, trying to get that transition. I met a woman in Colorado who has been clean four years, and her journey there from having her wisdom teeth taken out, becoming addicted and going to heroin is a journey we don't want people to travel, and so getting that medicated assisted treatment and those other things in place are three specific evidence-based approaches.

Mr. DESAULNIER. Thank you, Madam Secretary. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Mr. Bishop, you're recognized.

Mr. BISHOP. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today. I appreciate your testimony and the discussion. I know there are a dozen windows that are opened up right now, but I'd like to talk to you specifically about the exchange enrollment issues that I'm seeing in my office.

It's an ongoing concern I'm hearing from constituents, and I want to make sure while I have your attention, that I address the concern.

The Government Accountability Office recently put out an alarming report highlighting various shortcomings of Healthcare.gov, which resulted in numerous fictitious enrollees gaining access to coverage and subsidies paid by the American taxpayers. In the meantime, as I said, I've heard from any of the number of my constituents, one anecdote after the next, very frustrated with regard to how this is working, purchased or tried to purchase on the Web site insurance, only to have their coverage canceled because of a minor mistake they made on their application.

And by the time they get to me, they are furious, and I can't say that I blame them. As a parent, who has a family and is expected to provide for my family, my heart goes out to them, but it becomes me being the reason why.

They also have problems getting the issue corrected and lackluster communication with the Department, how we can correct the issue, long wait times, there is just so many issues with regard to this. And GAO's information suggests that significant fraud is being—is being rewarded, while at the same time some of these minor mistakes are being punished. I'm wondering what we can do to address that if you've had this same communication from other members, if we're addressing them, and if you could just quickly comment on that.

Secretary BURWELL. So first of all, with regard to the communication coming into your office, please reach out, reach out to me directly, let's work on those individuals and work through those individual issues, so please make sure, just reach out to us, our office, we will work on those.

Mr. BISHOP. Okay.

Secretary BURWELL. With regard to, though, actually it's both sides of the coin because the GAO, we don't actually know. We don't know when they falsified, whether they falsified a Social Security or what, the small issues. What we're trying to do is program integrity, and that's what your folks are getting caught in because they have done that, and we're doing it in a strict way. That's what people are feeling is because we are trying, if you do not provide the data that's required to say your income is X or to say that you are of a certain status, that you know, that's what's happening to the examples.

And so actually, we don't exactly know because the GAO hasn't told us what those examples are. Those are actually two very related things in terms of us doing the program integrity that we're being asked for. We don't know that the examples of the GAO are more than the examples that you're talking about.

When we get to recommendations, we may know that, but at this point, we don't, and so right now, what we're doing is trying to do program integrity, but we want to make sure that if there are individuals—because many of the people are like you said, we don't have the right information but they still may be eligible, so please let us know about those examples.

Mr. BISHOP. Thank you, Madam Secretary. I yield back.

Chairman KLINE. Thank you. The gentlewoman, Ms. Wilson.

Ms. WILSON of Florida. Thank you, Mr. Chair. I ask unanimous consent that the Office of the Assistant Secretary for Planning and Evaluations' research brief showing that increases in cost sharing can discourage low income individuals from accessing necessary medical care which can have negative health consequences be entered into the record.

Chairman KLINE. Without objection.

[The information follows:]

[Additional Submissions by Ms. Wilson follow:]

ASPE
ISSUE BRIEF

FINANCIAL CONDITION AND HEALTH CARE BURDENS OF PEOPLE IN DEEP POVERTY[1]

(July 16, 2015)

Americans living at the bottom of the income distribution often struggle to meet their basic needs on very limited incomes, even with the added assistance of government programs. The following analyses describe the characteristics of the poor population; available income for those at the deepest levels of poverty; and average medical care needs among those living in poor and deep poor families (meaning those with incomes below 50 percent of the poverty threshold).[2] The brief concludes with implications for medical cost sharing among those with few resources available. Analyses are restricted to those under the age of 65 and those in families headed by an adult under age 65.

Key findings include:

- Low-income individuals are especially sensitive to even nominal increases in medical out-of-pocket costs, and modest copayments can have the effect of reducing access to necessary medical care.
- Medical fees, premiums, and copayments could contribute to the financial burden on poor adults who need to visit medical providers.
- The problem is even more pronounced for families living in the deepest levels of poverty, who effectively have no money available to cover out-of-pocket medical expenses including copays for medical visits.

Who are the People Living in Poverty and Deep Poverty?

According to the most recent data from 2013, the official poverty rate is 14.5 percent of the population, with 45.3 million people officially poor. Among the poor, 19.9 million people are in deep poverty, defined as income below 50 percent of the poverty threshold. Of the total U.S.

[1] Analysis conducted by Lauren Frohlich, Kendall Swenson, Sharon Wolf, Suzanne Macartney, and Susan Hauan.
[2] For 2013, a single parent family with two children is in poverty if their income falls below 100 percent of the poverty threshold ($18,769) and deep poverty if their income falls below 50 percent of the poverty threshold ($9,385).

population, 6.3 percent are in deep poverty. Nearly 6.5 million children under the age of 18 are in deep poverty, making up about one-third of the deep poverty population.[3]

Table 1 describes the demographic and economic characteristics of the population in poverty by depth of poverty.

- Nearly two-thirds (64 percent) of working age adults with family incomes below 50 percent of the poverty threshold are adults that live with no children, while over one-third (36 percent) live in households with children.
- Among working age adults with family incomes between 50 and 100 percent of the poverty threshold, about one-third (33-34 percent) work part-time or part-year, compared with one-quarter (26 percent) of those with family incomes below 50 percent of poverty.
- Looking at those in deep poverty, for adults with family incomes between 25 and 50 percent of poverty, about half report no work hours, and for those with incomes below 25 percent of poverty, 81 percent report no work hours. Working age adults in deep poverty report illness or disability (23 percent), taking care of their family (27 percent), and attending school (21 percent) as the main reasons why they are not working.[4]
- Just above the poverty threshold, more than half (57 percent) of uninsured adults ages 19 to 64 who could gain Medicaid coverage (between 100 and 138 percent of poverty) work, and nearly three out of four (72 percent) live in a family with at least one worker.[5]

Table 1. Demographic and Economic Characteristics Distribution by Poverty Status

	Percentage of Poverty Threshold				In Deep Poverty	In Poverty (Below
	0-24%	25-49%	50-74%	75-99%	(Below 50%)	100%)
Race/Ethnicity (ages 0-64)						
White, non-Hispanic	42	39	37	40	41	39
Black, non-Hispanic	23	25	24	21	24	23
Hispanic	25	28	32	32	26	29
Other	9	7	7	7	9	8
Family Household Type (ages 18-64)						
Adults, no children in household	70	51	52	56	64	59
1 Adult with child in household	8	14	11	7	10	9
2+ Adults with child in household	22	35	37	36	26	32
Employment status (ages 18-64)						
30+ hours, full year	2	7	12	20	4	10
Part time or part year	17	43	34	33	26	30
No hours	81	50	53	47	71	59

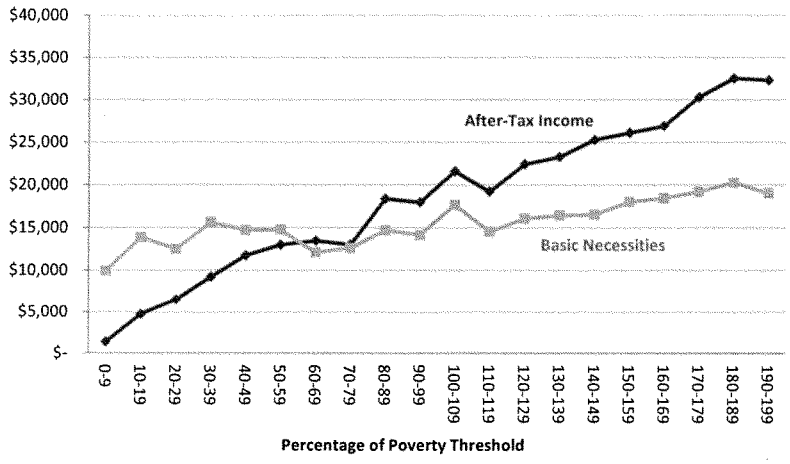
Note: Columns add to 100 percent in each panel.
Source: HHS-ASPE tabulations from the U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement.

[3] HHS-ASPE tabulations from the U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement.
[4] Additional reasons include inability to find work (15 percent) and retirement (8 percent). HHS-ASPE tabulations from the U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement.
[5] Kaiser Family Foundation, 2015. "Are Uninsured Adults Who Could Gain Medicaid Coverage Working?"

Income and Expenditures

Many families living in poverty and deep poverty face difficulties making ends meet financially, as presented in Figure 1 and Table 2. The dark blue line in Figure 1 depicts families' ***after-tax income***, including benefits from the Supplemental Nutrition Assistance Program (SNAP) and tax credits such as the Earned Income Tax Credit (EITC). The light blue line depicts families' actual spending on the most ***basic necessities***, defined here as food, clothing, housing, and utilities. The definition of basic necessities for these figures is quite conservative, as it excludes expenditures on many other high-priority categories such as health care, transportation, education, and child care. In addition, as shown in Figure 1 and Table 2, families' spending on these basic necessities rises with income, which suggests that families with low incomes would be spending more in these areas if they did not face such serious financial pressures. Thus, the estimates shown in Figure 1 and Table 2—which are based on families' actual spending—may understate, potentially substantially, the actual income required to ensure that families can achieve a minimally adequate standard of living, even focusing solely on basic necessities.

Figure 1. After-Tax Incomes and Expenditures on Basic Necessities (Food, Clothing, Housing, and Utilities) for Non-Elderly Families by Poverty Status



Source: HHS-ASPE tabulations from the 2011 Panel Study of Income Dynamics.

Even under this conservative approach, the data displayed in Figure 1 show that poor families' incomes are often not enough to cover even the most basic necessities. For example, a family with income between 40 and 50 percent of the poverty threshold spends on average $3,000 more on necessities than its income. For a family with income between 20 and 30 percent of the poverty threshold, expenditures on basic necessities exceed income by $6,000 on average. Families living in deep poverty have incomes that are below their expenditures for the most basic necessities and often must borrow or use savings to meet basic needs, before even considering the other types of high-priority spending noted above or accounting for the fact that these families may not be spending enough on basic necessities to ensure even a minimally adequate standard of living in these areas. Families in poverty but with slightly higher incomes still struggle to meet basic needs, as do many families above the poverty threshold.

Table 2. Average Annual After-Tax Incomes, and Incomes After Expenditures on Basic Necessities (Food, Clothing, Housing, and Utilities) for Non-Elderly Families by Poverty Status

Percentage of Poverty Threshold	After-Tax Income	Expenditures on Basic Necessities	Income After Expenditures on Basic Necessities
0-9%	$1,400	$9,900	-$8,500
10-19%	4,700	13,900	-9,200
20-29%	6,500	12,500	-6,000
30-39%	9,200	15,600	-6,400
40-49%	11,700	14,700	-3,000
50-59%	13,000	14,700	-1,800
60-69%	13,400	12,100	1,400
70-79%	13,000	12,600	400
80-89%	18,400	14,700	3,700
90-99%	17,900	14,100	3,800
100-109%	21,600	17,700	3,900
110-119%	19,200	14,500	4,700
120-129%	22,400	16,100	6,400
130-139%	23,200	16,400	6,800
140-149%	25,200	16,500	8,700
150-159%	26,100	18,000	8,100
160-169%	26,900	18,400	8,500
170-179%	30,300	19,200	11,100
180-189%	32,500	20,200	12,200
190-199%	32,300	19,000	13,300

Note: Dollar amounts are rounded to the nearest $100. Estimates are averaged across families of all sizes. Family heads are under age 65.
Source: HHS-ASPE tabulations from the 2011 Panel Study of Income Dynamics.

Medical Care Among People in Poverty and Deep Poverty

In addition to the most basic necessities of food, clothing, housing, and utilities, poor and deep poor families also must consider their health and medical visit needs. Medical fees and copayments potentially contribute to a yet greater financial burden on people who visit their medical providers more frequently. Table 3 presents estimates of the average number of annual outpatient medical visits for working age adults living in poverty and covered by Medicaid. As indicated in the table, poor individuals have 6.6 medical visits per year on average. For those living in deep poverty, the average number of visits is similar (6.2). Out-of-pocket costs for these visits can put a substantial strain on household budgets. But the negative effects of out-of-pocket costs are even more pronounced, because the distribution of medical visits among adults covered by Medicaid is concentrated among some recipients who are even more burdened by out-of-pocket costs. One way to examine this distribution is to place adults covered by Medicaid into four quartiles based on number of annual visits (Table 3). When considering the average number of visits by quartiles for the poor, estimates indicate that those in the fourth quartile— and therefore most likely to visit the doctor— average 13.3 medical visits each year.

Table 3. Average Annual Number of Outpatient Medical Visits for Adults Ages 19-64 Covered by Medicaid

		Distribution by Number of Medical Visits			
Percentage of Poverty Threshold	Average annual visits	First quartile	Second quartile	Third quartile	Fourth quartile
0-99%	6.6	0.0	1.0	2.4	13.3
0-49%	6.2	0.0	1.0	2.4	13.5
50-99%	6.9	0.0	1.0	2.4	13.2

Source: HHS-ASPE tabulations from the Survey of Income and Program Participation 2011.

People with income at or slightly above the poverty threshold have little income to direct towards key goods and services like transportation, precautionary savings, and educational investments. Cost sharing through copayments and premiums for a necessity like medical care and health insurance will discourage use of needed care, including preventive services, and place significant strain on already limited household budgets.

Implications of Cost-Sharing for the Poor

The analysis above demonstrates that families living in poverty, and particularly those in deep poverty, have few resources available after they pay for the most basic necessities, even before other critical expenditures such as health care, child care, and transportation are taken into account (Table 2). Low-income adults tend to be less healthy than higher-income adults. About one-quarter of adults ages 19 to 64 living in poverty report fair or poor health, compared with about 8 percent of those living above 200 percent of the poverty threshold.[6] When subject to copayments and premiums, low-income individuals must decide whether to go to the doctor,

[6] U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement, CPS Table Creator, *available at* http://www.census.gov/cps/data/cpstablecreator.html.

fulfill prescriptions, or pay for other basic needs like child care and transportation. As a result of these daily tradeoffs, low-income individuals are especially sensitive to modest and even nominal increases in medical out-of-pocket costs.

Research shows that increases in cost-sharing in the form of copayments can discourage individuals with low income from accessing necessary medical care, which can have negative health consequences. An analysis of the Oregon Health Plan redesign implemented between 2003 and 2005 found that increased out-of-pocket costs such as mandatory copayments are associated with unmet health care needs, reduced use of care, and financial strain for already vulnerable populations.[7] A study of Utah's Medicaid program found that $2 copayments for physician services resulted in Medicaid patients seeing doctors less often.[8] The national RAND Health Insurance Experiment found that low-income individuals reduce their use of effective care by as much as 44 percent after being subject to copayments.[9] The study also found that copayments lead to poorer health outcomes among low-income adults and children due to a reduction in the use of care, including worse blood pressure and vision and higher rates of anemia.[10]

Americans living in poverty have significantly constrained budgets that severely limit their ability to pay out-of-pocket health care costs; those in deep poverty have literally no available income after they pay for their most basic necessities each month, necessities which do not include health care, child care, or transportation. People in poverty tend to be less healthy than those with higher incomes and therefore need more medical care. But people in poverty are often unable to afford even nominal premiums and copayments, and research shows that they may forgo necessary medical treatment as a result of required cost-sharing.

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[7] Wright, Bill J. et al, 2010. *Health Affairs.* "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out."
[8] Ku, Leighton et al., 2004. *Center on Budget and Policy Priorities.* "The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program."
[9] Newhouse, Joseph, 1996. *Free For All? Lessons from the Rand Health Insurance Experiment,* Cambridge: Harvard University Press; Ku, Leighton. *Center on Budget and Policy Priorities*, 2003. "Charging the Poor More for Health Care: Cost-Sharing in Medicaid." Effective care refers to services the researchers judged to be clinically effective in improving health outcomes.
[10] *Id.*

Methodological Appendix

Current Population Survey (CPS)
The data for Table 1 come from the 2014 CPS Annual Social and Economic Supplement (ASEC), which sampled about 68,000 households for the newly redesigned income items. Income and poverty data are for the 2013 calendar year. Following Census Bureau methodology, calculations for determining poverty use pre-tax cash income. Poverty thresholds vary by family size and composition. Table 4 shows the poverty thresholds by family type, divided by poverty sublevel.

Table 4. Annual Poverty Thresholds by Family Type, 2013

	Percentage of Poverty Threshold									
Family Type	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**
1 adult	$1,212	$2,424	$3,636	$4,848	$6,060	$7,271	$8,483	$9,695	$10,907	$12,119
2 adults	1,560	3,120	4,680	6,240	7,800	9,360	10,920	12,480	14,040	15,600
1 parent, 2 children	1,877	3,754	5,631	7,508	9,385	11,261	13,138	15,015	16,892	18,769
2 parents, 2 children	2,362	4,725	7,087	9,450	11,812	14,174	16,537	18,899	21,262	23,624
1 parent, 4 children	2,738	5,475	8,213	10,950	13,688	16,426	19,163	21,901	24,638	27,376

Source: HHS-ASPE tabulations from the U.S. Census Bureau, Current Population Survey, 2014 Annual Social and Economic Supplement.

Panel Study of Income Dynamics (PSID)
The data for Figure 1 and Table 2 were calculated from the 2011 wave of the PSID, a national longitudinal survey that collects income and expenditure data on a sample of families in the United States.[11] Previous research has found that average reported expenditures on the PSID are similar to expenditures reported on the Consumer Expenditure Survey.[12] Basic necessities include expenditures on four categories that are widely believed to be basic necessities including: food, clothing, housing, and utilities. Utilities include expenditures on electricity, gas, water and sewer, telephone and Internet, and other utilities. The definition of basic necessities excludes expenditures on many other high-priority categories such as health care, transportation, education, and child care expenses.

Family income includes after-tax earnings, cash income transfers such as Social Security, disability payments, and Temporary Assistance for Needy Families (TANF), and near-cash benefits from the Supplemental Nutrition Assistance Program (SNAP), formerly called the Food Stamp program. It excludes income from capital gains, and other non-cash transfers such as the Women, Infants, and Children (WIC) nutrition program, the Low Income Home Energy Assistance Program (LIHEAP), and housing assistance. Taxes are measured using National Bureau of Economic Research's TAXSIM model and include estimates of federal, state, and the employee's portion of Social Security and Medicare taxes, as well as the value of tax credits such as the Earned Income Tax Credit (EITC). Percent of poverty is calculated by dividing each

[11] Andreski, Patricia et al., 2013. "PSID Main Interview User Manual: Release 2013."
[12] Li, Geng et al., 2010. "New Expenditure Data in the Panel Study of Income Dynamics: Comparisons with the Consumer Expenditure Survey Data," *Monthly Labor Review*.

family's pre-tax income by their corresponding poverty threshold. The analysis excludes families that were not living in the United States at the time of the survey, families living in institutions, and families headed by persons ages 65 and older. Estimates are averaged across families of all sizes.

Survey of Income and Program Participation (SIPP)
The data in Table 3 are from the 2008 SIPP, which sampled about 42,000 households starting in 2008 and interviewed all individuals in the household over the age of 15. Estimates of income and medical visits come from the tenth wave of the panel, reflecting the period from September – December of the 2011 calendar year. The number of medical visits is self-reported by all individuals. Specifically, respondents answered the question: "Not including contacts during hospital stays during the past 12 months, that is, since (interview month) 1st of last year, about how many times did you see or talk to a medical doctor, or nurse, or other medical provider about your health?" The responses ranged from zero to 366 visits. While the responses do not include hospital stays, they may include emergency room visits. The quartile analysis is conducted by dividing the sample into four ordered groups based on the number of self-reported medical visits, and estimating the mean value separately for each quartile.

Ms. WILSON of Florida. Secretary Burwell, thank you so much for being here today and for working with Florida, especially, and our head start and elder care and all of the other things that you do. I appreciate your testimony on how ObamaCare is working for the American people, and I call it ObamaCares, because I believe that Obama cares about the people of this Nation, and that's why we have this healthcare law.

It's here to stay. It's the law of the land. The people of Florida are much better off because of this. We have led the Nation in new enrollments through the Federal exchange. My district Florida—in my District 24 has the third highest number of people in the Nation who benefit from subsidies. Unfortunately, we have not expanded Medicaid, but I thank you for your commitment to working with the Florida legislature and the governor to expand Medicaid, and consider me as a partner in this pursuit and hopefully for a better outcome in the future. I also want to thank you for helping securing low income pool funding for Florida. That was very special to us.

I want to thank you for your testimony on the importance of investment in high quality early learning, so I commend you and the President for your commitment to expanding and investing in early education. I have several questions. I want to try to combine them in one.

The President's budget includes an additional $1.5 billion to improve quality head start. Why is this crucial? What is head start doing to ensure that all head start children and early childcare are eligible, have access to high quality early learning? What is at stake if our Nation ignores the ever growing body of research? And can you describe how the revised program performance standards will help, and can you please speak to the negative impact of spending caps?

Secretary BURWELL. So I will try and get through as many of those as I can with our time. One is with regard to the changes, there are a number of changes that are part of the proposal, and they are about using the evidence with regard to extending the day and the question of extending the year, but there are other important changes in terms of what curriculum should be used in terms of the teachers and those participating.

There are also a number or safety issues, making sure that the grantees and others that are doing the services do it in a safe way. We also try to reduce the bureaucracy to make it easier for people to come in and apply and be a part of that system. So we put the money in the budget to match the changes that we have proposed as we go forward.

With regard to the ramifications—

Chairman KLINE. I'm sorry; the gentlelady's time has expired.

Mr. Messer.

Mr. MESSER. Thank you, Mr. Chairman. Thank you, Secretary Burwell, for being here. I'd like to talk a little bit about the 49'er phenomena under the *Affordable Care Act,* the idea that the *Affordable Care Act* only applies to businesses of 50 or larger, and so there's has been questions about some businesses staying at that 49 threshold, not being willing to hire that 50th person because

they would make themselves subject to all the mandates and requirements of the President's healthcare law.

The administration has helped ease that burden somewhat by delaying that 50 figure by making it up to 100 so that businesses that were 100 and less wouldn't be forced to —wouldn't be required to comply with the law.

Could you talk a little bit about the rationale of lifting that to 100? Why was it businesses 100 and less that the administration said wouldn't be subject to the law up until 2016?

Secretary BURWELL. So I think there are also two different issues in terms of application proportions of the law.

Mr. MESSER. Yeah.

Secretary BURWELL. And some of those have to do with what benefits but also what category, and so I'm not sure if you're—

Mr. MESSER. Like the employer mandate example. You're not—

Secretary BURWELL. If it's a question of the category in terms of—

Mr. MESSER. You're not subject to the employer mandate under your delay until—for businesses of 100 or less until 2016. I'm just trying to get at what was it that made you decide to lift it to 100 from the 50.

Secretary BURWELL. So with regard to that issue, it is that, you know, 96—you know, as we look at the number of employers, and even when we go to those higher levels, I think we believe that employers at that level should be providing that type of care and can do that, and we can do that in a way that you can do it if there are pooled markets in affordable ways, and that's what we believe that can be done because we want to make sure that small businesses that have this—

Mr. MESSER. But to the precise question of why you lifted it from 50 to 100, why was it that you guys said businesses 100 and less could be delayed until 2016? Because the law says 50 and less.

Secretary BURWELL. So, just want to make sure you're referring to which piece, because we've already had a conversation earlier, I think you heard about a particular question of the provision, of whether or not 50 to 100 applies to whether those small businesses, which market they will be, and those are two different things.

Mr. MESSER. Again, I'm reclaiming my time because I only have so much time. I think it's clear that you guys have acknowledged that businesses of 100 and less are small businesses that make it difficult to comply with all the elements of this law. I've actually introduced legislation, H.R. 2881, the *Small Business Job Protection Act of 2015* that would make that level of 100—businesses of 100 employees and less—the permanent standard under the law, just essentially continuing the delay that you guys moved in to 2016.

It's not really a trick question. I think that the reality is, is that there are a lot of very small businesses of that 50 or less employees, and the mandates and requirement of this law are difficult to comply with. I think businesses of 100 and less—while I'd like to see the mandate go away entirely—they're at least a different kind of business than a business of 50 and less. Appreciate your testimony.

Secretary BURWELL. Thank you.

Chairman KLINE. The gentleman's time is expired.

Mr. Polis.

Mr. POLIS. Thank you, Madam Secretary. Back in April I had the opportunity to visit the head start program at the Wilderness Early Learning Center in Boulder, and I've seen firsthand the benefits head start can provide for kids and communities.

As you know, head start's grants are given to nonprofits, community centers, and often traditional public schools, but to my knowledge, no charter schools have ever received head start grants and very few have applied. Can you talk about what your agency is doing to clarify guidance so that charter schools, which are public schools that have the autonomy to offer unique curriculum for students, know that they're eligible to apply for head start grants and understand how to meet head start requirements?

Secretary BURWELL. This is an issue I'm not familiar with in terms of charters and application for head start, so one we'll have to get back to you.

Mr. POLIS. Great. We'd be happy to hear from you about a specific plan to make sure that charter schools are aware of the opportunity to apply and what they need to do.

Earlier this year, as you know, the FDA published revised recommendations pertaining to blood donations by gay men. The policy change eliminated the lifetime ban and replaced it with a one year deferral policy, which on the margins can save a few more lives.

While it's a positive step forward, I'm hoping you can speak about your opinion of whether the new policy truly reflects the most up-to-date science on the issue. As you know, the large majority of gay men don't engage in risky behavior and are not at higher risk of contracting HIV than the general population. In fact, the FDA's own blood drive survey found that the prevalence of HIV in gay male blood donors, was just .25 percent, actually lower than the overall prevalence of HIV in the total U.S. population, which is .38 percent.

Would the FDA consider a policy that screens for specific risky behavior rather than grouping all gay men into one black blanket high risk category?

Secretary BURWELL. With regard to the policy that we have announced, we've tried to move the policy forward based on the scientific evidence that we have in front of us, both with regard to issues of self-reported monogamy as well as the penetration of HIV in particular populations. We always welcome the additional—

Mr. POLIS. I believe it's self-reported abstinence, not self-reported monogamy; is that correct?

Secretary BURWELL. I will have to check exactly what is the self-reported—my indication.

Mr. POLIS. I think if we could move for it, would you be supportive of moving to self-supported monogamy?

Secretary BURWELL. What we are always open to is reviewing evidence in terms of the decisions that we're making in this space. We believe that the decisions that we've made at this point are evidence based. If there's additional evidence that we should know about, we always welcome it.

Mr. POLIS. Well, I'm looking forward to your implementation of the self-reported monogamy recommendation, which I am certainly in strong support of, as an indication of risky behavior, certainly in those who are in monogamous or married relationships would be at much lower risk than those who are not, and I yield back.

Chairman KLINE. The gentleman yields back.

Ms. Stefanik.

Ms. STEFANIK. Thank you, Mr. Chairman, and thank you, Madam Secretary, for your testimony today.

The President's healthcare law mandates certain employers provide healthcare coverage to their employees and will soon tax employers if that coverage is too generous. And Section 1511 of the healthcare law requires employers to automatically enroll new employees and continue enrolling current employees into their healthcare coverage, giving employees only a very small window to choose to opt out.

This mandate takes away the ability for employees to choose coverage that best meets their needs, and it could result in a loss of take-home pay to cover possibly more expensive health insurance than they otherwise would not have chosen.

I've introduced H.R. 3112, the *BE OPEN Act* to eliminate this harmful and unnecessary provision. But could you specifically discuss whether mandatory auto-enrollment can trigger individual mandate penalties for employees receiving subsidized exchange coverage?

Secretary BURWELL. With regard to the specific of that implementation issue, that is an issue that I would defer to my colleagues at Treasury. The implementation of the tax portion that I think is within the context of what you're referring to is a Treasury issue. I think, as you probably know, we have guidance out for comment right now, and so with regard to the specifics of that, that's a place where I would defer to my colleagues with Treasury, and we can take that question and give it to them.

Ms. STEFANIK. Let me ask this question a different way. What about those employees who become enrolled in double coverage because of this mandate and they miss the 90-day window in which to opt out? Should those employees, in your opinion, be penalized by paying multiple premiums because of a requirement imposed on by employers in the ACA?

Secretary BURWELL. With regard to the specifics of this question in terms of the detail of how it would be implemented, I would want to know and understand what the implementation is that the Treasury is thinking with regard to this issue, so I'd want to coordinate with my colleagues at Treasury.

Ms. STEFANIK. Sure. I look forward to getting a response from the Department of Treasury, but I also believe that this is duplicative and it's an unnecessary mandate requiring employers to automatically enroll employees into health plans where they have little choice and sometimes they don't have knowledge of that.

So I understand you want to defer to the Department of Treasury, but I think it's an important broken aspect of the ACA where I'd like HHS' feedback on. I yield back.

Chairman KLINE. The gentlelady yields back.

Mr. Jeffries.

Mr. JEFFRIES. I thank you, Mr. Chair, and thank you, Madam Secretary, for your testimony here today as well as for your tremendous leadership.

I want to begin by asking a question about sort of providing care to some of the most disenfranchised, economically isolated individuals, in this particular case, many of the constituents that I represent. Over the last several years, we've had a crisis throughout Brooklyn with the closure of several safety-net hospitals, and in other instances, significant financial distress that many of these safety-net hospitals have experienced, largely as a result of perhaps the overutilization of certain aspects of the hospital, the emergency room for issues that can be taken care of in a primary care context.

And for instance, the fact that, traditionally, in many socioeconomically disadvantaged communities, you've got a mix of individuals who are either on Medicaid or totally indigent and uninsured, the access to private insurance traditionally has not been a healthy mix, and it's created a situation where many of these safety-net hospitals are under severe financial distress.

That's beginning to change given the onset of the *Affordable Care Act,* which is tremendous, but there's still, I think, is an effort to begin to direct individuals more into the primary care context and away from the overutilization of these safety-net hospitals. Could you speak more about that, what the administration is doing and where you think we need to go?

Secretary BURWELL. So one of the things that the administration is doing is part of the overall effort. There are many new people who are newly insured, and the actual employee-insured based population has many new—access to many new services in terms of prevention.

And so at CMS, one of the things we are working on is something called, "Coverage to Care," and it's both for those that are newly insured, but it's also for those that are in the insurer base market to help people understand how to use that coverage to access a primary care physician, to get a health home so that we can start to solve some of these issues and to do things as simple as some people, and even in the employer-based market, understanding your bill. Those kinds of things are often complicated and difficult to do.

So at CMS, we are having a program. We are working on it. We want to use the resources that are part of the teams that have helped get people insured to make sure we're moving that information. It comes back also to that Medicare point I raised earlier that many people in Medicare don't know that they can get access to these services without copays. So we want to focus on greater education to get people into those primary care settings.

Mr. JEFFRIES. And is enhanced Medicaid reimbursement for primary care services also a part of what can be helpful moving forward?

Secretary BURWELL. It is. And as you know, we've proposed to extend that.

Mr. JEFFRIES. Thank you. I yield back.

Chairman KLINE. The gentleman yields back.

Mr. Brat.

Mr. BRAT. Thank you, Mr. Chairman. Thank you for being with us today. I have two quick questions. I guess I just got dinged from five minutes down to three, so I'll make it real quick.

On ObamaCare overall: productivity, claims that it's good for the economy. The basics in 2014, CBO reported they expect ObamaCare will result in a 2.5 million person job reduction and full-time equivalent employment by 2024. And so if you do the math on that, 2.5 million people times 40 hours a week is 100 million hours, and then you do that for the year, and you get 100 million times 50 weeks in a year, and you are at five billion hours in labor productivity gone due to this single program, and that's the response I get when you walk door-to-door, small business to small business, from people on the street is like we can't hire anybody, this is devastating us, and so I'll ask for your remarks on that.

The economy is already struggling to keep up with a kind of a 2 percent rate, if that, and so the claim that the program is good for the economy, I struggle with. And then secondly, I'll just ask you a quick one and ask for your response. At the micro-level, I have constituents who have approached me with concerns about FDA's proposed rules to regulate premium cigars.

Premium cigars don't have youth access issues, sold in adult establishments. The specific goal of the *Tobacco Control Act* were to limit youth access and prevent negative health effects from habitually used products, neither of which apply to premium cigars.

So, shouldn't the FDA leave this category out of regulations? By the FDA's own estimation again, over half of premium cigar stores and manufacturers will be shut down if FDA chooses option one in the proposed regulation. And so on this level, too, how do you justify the regulation when it's eliminating so many jobs and will have such a great impact on my constituents?

Secretary BURWELL. With regard to the premium cigar issue, I think one of the things we asked for was the evidence, the evidence with regard to child use, and so, that's why we put out two different proposals. As we review that, it is about the evidence we receive with regard to the question of premium cigars and child use, getting to the core part of the statute that you articulated, and we'll continue to work on that.

With regard to the broader economic issues, I think in that same CBO report, what we do know is the reflection of what happens in the out years with the *Affordable Care Act* in terms of why there's long-term deficit reduction and it's also both about productivity as well as cost, and we see large numbers in terms of those out years, and so as that works through the system.

I think the other thing is we think about these issues of jobs and job creation. We know that we have had the longest stretch of job creation as a Nation in terms of constant stretch of job creation. And the other thing that we see in that is we have not seen any rise in the number of people who are looking for, you know, at that 40-hour level.

Mr. BRAT. Let me ask you on that. The generic phrase, "we have seen an increase in jobs," isn't consistent with the clear evidence that the workforce participation rate is at its lowest in history, so yes, I mean, we're gaining jobs, the population is bigger, but the

labor force participation rate is at it's all time low, can those be squared?

Chairman KLINE. I'm sorry; the gentleman's time has expired. We're jamming up against the clock here.

Mr. BRAT. Thank you.

Chairman KLINE. Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman.

Madam Secretary, I understand that my colleague from California, Mr. DeSaulnier asked you about graduate medical school education. I just want to associate myself with those remarks. In Riverside County, which I represent, there are about only 34 primary care physicians for every 100,000 people, half the number of doctors needed to provided adequate access to care. And I understand that the GME levels have been frozen under the Medicare and Medicaid budgets since around 1996, so I associate myself with the exchange.

I hear from many of my colleagues about rising healthcare costs, and Mr. Courtney of Connecticut commented on the slow rates of growth there. In that case, it's a good thing. The *Affordable Care Act* is bending the cost curve. Last year, healthcare spending grew at the slowest rate on record since 1960, and healthcare price inflation is at its lowest rate in 50 years.

Just this week, as you mention in your testimony, California released its premiums for the 2016 planned year. Statewide, the average increase in premiums is just 4 percent. It's even lower than last year and a far cry from the years of double-digit premium growth we had before the ACA. Covered California also announced that if consumers shop around, they can reduce their premium by an average of 4.5 percent. That's incredible.

Madam Secretary, can you share more about how the ACA is containing healthcare costs?

Secretary BURWELL. I think you've outlined a number of the places that it is in terms of that downward pressure on premiums and also what happens in competition, your point that people can go on the marketplace and shop in the individual market.

We have also seen some of that downward pressure in overall price. It's also in the employer-based market. And the only other piece that I would mention is I think it's important to reflect that we've had a reduction of $317 billion in the projected Medicare spending from the period of the passage.

Mr. TAKANO. Real quick, before my time is up, how many years has the solvency of the Medicare trust fund been extended thanks to the ACA?

Secretary BURWELL. It is I want to say 17. It's at 2030, and when we came in, it was in the 2017, 2019 range.

Mr. TAKANO. So it's increased—with increased—

Secretary BURWELL. Thirteen to 17 years.

Mr. TAKANO. By 17 years.

Secretary BURWELL. Thirteen to 17. I want to go back and check exactly. It is 2030, and I think that previous number—I just don't know what the previous historical number was.

Mr. TAKANO. So the cost containment seems to be working, and I congratulate, you know, all of us for standing by the law. And I

know there's much more that we need to do to fix it. And I'm going to run out of time, I'm pretty sure, so Mr. Chairman, I yield back.

Chairman KLINE. The gentleman yields back.

Ms. Clark.

Ms. CLARK. Thank you, Mr. Chairman, and thank you, Madam Secretary, for being here today. I appreciate your leadership in so many areas, especially early childhood education and access to affordable high quality healthcare for all Americans.

Today I want to focus in my brief time on a topic that has come up with my colleagues from Georgia and California around the opioid crisis, and I commend you for your recent announcement and hope that Congress will support the 100 million that you want to invest in this crisis.

As you know, it doesn't matter when it comes to opioid abuse, whether you are rich or poor, your level of education attainment, but an area where we are seeing growth is in women using heroin, which has more than doubled in the last decade.

I introduced legislation called, *Protecting Our Infants Act,* which focuses on care for babies that are being born dependent to opiates, but it also looks at the effectiveness of programs specifically aimed at women and helping with substance abuse disorders.

Can you discuss any efforts that you have made to evaluate and respond to the circumstances of unique populations, including young women and others, in addressing this crisis?

Secretary BURWELL. With regard to, I think that it is especially important for young women, especially pregnant young women, to get into medicated assisted treatment quickly. And, actually, just a week ago, I was in Colorado visiting a clinic that did this work. And they do it, obviously, they do medicated assisted treatment, but they are an integrated facility so that a woman can come work on these issues at the same time she gets her prenatal care in a facility that is all in one place.

And so the emphasis and importance on medicated assisted treatment is something that we believe is a key part with this type of population, especially the pregnant women, so that we're protecting that newborn.

Ms. CLARK. Another area, shifting gears, but still talking about pregnant women and new moms, is the issue of postpartum depression.

Secretary BURWELL. Yes.

Ms. CLARK. I just dropped a bill today looking at this, hoping to expand grants to States. one in seven new moms are going to experience this depression. Can you talk about your efforts in this area, and what you think we can do to improve screening and access to treatment?

Secretary BURWELL. We believe that this is an essential part of prenatal and maternal care. As part of the prenatal care, making sure people know and understand this issue. We believe it's part of the full integration of behavioral health, and that's something that was done through the *Affordable Care Act;* it's something that was done in terms of the *Mental Health Clarity Act,* and making sure that we bring the—so it's all about maternal care. It's not about one or the other. This is an element of maternal care.

And so making sure that we have the right wellness visits and the right questions being asked as part of those wellness visits, and that is the integrated care that we believe is part of delivery system reform across the board.

Ms. CLARK. Thank you.

I yield back.

Chairman KLINE. I thank the gentlelady.

Mr. Curbelo, you are wrapping up here. You are recognized for three minutes.

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

And thank you, Madam Secretary, for your time and for your testimony here today.

The rising costs of healthcare coverage remains a major issue for people in my community. I'm talking employers and employees. And one issue that's starting to come onto people's radars is the Cadillac tax, the 40 percent tax on so-called high-cost plans has resulted in many employers already making changes to their plans to avoid hitting the tax in 2018 because, at the same time, they also have to offer minimum value coverage to avoid an employer penalty. So, it's a careful balancing act that a lot of employers are trying to make.

According to Towers Watson, 84 percent of large businesses surveyed expect to make changes to their full-time employee health benefits over the next three years. We hear stories now of how employers are making plan design changes such as increasing cost sharing and narrowing provider networks.

Miami-Dade County Public Schools, the second largest employer in the State of Florida, reported to me that they could see devastating effects as a result of this tax from an estimated $500,000 impact in 2018 up to a $10 million impact in later years.

Madam Secretary, if we are concerned about the costs of coverage, wouldn't it make sense to get rid of this excise tax because it's forcing the costs of coverage to go up for employees? Shouldn't the answer be to get rid of it and allow employers to offer the health benefits their employees are requesting and willing to pay for?

I really see this as one of those examples where the government actually ends up hurting the people who most need the help. When you're talking Miami-Dade County Public Schools, it's a lot of teachers; it's a lot of low-income earners, and now they face losing their health insurance or seeing fewer healthcare benefits as a result of this tax. Could you share some of your views on this issue?

Secretary BURWELL. Yes. One of the things is that for those populations and for those communities, the types of increases that we were seeing in terms of the percentage increase in premiums already existed. Some of the shifts that you're talking about in terms of how companies are doing cost sharing and their networks and deductibles, those things were occurring already.

By having the downward pressure of the excise tax in terms of the question of people's interests and companies and other employers' interests in trying to control their healthcare cost, we believe it's something that actually does put downward pressure on overall costs. I think the other issue at hand that we all have to consider

with regard to this excise tax is the Federal deficit and the question of any changes and how it interrelates with the Federal deficit.

So, those are the two issues that I think come to the floor. The question of whether or not overall it has downward pressure on prices and then the second is the fiscal responsibility.

Mr. CURBELO. But do you have any concern for those low-income earners who don't make a lot of money but at least for many years and I can speak as a former board member of Miami-Dade County schools, they knew that they had a good healthcare plan that they and their family members could rely on. They may lose those plans. Is that a concern for you?

Chairman KLINE. I'm sorry. The gentleman's time has expired. We are exceeding the hard stop time.

I'd like to recognize Mr. Scott for any closing remarks that he has.

Mr. SCOTT. Thank you, Mr. Chairman.

Could I ask one question—

Chairman KLINE. Please.

Mr. SCOTT. Just a brief question. My distinguished colleague from Virginia asked about people who might lose their job because of the *Affordable Care Act.* Could you make a quick comment about the effect of job lock and how that creates the situation you referred to?

Secretary BURWELL. Just that the question of job lock and those numbers have to do with many people are going to make a choice to start their own business.

I think the other thing in terms of job creation as I said with the Medicaid numbers, what we see is increased jobs because of some of the changes.

Mr. SCOTT. And so when you talk about people leaving the job, that's because they were only working on the job because they had a preexisting condition and wouldn't have insurance before, and they count that as a bad thing that they have another choice to leave their job I think is not looking at the positive effect that the *Affordable Care Act* has.

And so I want to thank you for talking about the President's priorities, especially healthcare, early childhood education, the effect of sequester on all of your programs, and I look forward to working with you as we go forward with the budget.

Secretary BURWELL. Thank you.

Chairman KLINE. I thank the gentleman.

Madam Secretary, I just have a quick follow-up to clarify an earlier question you were asked about Planned Parenthood. I know that came up a couple of times as you pointed out an issue that there's a lot of passion. I just want to be clear, is it your testimony that the Department of Health and Human Services has no intention of looking into this matter?

Secretary BURWELL. What the Department of Health and Human Services will do, and we didn't discuss it today, is with regard to the issue of our grantees and the Department of NIH, part of HHS that does our research, there's funding with regard to grantees, and some of those grants actually use fetal tissue. With regard to that, what we are doing is making sure that what we do have in place, which is clarity around the issue of the fact that for any of

those grantees that are going to do that research, that as they come through the process and before we do the grant making, there are terms and conditions that clearly list what the law is with regard to fetal tissue. They need to assert and certify that they understand the laws and that they will abide by that.

And then on an annual basis, with regard to when they re-up the grants, we ask them to certify, again, that they will obey the laws and the terms and conditions of which this is a specific place.

So, with regard to the piece that interacts with the Department, these are steps that we are taking to make sure that we have appropriate procedures in place to make sure that people know the law and certify that they are abiding by it.

Chairman KLINE. And so, the activities which have been so important to so many of us that have been revealed in these videos that are the actions of Planned Parenthood, you believe that is solely a matter for the Department of Justice; is that correct?

Secretary BURWELL. With regard to the determination of if the law has been broken, that is the Department of Justice. If there are any concerns at all with our grantees, we would want to refer that to our IG and/or the Department of Justice, depending on those circumstances.

Chairman KLINE. Okay. Thank you.

I really want to thank you. You were very indulgent here. We have gone over by eight minutes. I appreciate your patience. We very much appreciate your coming today. And there being no further business, we're adjourned.

Secretary BURWELL. Thank you, Mr. Chairman.

[Questions submitted for the record and their responses follow:]

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September 11, 2015

The Honorable Sylvia Burwell
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Dear Secretary Burwell:

Thank you for testifying at the July 28, 2015, Committee on Education and the Workforce hearing entitled "Reviewing the Policies and Priorities of the U.S. Department of Health and Human Services." I appreciate your participation.

Enclosed are additional questions submitted by Committee members following the hearing. Please provide written responses no later than September 25, 2015, for inclusion in the official hearing record. Responses should be sent to Callie Harman of the Committee staff, who can be contacted at (202) 225-7101.

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

Sincerely,

John Kline

JOHN KLINE
Chairman
Committee on Education and the Workforce

Enclosure

cc: The Honorable Robert C. "Bobby" Scott, Ranking Member, Education and the Workforce Committee

Questions Submitted by Chairman Kline (MN)

1. The department's "Final Rule on Notice of Benefit and Payment Parameters for 2016"[1] embedded individual maximum out-of-pocket insurance coverage limits within family limits beginning in 2016. However, most employers already prepared their plans for open enrollment this fall, prior to the department implementing this policy change. In fact, many employers did not become aware of this change until HHS and the Treasury and Labor Departments issued a "Frequently Asked Questions" document on May 26, 2015, requiring compliance by January 1, 2016. Representatives of large plan sponsors, including the ERISA Industry Committee, the American Benefits Council, and the National Coalition on Benefits, have all pointed out that compliance will not be possible by January 1, 2016.
    - Did the department consider if employers could be ready to comply with this policy change by January 2016? If not, why?
    - Now that the department is aware that compliance by January 2016 will be burdensome or impossible, and given the highly unusual mode of announcing this policy shift, will the administration delay the effective date or enforcement? Should employers expect penalties if they are unable to comply in time?
    - What studies did the administration perform to determine the regulatory impact of this significant policy change on the design and cost structure of plans? How will this change affect employee insurance premiums?

2. In September 2014, the Government Accountability Office (GAO) issued a report entitled "HealthCare.gov: Actions needed to Address Weaknesses in Information Security and Privacy Controls." Among other things, this report provided HHS with six specific recommendations to ensure proper protection of personally identifiable information collected from millions of Americans using HealthCare.gov. Unfortunately, earlier this month before a joint subcommittee hearing of the House Science, Space, and Technology Committee, GAO information security expert Gregory Wilshusen testified he believes HHS has refused to act on these recommendations.
    - Has HHS taken steps to implement all six of GAO's recommendations?
    - If yes, when was direction given to adopt these recommendations, and when will they be implemented?
    - If no, why has HHS decided to not implement GAO's recommendations to protect HealthCare.gov's users' personally identifiable information?
    - What guarantees can HHS provide to users of HealthCare.gov to protect personally identifiable information during the upcoming enrollment season beyond those recommended by GAO?

3. Private sector wellness programs benefit employees, their families, and employers. Unfortunately, the Equal Employment Opportunity Commission (EEOC) has pursued litigation and issued regulations attacking employer wellness programs. This combined assault squarely conflicts with Congress' bipartisan intent to encourage employers to adopt and expand wellness programs for the benefit of employees and their families. In

[1] CMS, HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule." Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

response, the *Preserving Employee Wellness Programs Act* (H.R. 1189) protects these programs from counterproductive, burdensome, and non-statutory requirements. In light of EEOC's persistent attacks, what actions has HHS taken to encourage or protect wellness programs, so that health care costs are minimized for providers of employer sponsored coverage and employees alike?

Questions Submitted by Representative Foxx (NC)

1. I understand the department is working to update the Dietary Guidelines for Americans. While I support efforts to provide nutrition information to the public, I am concerned by some of the recommendations made by the Dietary Guidelines Advisory Committee that are simply not scientifically justified. For example, the report recommends avoiding caffeine in certain drinks but suggests that much higher levels of caffeine in coffee are acceptable. What evidence exists to support this recommendation? While I understand providing general guidance on caffeine consumption, I am not aware of any evidence that warrants targeting specific products. Is there any difference between the caffeine in coffee, tea, soda, or energy drinks? What steps will you take to ensure the final Dietary Guidelines are based on sound science?

Questions Submitted by Representative Roe (TN)

1. I want to ask about the Medicare Hospital Area Wage index, which is supposed to ensure that hospital payments reflect geographic differences in wages. Over the years, many have raised concerns about the accuracy and fairness of the area wage index. The fact that one-third of all hospitals receive exceptions through the area wage index shows that the system is in great need of a fix – a sentiment that even MedPAC shares. While hospitals in my state are seeing their area wage index levels drop, hospitals in other states are seeing their area wage index levels increase. The rationale for this widening gap is unfair. Tennessee hospitals are being punished because they experience increases in costs, but these increases are not as high as the hospitals in other states. At a time when we are talking about solvency of the Medicare program, this hardly is an incentive for hospitals to keep their costs down. What can HHS do to remedy this situation?

2. I would like to discuss the recovery audit contractor or RAC program. I share the commitment to ensuring program integrity in Medicare, but I question the fairness and effectiveness of the RAC program. Whenever I discuss RACs with providers from Tennessee, I consistently hear that rather than guard against waste, fraud, and abuse, RACs increase the cost of providing care, inundate providers with massive document requests and flood the government appeals process with denials that get overturned - but only after a lengthy and expensive appeals process. Since RACs receive a contingency fee for each denied claim, they have the incentive to deny as many claims as possible regardless of whether the denial is justified or not. The fact that hospitals in Tennessee win around 72 percent of their appeals of RAC denials casts doubt on the effectiveness of these audits. There clearly is a need for better oversight and accountability of the RAC program. What is HHS doing to address these issues?

3. The Independent Payment Advisory Board (IPAB) process will begin, according to the latest Medicare Trustees report, in 2017. Assuming that the IPAB still has no appointed

members at that time, the Secretary of Health and Human Services will have to propose cuts to the Medicare program. Do you believe that any one person should have the power to propose cuts to Medicare? And if you were advising your successor on making cuts, what types of changes would you recommend?

4. As of today, have you watched any of the videos released by the Center for Medical Progress, and if so, which ones?

5. Please provide a list of all communications that took place between officials at the Department of Health and Human Services and officials at Planned Parenthood – or any of its affiliates – beginning on the day the first video was released.

Questions Submitted by Representative Barletta (PA)

1. The Bloomsburg Fair has been held every year since 1855. A major burden for the Fair, and other companies that employ seasonal workers, is determining whether or not they are a large or small employer under the president's health care law, and then who they are required to offer health insurance to. Under the employer shared responsibility requirements, the terms "seasonal worker" and "seasonal employee" do not mean the same thing. This is causing confusion among employers, making it more complicated for them to determine their compliance. Can you tell the Committee what steps you are taking to reduce this burden on small businesses that employ seasonal workers?

2. Pennsylvania faces a growing heroin and prescription drug abuse problem. More Pennsylvanians die from drug overdoses than from any other type of injury, including car accidents. I believe there should be greater access to the lifesaving drug naloxone to combat the rise of these overdoses. Organizations such as the American Medical Association along with several individual States, including Pennsylvania, are encouraging the practice of co-proscribing naloxone to patients receiving powerful painkiller prescriptions. I am told this practice is one of the most effective ways to get naloxone into the hands of as many at risk individuals as possible. It's commonsense. You would never want to be in a house without a fire extinguisher or head out on a boat without a lifejacket. Why should taking a potentially deadly painkiller be any different? The Veterans Affairs Administration has already put guidelines in place to facilitate this practice. While I am aware of the Administration's $99 million plan to combat overdose deaths, I would like an update on what *specifically* has been done to increase co-prescribing practices.

3. As a follow up, would you commit to working with Congress to address co-prescribing practices?

Questions Submitted by Representative Allen (GA)

1. In Georgia, health insurance costs have sky rocketed, going up 20-30 percent this year. This comes at a time when families are finding it more and more difficult to make ends meet because of the slow growth of the economy. In your opinion, how do we reduce the cost of health care?

2. I recently finished a series of meetings with physicians and hospital administrators. The consensus I heard from doctors and hospital administrators is that nothing has changed since Obamacare was implemented; people continue to show up at emergency rooms without insurance. Why has emergency room admittance not changed under Obamacare?

3. What is the premium for the average family making less than $50,000 a year, and what are their typical deductibles and out of pocket costs?

4. I received notice that the proposed CMS 2016 Medicare Physician Fee Schedule (MPFS) will cut colonoscopy reimbursements by almost 20 percent – what is the justification for this cut? You should keep in mind that these tests have substantially reduced the costs and deaths from colon disease and cancers.

5. Self-funded employers are required to contribute to the Transitional Reinsurance Fee program for three years, yet do not receive any benefit from the funds, which solely support the individual market by reimbursing insurers for high claims. According to a June 17 memo, CMS announced it had collected more funds than necessary for the program in 2014. Instead of rolling over the excess 2014 funds to 2015, CMS decided to pay back 100 percent of the insurer's highest costs, rather than the previously designated 80 percent.
    - What justification does the department have for not rolling the excess 2014 collections forward to the 2015 benefit year?
    - Will the department consider ending the regulatory practice of self-funded employers and multiemployer plans contributing to the reinsurance fee program for future benefit years?
    - Is the department considering extending the Transitional Reinsurance Program past 2016?

6. In September 2013, the Treasury Department released guidance prohibiting employers from using standalone Health Reimbursement Arrangements (HRAs) to reimburse employees for health care related expenses to meet the employer coverage requirements under Obamacare or face a $36,500 per employee fine.
    - Why is this administration opposed to HRA's as a cost-sharing option that enables employers to use pre-tax dollars to give employees a defined contribution for health care expenses?

Questions Submitted by Representative Scott (VA)

1. The Department of Justice issued a memo in 2007 from the Office of Legal Counsel (OLC) concluding that the Religious Freedom and Restoration Act provides faith-based grantees a basis for circumventing statutory civil rights protections. Specifically, the OLC memo permits employment discrimination on the basis of religion in federal grant programs. It also has the effect of sanctioning discrimination in hiring by faith-based grantees in directly federally funded grant programs, like Head Start and the Substance Abuse Mental Health Services Administration (SAMHSA). This was affirmed most recently on April 9, 2014 when the Department of Justice issued an FAQ indicating that the OLC memo can be used to undermine the plain language of the non-discrimination

provision added to the *Violence Against Women Act* (VAWA) when the law was reauthorized last Congress.

In 2010, President Obama signed Executive Order 13559 to reinstate vital religious liberty protections into the rules that govern partnerships between the government and faith-based organizations that provide social services. I'm disappointed to say that it's been explicitly indicated that the issue of hiring discrimination will not be addressed in these forthcoming rules. However, issues that may be addressed include the requirement to inform beneficiaries of their religious liberty rights and how to provide beneficiaries the right to access an alternative provider if they object to the religious character of a social service provider. These rules would impact programs being run by various agencies, including HHS. Madam Secretary, what is your understanding of the timetable for those proposed regulations? What else can or should the department do to make sure that social service grantees are not engaging in hiring discrimination while at the same time receiving federal funds?

2. Secretary Burwell, can you discuss the value of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit in Medicaid and why it is so important for children to have access to comprehensive health care services?

3. Secretary Burwell, can you please speak to the agency's actions to increase coordination between implementation of early learning programs under your jurisdiction and implementation of IDEA Part C funds for early intervention to ensure needs of children with disabilities are met?

4. Over half of all hospital costs are incurred by Medicare and Medicaid beneficiaries. Insofar as hospitals are therefore receiving the bulk of their revenue from the federal government, what actions is the department taking to ensure that hospitals are engaging with minority-owned, women-owned, and disadvantaged businesses in the provision of contracted services in hospitals?

Questions Submitted by Representative Fudge (OH)

1. Secretary Burwell, as I am sure you know, heroin and opioid use is growing rapidly in this country. No one is immune; this increase touches both men and women and reaches across all demographics. In Ohio alone, more than 980 people died in 2013 from overdose. In an effort to combat this growing epidemic I introduced the *Breaking Addiction Act of 2015*, a bill that would increase our nation's dangerously inadequate capacity for substance use disorder (SUD) services and expand access to treatment through selective waiver of the IMD exclusion. This exclusion forbids federal Medicaid matching payments to certain facilities that primarily serve individuals with mental illness, including those with substance use disorders. While I applaud CMS's recent announcement allowing states to develop and test innovative treatment delivery programs, does HHS have any plans to further address the issue of IMD exclusions and increase the utilization of waivers? What other action is the department taking to reduce the abuse of heroin and opioids and increase access to treatment?

2. Childhood obesity has increased by over 400 percent over the past 40 years. A study by University Hospital in Cleveland found the obesity rate for children in Ohio ages 10-17 is 36 percent. If we do not find a way to curb this epidemic, 23 million children are at risk of being the first generation to live shorter lives than their parents. What is the department doing to combat this growing public health epidemic and ensure our nation's children grow up to lead healthy, full lives?

3. As we celebrate the 50th anniversary of Medicare and Medicaid, what action points are departmental priorities for protecting and improving these vital programs? As some states have chosen not to expand Medicaid coverage under the ACA, what is the department doing on its own to improve and increase coverage to those Americans who need it the most?

Questions Submitted by Representative Polis (CO)

1. Back in April, I had the opportunity to visit the Head Start program at the Wilderness Early Learning Center in Boulder, and I've seen firsthand the benefits Head Start can have for its kids and the community it serves. I'm also a strong advocate for high-quality charter schools. Charter schools, which are public schools, have the autonomy to offer a unique curriculum for students, and many students and parents choose to take advantage of that.

   As you know, Head Start grants are given to non-profits, community centers, and sometimes traditional public schools, but to my knowledge, no charter schools have received Head Start grants, and very few have applied. Can you talk about what your agency is doing to clarify guidance so that high-quality charter schools know they are eligible to apply for Head Start grants and understand how to meet Head Start requirements?

2. Earlier this year, the FDA published revised recommendations pertaining to blood donations by men who have had sex with men. The policy change would eliminate the outdated lifetime ban for gay and bisexual men and instead institute a one-year deferral policy from the date of the last sexual contact with a man. This is a positive step forward, and will indeed allow more lives to be saved, but can you speak about your opinion on whether the new policy reflects the most up-to-date science on this issue? The large majority of gay men do not engage in risky behavior and are not at higher risk of contracting HIV than the general population.

   In fact, the FDA's own BloodDROPS survey has found that the prevalence of HIV in male blood donors who reported that they have had sexual relations with men is just .25 percent – lower than the overall prevalence in the total U.S. population, which is .38 percent. In your opinion, does the one-year deferral policy reflect the most scientifically sound policy to save as many lives as possible, or do you view the one-year deferral as just a first step toward modernizing the FDA's policy with respect to donations by gay and bisexual men? Would the FDA consider a policy that screens for specific risky behavior rather than grouping all men who have had sexual relations with men into one blanket, high-risk category?

[Secretary Burwell's response to questions submitted for the record]

Secretary Sylvia Mathews Burwell
Hearing on "FY 2016 President's Budget"
Before
House Education & Workforce Committee

Questions for the Record

Questions Submitted by Chairman Kline (MN)

1. **The department's "Final Rule on Notice of Benefit and Payment Parameters for 2016"[1] embedded individual maximum out-of-pocket insurance coverage limits within family limits beginning in 2016. However, most employers already prepared their plans for open enrollment this fall, prior to the department implementing this policy change. In fact, many employers did not become aware of this change until HHS and the Treasury and Labor Departments issued a "Frequently Asked Questions" document on May 26, 2015, requiring compliance by January 1, 2016. Representatives of large plan sponsors, including the ERISA Industry Committee, the American Benefits Council, and the National Coalition on Benefits, have all pointed out that compliance will not be possible by January 1, 2016.**
    - **Did the department consider if employers could be ready to comply with this policy change by January 2016? If not, why?**
    - **Now that the department is aware that compliance by January 2016 will be burdensome or impossible, and given the highly unusual mode of announcing this policy shift, will the administration delay the effective date or enforcement? Should employers expect penalties if they are unable to comply in time?**
    - **What studies did the administration perform to determine the regulatory impact of this significant policy change on the design and cost structure of plans? How will this change affect employee insurance premiums?**

Answer: As you know on May 26, 2015 the Department of Health and Human Services, together with the Departments of Labor and Treasury released a set of frequently asked questions (ACA FAQ Part XXVII) on the annual limitations on cost sharing as those limitations apply to non-grandfathered self-insured and large group health plans. The Affordable Care Act (ACA) added a new requirement to the Public Health Service Act, incorporated under the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code, that requires that "[a] group health plan . . . ensure that any annual cost-sharing imposed under the plan does not exceed the limitations provided for under paragraphs (1) and (2) of section 1302(c) [of the ACA]." Section 1302(c)(1) in turn provides for a maximum out of pocket (MOOP) limit amount that applies to "self-only" coverage, and a higher total limit that applies to "other than self-only" coverage.

On November 26, 2014, HHS published a notice of proposed rulemaking (NPRM) in which HHS proposed that "the annual limitation on cost sharing for self-only coverage [be] applie[d] to all

[1] CMS, HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, Final Rule." Available at: http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf

individuals regardless of whether the individual is covered by a self-only plan or is covered by a plan that is other than self-only."[2] On February 27, 2015, HHS published the Notice of Benefit and Payment Parameters for 2016 Final Rule, which finalized this proposal.

These MOOP limits were implemented through the Federal Register notice and comment procedures provided for under the Administrative Procedure Act, and under the Secretary's rulemaking authority in section 2792 of the Public Health Service Act to "promulgate any . . . rules the Secretary determines are appropriate to carry out [the Public Health Service Act provision incorporating the MOOP requirements]." Applying the individual $6,850 maximum annual limitation on cost sharing to individuals covered by a plan that is other than self-only helps remedy the difficulty a consumer could face in paying up to $13,700 out-of-pocket for certain covered medical care under the plan because he or she purchased family coverage instead of self-only coverage. It also prevents consumers from being penalized for purchasing family coverage rather than self-only coverage.

The NPRM published on November 26, 2014 clearly proposed policies for implementing these MOOP limits. These limits were finalized on February 27, 2015 providing notice of implementation for the 2016 plan year.

As stated in the May 26, 2015 FAQ, this final rule applies to all non-grandfathered small group and large group health plans, including self-insured plans, for plan or policy years beginning on or after January 1, 2016. For these plans, the annual limitation on cost sharing only applies to covered benefits that would be essential health benefits under Section 1302 of the Affordable Care Act.

2. **In September 2014, the Government Accountability Office (GAO) issued a report entitled "HealthCare.gov: Actions needed to Address Weaknesses in Information Security and Privacy Controls." Among other things, this report provided HHS with six specific recommendations to ensure proper protection of personally identifiable information collected from millions of Americans using HealthCare.gov. Unfortunately, earlier this month before a joint subcommittee hearing of the House Science, Space, and Technology Committee, GAO information security expert Gregory Wilshusen testified he believes HHS has refused to act on these recommendations.**
    - **Has HHS taken steps to implement all six of GAO's recommendations?**
        - **If yes, when was direction given to adopt these recommendations, and when will they be implemented?**
        - **If no, why has HHS decided to not implement GAO's recommendations to protect HealthCare.gov's users' personally identifiable information?**
        - **What guarantees can HHS provide to users of HealthCare.gov to protect personally identifiable information during the upcoming enrollment season beyond those recommended by GAO?**

Answer: Thank you for raising the crucial issue of cybersecurity; it is a top priority of mine. Each and every day, U.S. businesses face a myriad of cyber threats, and government IT systems

[2] 79 Fed. Reg. 70674, 70723-70724

are no different. There are inherent risks for every IT system, and while no website is immune from attempted attacks, CMS will continue to maintain and strengthen the security of HealthCare.gov.

CMS developed the Marketplace systems relying on Federal statutes, guidelines, and industry standards that helped us to create standards, processes, and controls for the security and integrity of the systems and the data that flow through them. We know that consumers put their trust in us when they visit HealthCare.gov, and that is why we are constantly strengthening our security controls and evaluating our risk posture. No person or group has maliciously accessed personally identifiable information (PII) from the site.

Making the website secure is a continuing process. Leading up to the second open enrollment period, our systems were audited by outside experts from the Government Accountability Office (GAO), the Department of Health & Human Services (HHS) Office of Inspector General (OIG), the Department of Homeland Security (DHS), and the Internal Revenue Service (IRS), along with independent Security Control Assessment auditors. These experts from the public and the private sector helped improve our practices and execute new heightened security measures. The Centers for Medicare & Medicaid Services (CMS) worked to implement recommendations and mitigate any risks identified by these external parties. Specifically, CMS began implementing the GAO's recommendations soon after its report was issued and has provided the GAO documentation to complete the process of officially closing the recommendations from its report.

CMS has implemented measures to protect personal information and constantly evaluates systems to discover new threats, vulnerabilities, and possible intrusion points. These measures include ongoing penetration testing and automated scanning, consistent with FISMA requirements and industry best practices so that security controls are effective in safeguarding consumers' personal information. As part of the ongoing testing process, and in line with Federal and industry standards, any open risk findings are addressed with risk mitigation strategies and compensating controls. The security of the system is also monitored by sensors and other tools to deter and prevent unauthorized access. CMS conducts continuous monitoring, maintains a 24/7 security operations center, utilizes a multi-layer IT professional security team, conducts routine penetration testing, and performs ongoing testing and mitigation strategies. These layered controls help protect the security and privacy of PII related to the Federally-facilitated Marketplace.

CMS continues to test security functionality through quarterly security control testing which exceeds the industry standard. In addition to daily operational security testing, we conducted a comprehensive end-to-end Security Control Assessment (SCA) that meets Federal and industry standards before the start of the second Open Enrollment period.

With the help of partner agencies across the federal government, CMS has taken additional steps to strengthen the security of HealthCare.gov. For instance, we are working with the DHS National Cybersecurity Assessment and Technical Services team to identify risks, provide recommendations and perform cyber hygiene, which is a weekly external scan of public-facing Marketplace systems for vulnerabilities, enhancing the existing scanning conducted by CMS. This provides us a 360 degree picture of our vulnerability management program and allows us to remediate or mitigate potential vulnerabilities.

We also sought and obtained the Federal Risk and Authorization Management Program (FedRAMP) certification authority – the gold standard within the federal government for cloud security - for our Verizon facility, which hosts the Federally-Facilitated Marketplace.

We are committed to the protection of consumer information entrusted with us at HealthCare.gov and will continue our ongoing review for additional ways to strengthen our security practices.

3. **Private sector wellness programs benefit employees, their families, and employers. Unfortunately, the Equal Employment Opportunity Commission (EEOC) has pursued litigation and issued regulations attacking employer wellness programs. This combined assault squarely conflicts with Congress' bipartisan intent to encourage employers to adopt and expand wellness programs for the benefit of employees and their families. In response, the *Preserving Employee Wellness Programs Act* (H.R. 1189) protects these programs from counterproductive, burdensome, and non-statutory requirements. In light of EEOC's persistent attacks, what actions has HHS taken to encourage or protect wellness programs, so that health care costs are minimized for providers of employer sponsored coverage and employees alike?**

Answer: HHS supports workplace health promotion and prevention as a means to reduce the burden of chronic illness, improve health and limit growth of health care costs, while ensuring that individuals are protected from discriminatory underwriting practices that could otherwise reduce benefits based on health status. The cost of treatment for those with chronic conditions like heart disease, cancer, strokes, and diabetes accounts for over 75 percent of our annual medical care costs. In addition to these direct costs, the indirect costs associated with poor health – such as worker absenteeism, reduced productivity, and disability – may be significantly higher.

Wellness programs are good for employers and employees alike, but should protect privacy and prevent discriminatory underwriting practices in the process. The current tri-Department wellness-program regulations offer flexibility to employers by increasing the maximum reward that may be offered under appropriately designed wellness programs, including outcome-based programs. These rules also protect consumers by requiring that health-contingent wellness programs be reasonably designed, be uniformly available to all similarly situated individuals and accommodate recommendations made at any time by an individual's physician, based on medical appropriateness.

I appreciate your interest in this important issue and we look forward to partnering with you and with employers in this work.

Questions Submitted by Representative Foxx (NC)

1. **I understand the department is working to update the Dietary Guidelines for Americans. While I support efforts to provide nutrition information to the public, I am concerned by some of the recommendations made by the Dietary Guidelines Advisory Committee that are simply not scientifically justified. For example, the report recommends avoiding caffeine in certain drinks but suggests that much higher levels of caffeine in coffee are acceptable. What evidence exists to support this**

recommendation? While I understand providing general guidance on caffeine consumption, I am not aware of any evidence that warrants targeting specific products. Is there any difference between the caffeine in coffee, tea, soda, or energy drinks? What steps will you take to ensure the final Dietary Guidelines are based on sound science?

Answer: The 2015 Dietary Guidelines Advisory Committee's (Advisory Committee) role was to provide advice and recommendations to the Government on the current state of scientific evidence on nutrition and health. Their Advisory Report serves as a starting point for the Departments of Health and Human Services and Agriculture, which consider the scientific evidence, recommendations of the Advisory Committee, as well as comments from both the public and federal agencies in drafting the 2015 Dietary Guidelines.

The Advisory Committee used four approaches to answer its questions: 1) original systematic reviews created by USDA's Nutrition Evidence Library; 2) existing systematic reviews or reports; 3) data analyses; and 4) food pattern analyses. This enabled the Committee to consider the totality of the evidence rather than selectively picking studies that could lead to biased findings. Systematic reviews are the gold standard for informing the creation of clinical practice guidelines and public health policies worldwide. In addition to the Advisory Report, HHS and USDA are reviewing comments from Federal Agencies and the public on the Advisory Report as we work to update the current (2010) *Dietary Guidelines for Americans.* The 2015 edition will be based on the preponderance of current scientific evidence.

The review of caffeine by the Advisory Committee was changed to a review of coffee/caffeine when it became apparent that the majority of the literature on caffeine and health outcomes used coffee as the source of caffeine intake. The Advisory Committee reviewed the scientific literature on coffee/caffeine at usual consumption levels as well as at high doses with respect to health outcomes using systematic reviews (SRs)/meta-analyses (MA). The Committee concluded that there exists strong and consistent evidence showing that, in healthy adults, moderate coffee consumption is not associated with an increased risk of cardiovascular disease (CVD), cancer, or premature death and may be associated with reduced risk of type 2 diabetes and CVD.

The Committee also found that the amount of caffeine in a product varies widely. The amount of caffeine in brewed coffee ranges from 9 -21 mg/oz, in espresso up to 63 mg/oz, in tea from 1-9 mg/oz, and in soda 0-6 mg/oz. The caffeine content of energy drinks varies widely from about 1.5 to 32 mg/oz whereas energy shots (considered a dietary supplement) may have much higher caffeine concentrations.

With regard to caffeine and energy drinks, the Committee noted that these drinks are highly variable in caffeine content and agreed with the American Academy of Pediatrics and the American Medical Association that until safety has been demonstrated, limited or no consumption of high-caffeine drinks or other caffeine-containing products is advised for children and adolescents. However, it judged the strength of the evidence of its literature review as limited and recommended several future research questions to address these issues as well.

The marketing and availability of high-caffeine beverages and products is on the rise. Unfortunately, only limited evidence is currently available to ascertain the safety of high caffeine intake (greater than 400 mg/day for adults and undetermined for children and adolescents) that may occur with rapid consumption of large-sized high-caffeine drinks. Limited data suggest adverse health outcomes, such as caffeine toxicity and cardiovascular events and the Committee recommended further research on the effect that high dose caffeine has on health. Concern is heightened when caffeine is combined with alcoholic beverages. Drinks with high levels of caffeine and alcoholic beverages should not be consumed together, either mixed together or consumed at the same sitting.

Thank you for your ongoing interest in the Dietary Guidelines. We are committed to ensuring that the final Guidelines are grounded in sound science.

Questions Submitted by Representative Roe (TN)

1. **I want to ask about the Medicare Hospital Area Wage index, which is supposed to ensure that hospital payments reflect geographic differences in wages. Over the years, many have raised concerns about the accuracy and fairness of the area wage index. The fact that one-third of all hospitals receive exceptions through the area wage index shows that the system is in great need of a fix – a sentiment that even MedPAC shares. While hospitals in my state are seeing their area wage index levels drop, hospitals in other states are seeing their area wage index levels increase. The rationale for this widening gap is unfair. Tennessee hospitals are being punished because they experience increases in costs, but these increases are not as high as the hospitals in other states. At a time when we are talking about solvency of the Medicare program, this hardly is an incentive for hospitals to keep their costs down. What can HHS do to remedy this situation?**

Answer: Thank you for your expressing your concerns regarding the Medicare Hospital Area Wage Index and your request for greater equity among labor market areas. As you know, under the inpatient prospective payment system (IPPS), as part of administering the Medicare program, the law requires the Secretary to adjust for different area wage levels in determining payment based on the proportion of hospitals' costs attributable to wages and wage-related costs. This is known as the Medicare wage index and underpins the concept of prospective payment across many provider settings. Section 3137(b) of the Affordable Care Act required the Secretary of Health and Human Services to submit to Congress a report that includes a plan to reform the Medicare wage index applied under the Medicare hospital inpatient prospective payment system (IPPS). In developing this plan, the Secretary was directed to consider the goals for reforming the wage index that were set forth by the Medicare Payment Advisory Commission's June 2007 report entitled, "Report to Congress: Promoting Greater Efficiency in Medicare.

The Secretary's Report to Congress describes the concept of a Commuting Based Wage Index (CBWI), which takes into account hospital hiring patterns in calculating the wage index by using commuting data to establish a labor market area and wage index value for each hospital (as opposed to labor market areas). The CBWI would use smaller, more discrete labor market areas and only incorporates wage data from hospitals that actually employ workers in that area. The result would be a wage index specific to an individual hospital based upon the labor markets

from which that hospital hires its workers. Thus, the CBWI could accomplish the major goals of moving towards a wage index system that yields greater accuracy and less distortion - in particular, one that is focused on eliminating large differences, or "cliffs." As the Report notes, some elements of this concept require statutory changes to implement.

The Report is available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Reform.html. We look forward to working with you on this important issue, and to continuing to build on our work to support rural hospitals in Tennessee and across the nation.

2. **I would like to discuss the recovery audit contractor or RAC program. I share the commitment to ensuring program integrity in Medicare, but I question the fairness and effectiveness of the RAC program. Whenever I discuss RACs with providers from Tennessee, I consistently hear that rather than guard against waste, fraud, and abuse, RACs increase the cost of providing care, inundate providers with massive document requests and flood the government appeals process with denials that get overturned – but only after a lengthy and expensive appeals process. Since RACs receive a contingency fee for each denied claim, they have the incentive to deny as many claims as possible regardless of whether the denial is justified or not. The fact that hospitals in Tennessee win around 72 percent of their appeals of RAC denials casts doubt on the effectiveness of these audits. There clearly is a need for better oversight and accountability of the RAC program. What is HHS doing to address these issues?**

Answer: CMS strives to manage programs in an efficient manner that balances the need to limit burden on Medicare providers with our responsibility to protect Trust Fund dollars.

CMS has many safeguards in place to ensure Recovery Auditors are not financially incentivized to inappropriately deny claims. For one, if the claim is overturned at any level of appeal, the Recovery Auditor does not receive a contingency fee payment. When Recovery Auditor determinations are in fact appealed, many of these decisions are upheld. Overall, only 9.3 percent of all Recovery Auditor determinations were challenged and later overturned on appeal in FY 2013. CMS also contracts with an independent entity that reviews a random sample of claims from each Recovery Auditor to establish an accuracy rate, which is a measure of the accuracy of each Recovery Auditor's overpayment and underpayment determinations. The combined accuracy rates for the Recovery Auditors are consistently above 90 percent. In addition, continued poor performance by a Recovery Auditor will result in negative performance evaluations and may result in work stoppage, corrective action plans and/or contract modification or termination.

We appreciate and share your commitment to ensuring program integrity in Medicare, and look forward to continuing discussions on this important issue.

3. **The Independent Payment Advisory Board (IPAB) process will begin, according to the latest Medicare Trustees report, in 2017. Assuming that the IPAB still has no appointed members at that time, the Secretary of Health and Human Services will have to propose**

cuts to the Medicare program. Do you believe that any one person should have the power to propose cuts to Medicare? And if you were advising your successor on making cuts, what types of changes would you recommend?

Answer: The Independent Payment Advisory Board (IPAB) was designed as a backstop to protect against excessive cost growth in the Medicare program. While I am encouraged that our current efforts to improve quality and efficiency in Medicare are contributing to historic lows in the cost growth of the program, there is more work to be done to control its long-term cost growth..

The Affordable Care Act requires the President, in consultation with bipartisan Congressional leaders, to nominate board members, who then must be confirmed by the Senate. To date, Congressional leaders have not provided any names of suggested Board members. In any year in which the Board would be required to submit a proposal to achieve Medicare savings, without a Board in place to submit a proposal that the Chief Actuary certifies will achieve the savings target, the Secretary is required to submit a proposal that will achieve that amount of savings.

The Secretary's proposal is submitted to Congress for consideration and action; thus, Congress may change any submitted proposals to achieve the required savings. Any proposals submitted for consideration would be consistent with requirements for IPAB proposals, which prohibit increases in cost-sharing or beneficiary premiums, restrictions on benefits, rationing of health care, or changes in eligibility.

4. **As of today, have you watched any of the videos released by the Center for Medical Progress, and if so, which ones?**

Answer: No, I have not seen the videos you reference, but I have read news accounts that describe their content.

5. **Please provide a list of all communications that took place between officials at the Department of Health and Human Services and officials at Planned Parenthood – or any of its affiliates – beginning on the day the first video was released.**

Answer: On July 29th, 2015, Dr. Francis Collins, NIH Director, received a letter from Cecile Richards, President of Planned Parenthood Federation of America.

Questions Submitted by Representative Barletta (PA)

1. **The Bloomsburg Fair has been held every year since 1855. A major burden for the Fair, and other companies that employ seasonal workers, is determining whether or not they are a large or small employer under the president's health care law, and then who they are required to offer health insurance to. Under the employer shared responsibility requirements, the terms "seasonal worker" and "seasonal employee" do not mean the same thing. This is causing confusion among employers, making it more complicated for them to determine their compliance. Can you tell the Committee what steps you are taking to reduce this burden on small businesses that employ seasonal workers?**

Answer: Thank for your sharing this concern. We understand that, as with any complex system, it may have been challenging for some small businesses to make the necessary adjustments. We are committed to supporting them, and to listening to their feedback. The Affordable Care Act takes several steps forward for small businesses on affordability, access, and quality, by expanding access to quality, affordable health insurance for entrepreneurs and their employees.

Regarding the definition of seasonal worker and seasonal employee, on February 10, 2014, the IRS and Treasury provided these definitions in final regulations on section 4980H of the Code after issuing proposed regulations in 2013 that provided guidance on determining applicable large employer status and full-time employee status, including rules for calculating hours of service. I would refer you to the Department of Treasury for further information on this provision. As always, we are willing to work with Congress on any provisions that would improve health insurance affordability, access, quality and the overall health of the economy.

2. **Pennsylvania faces a growing heroin and prescription drug abuse problem. More Pennsylvanians die from drug overdoses than from any other type of injury, including car accidents. I believe there should be greater access to the lifesaving drug naloxone to combat the rise of these overdoses. Organizations such as the American Medical Association along with several individual States, including Pennsylvania, are encouraging the practice of co-proscribing naloxone to patients receiving powerful painkiller prescriptions. I am told this practice is one of the most effective ways to get naloxone into the hands of as many at risk individuals as possible. It's commonsense. You would never want to be in a house without a fire extinguisher or head out on a boat without a lifejacket. Why should taking a potentially deadly painkiller be any different? The Veterans Affairs Administration has already put guidelines in place to facilitate this practice. While I am aware of the Administration's $99 million plan to combat overdose deaths, I would like an update on what *specifically* has been done to increase co-prescribing practices.**

Answer: Thank you for commitment to this important issue; it is a top priority of mine. HHS is committed to expanding access to the lifesaving drug naloxone and has made it one of the three priorities in the Secretary's Opioid Initiative. As you know, the overall plan to reduce opioid overdose includes +$99 million in additional funding in the FY 2016 President's Budget through three priority areas. On naloxone, we are specifically focusing on:

- Supporting the development, review, and approval of new naloxone products and delivery options.
- Promoting state use of Substance Abuse Block Grant funds to purchase naloxone.
- Implementing the Prescription Drug Overdose grant program for states to purchase naloxone and train first responders on its use.

HHS agrees that co-prescribing naloxone is an important and promising method to ensure that those at high risk for overdose from prescription opioids have access to this life-saving product. The FDA held a public meeting in July 2015 to review and discuss specific steps to encourage additional access to naloxone. Two panels specifically focused on the mechanics of co-prescribing and how to optimally implement this practice. The FDA is committed to increasing access to overdose reversal products and has granted expedited review to naloxone formulations

that can be administered by non-medical providers. For example, EVZIO™ (naloxone hydrochloride injection) provides naloxone through an auto injector that can be used without specialized training; FDA approved this in April 2014, ahead of the product's prescription drug user fee goal date of June 20, 2014. FDA reviewed EVIZO under the agency's priority review program, which provides for an expedited review of drugs that appear to provide safe and effective therapy when no satisfactory alternative therapy exists, or offer significant improvement compared to marketed products. The product was also granted a fast-track designation, a process designed to facilitate the development, and expedite the review of drugs to treat serious conditions and fill an unmet medical need. HHS is also working with EVIZO's producer Kaléo to best target a program that will give away naloxone to hundreds of first responder agencies community-based programs, local health departments, and partners in the communities with the greatest need.

Furthermore, HHS has placed significant emphasis on the safe prescribing of opioid pain medication in the Secretary's Initiative. The CDC is working on national consensus guidelines to improve the way opioids are prescribed for safer treatment of chronic pain outside end of life care. The development process is currently underway and the guidelines are expected to be published in January 2016. They will represent state of the art knowledge on the most effective and safe use of opioids and reflect consensus on optimal prescribing by a wide-range of national experts on pain treatment and opioid prescribing.

3. **As a follow up, would you commit to working with Congress to address co-prescribing practices?**

Answer: Yes. HHS is very interested in working with Congress and other stakeholders to promote practices that reduce morbidity and mortality associated with prescription opioids including ways to encourage the co-prescription of naloxone when appropriate. I am personally committed to making progress on the issue, as I have discussed with many of your colleagues in Congress.

Questions Submitted by Representative Allen (GA)

1. **In Georgia, health insurance costs have sky rocketed, going up 20-30 percent this year. This comes at a time when families are finding it more and more difficult to make ends meet because of the slow growth of the economy. In your opinion, how do we reduce the cost of health care?**

Answer: HHS is working to transform our nation's health care delivery system to encourage better care at lower cost. Earlier this year, we announced measurable goals regarding paying for value and a timeline to move the Medicare program toward this approach to provider payment. We have a vision of a system that delivers better care, spends our health care dollars in a smarter way, and puts educated, empowered and engaged individuals at its center. We are taking action on these goals now, as evidenced by our recent rule allowing for bundled payments for joint replacements.

For consumers shopping for health insurance, the Marketplaces created by the Affordable Care Act foster competitive environments in which consumers can choose from a number of

affordable and high quality health plans. The Marketplaces offer consumers organized platforms to shop for health insurance coverage, apply for financial assistance, and purchase coverage without any medical underwriting or premium adjustment based on pre-existing conditions.

The Affordable Care Act increases competition and provides consumers with the opportunity to switch to a different plan if a better deal is available. Insurance companies project that most people will be enrolled in plans with proposed rate increases of less than 10% in 2016. Financial assistance can help make Marketplace plans more affordable. As of the end of March 2015, nationwide more than 8 in 10 individuals who selected a 2015 Marketplace plan qualified for financial assistance at an average of $272 per person per month. For the 37 states using the Healthcare.gov platform during 2015 Open Enrollment, nearly 8 in 10 people had the option to select a plan with a premium $100 or less per month after applying the advance premium tax credit.

2. **I recently finished a series of meetings with physicians and hospital administrators. The consensus I heard from doctors and hospital administrators is that nothing has changed since Obamacare was implemented; people continue to show up at emergency rooms without insurance. Why has emergency room admittance not changed under Obamacare?**

Answer: We are seeing real reductions in the uninsured rate thanks to the Affordable Care Act. Since the Affordable Care Act's coverage provisions took effect, about 16.4 million uninsured people have gained health insurance coverage. This includes 14.1 million adults who gained health insurance coverage since the beginning of open enrollment in October, 2013 (including 3.4 million young adults aged 19-25) through March 4, 2015. Over that period, the uninsured rate dropped from 20.3 percent to 13.2 percent – a 35 percent (or 7.1 percentage point) reduction in the uninsured rate. This number also includes 2.3 million young adults who gained health insurance coverage between 2010 and the start of open enrollment in October, 2013 due to the ACA provision allowing young adults to remain on a parent's plan until age 26.

As a result of Marketplace coverage and Medicaid expansion, we estimate that hospital uncompensated care costs were reduced by $7.4 billion in 2014, compared to what they would have been in the absence of the coverage expansion. Medicaid expansion states account for $5 billion of that reduction. That's almost 68% of the total. Before the ACA those uncompensated care costs typically were passed on to taxpayers and insured individuals.

One of the most effective ways that states' can further reduce the number of uninsured and uncompensated care is through expanding Medicaid. HHS is committed to working with all states on Medicaid expansion. And of the 11 states with the greatest reductions in uninsured rates in 2015, 10 had expanded Medicaid eligibility. As of November 2014, approximately 10.1 million additional Americans were enrolled in Medicaid and CHIP – a 17 percent increase over the average monthly enrollment for July through September 2013, the months before the Marketplaces first opened. Enrollment grew to nearly 68.5 million people in October 2014. Medicaid and CHIP enrollment in states with expanded Medicaid programs rose by over 24 percent since before the initial open enrollment in Marketplace began, in comparison to nearly 7 percent in states that have not expanded Medicaid.

3. What is the premium for the average family making less than $50,000 a year, and what are their typical deductibles and out of pocket costs?

Answer: Each family's situation is unique and will vary based on their individual circumstances. Many Americans, for example, receive health insurance through an employer. For those who purchased coverage through the Marketplaces, more than 8 in 10 individuals who selected a 2015 Marketplace plan qualified for financial assistance at an average of $272 per person per month as of the end of March 2015. For those individuals in states using the Healthcare.gov platform, during 2015 Open Enrollment nearly 8 in 10 people had the option to select a plan for less $100 per month with the advance premium tax credit.

In Georgia, for example, a family of four with income of $60,000 could purchase the benchmark (second-lower cost) "silver" plan for an average of $407 per month in 2015, after taking into account the advance premium tax credit, and families with lower incomes faced lower costs. While cost sharing provisions vary across plans, "silver" plans pay about 70 percent of the total costs of care for essential health benefits, on average, while the consumer pays 30 percent of these costs. Moreover, families with incomes between 100% and 250% of the Federal Poverty Level are eligible for additional cost sharing assistance. The Marketplaces offer a number of competing plans that offer a diverse selection of deductibles, premiums, and cost sharing arrangements so that each consumer can select the plan that best suits their needs.

The Affordable Care Act (ACA) helps ensure that health insurance provides meaningful financial security to families across America through a maximum annual limit on out of pocket costs for essential health benefits provided for under the ACA. This important consumer protection sets forth limits on out of pocket expenditures, providing consumers with additional financial protections.

4. I received notice that the proposed CMS 2016 Medicare Physician Fee Schedule (MPFS) will cut colonoscopy reimbursements by almost 20 percent – what is the justification for this cut? You should keep in mind that these tests have substantially reduced the costs and deaths from colon disease and cancers.

Answer: I agree that colonoscopies can play an important role in the detection of cancer. Per statute, the HHS Secretary is required to conduct a periodic review, not less often than every 5 years, of the relative value units established under the Physician Fee Scale (PFS). The statute also requires the Secretary to periodically identify potentially misvalued services using certain criteria and to review and make appropriate adjustments to the relative values for those services. After some gastrointestinal endoscopy services, including colonoscopies, were identified as potentially misvalued under this process, the Current Procedural Terminology (CPT) codes, which are used to report these services, were revised by the American Medical Association's CPT Editorial Panel for calendar year (CY) 2015. In addition, CMS heard from the relevant specialty societies that this code set did not allow for accurate reporting of services based upon current medical practice.

As part of the usual process, the American Medical Association/Specialty Society Relative Value Update Committee (the RUC) subsequently provided recommendations to CMS for valuing

these services. In the CY 2015 PFS final rule with comment period, CMS delayed valuing these gastrointestinal codes and indicated that we would propose values for these codes in the CY 2016 proposed rule, citing the new process for including proposed values for new, revised and potentially misvalued codes in the proposed rule.

In the CY 2016 PFS proposed rule, CMS proposed values for this set of codes. In determining the values to propose for each code we considered the RUC recommendations and other available information. The proposed rule describes these valuations, which include a proposed 11% reduction in the physician portion of payment for the base colonoscopy in the facility setting and a proposed 2.6% reduction for colonoscopy in the office setting. These proposed rates would also result in proportionate reductions to beneficiary cost-sharing for diagnostic colonoscopies. . We sought comments on the proposed values, and staff are considering the comments received in response to the proposed rule in determining final values that will be published in the final rule around November 1, 2015.

5. **Self-funded employers are required to contribute to the Transitional Reinsurance Fee program for three years, yet do not receive any benefit from the funds, which solely support the individual market by reimbursing insurers for high claims. According to a June 17 memo, CMS announced it had collected more funds than necessary for the program in 2014. Instead of rolling over the excess 2014 funds to 2015, CMS decided to pay back 100 percent of the insurer's highest costs, rather than the previously designated 80 percent.**
    - **What justification does the department have for not rolling the excess 2014 collections forward to the 2015 benefit year?**
    - **Will the department consider ending the regulatory practice of self-funded employers and multiemployer plans contributing to the reinsurance fee program for future benefit years?**
    - **Is the department considering extending the Transitional Reinsurance Program past 2016?**

Answer: Under the HHS Notice of Benefit and Payment Parameters for 2015 Final Rule (79 FR 13777), consistent with 45 CFR 153.230(d), if reinsurance collections exceed requests for reinsurance payments for a given benefit year, HHS will increase the coinsurance rate, up to a maximum of 100 percent. If funds remain after increasing the coinsurance rate to 100 percent, HHS will use the funds to make payments in the next benefit year. This will allow for the reinsurance program to continue offering its premium stabilization effects in the individual market. With respect to your question regarding extensions past 2016, section 1341 of the Affordable Care Act (ACA) and its implementing regulations established the collections of contributions for the transitional reinsurance program as temporary and time limited that will end after 2016. However, consistent with Section 1341(b)(4)(B) of the ACA, HHS may use amounts remaining unexpended as of December 2016 to make reinsurance payments for the 2-year period beginning on January 1, 2017.

6. **In September 2013, the Treasury Department released guidance prohibiting employers from using standalone Health Reimbursement Arrangements (HRAs) to reimburse**

employees for health care related expenses to meet the employer coverage requirements under Obamacare or face a $36,500 per employee fine.

- **Why is this administration opposed to HRA's as a cost-sharing option that enables employers to use pre-tax dollars to give employees a defined contribution for health care expenses?**

Answer: Under the Affordable Care Act, employer-sponsored insurance must meet market reforms that protect individuals against annual and lifetime limits and provide access to recommended preventive services without cost sharing. A standalone HRA cannot meet these requirements. The Departments of Labor, Treasury, and HHS have released guidance clarifying this issue and affirming the Administration's position. As always, we are willing to work with Congress on any provisions that would improve health insurance affordability, access, quality and the overall health of the economy.

Questions Submitted by Representative Scott (VA)

1. **The Department of Justice issued a memo in 2007 from the Office of Legal Counsel (OLC) concluding that the Religious Freedom and Restoration Act provides faith-based grantees a basis for circumventing statutory civil rights protections. Specifically, the OLC memo permits employment discrimination on the basis of religion in federal grant programs. It also has the effect of sanctioning discrimination in hiring by faith-based grantees in directly federally funded grant programs, like Head Start and the Substance Abuse Mental Health Services Administration (SAMHSA). This was affirmed most recently on April 9, 2014 when the Department of Justice issued an FAQ indicating that the OLC memo can be used to undermine the plain language of the non-discrimination provision added to the *Violence Against Women Act* (VAWA) when the law was reauthorized last Congress.**

   In 2010, President Obama signed Executive Order 13559 to reinstate vital religious liberty protections into the rules that govern partnerships between the government and faith-based organizations that provide social services. I'm disappointed to say that it's been explicitly indicated that the issue of hiring discrimination will not be addressed in these forthcoming rules. However, issues that may be addressed include the requirement to inform beneficiaries of their religious liberty rights and how to provide beneficiaries the right to access an alternative provider if they object to the religious character of a social service provider. These rules would impact programs being run by various agencies, including HHS. Madam Secretary, what is your understanding of the timetable for those proposed regulations? What else can or should the department do to make sure that social service grantees are not engaging in hiring discrimination while at the same time receiving federal funds?

Answer: My agency, in coordination with multiple other federal agencies, is working on a Notice of Proposed Rulemaking that will amend the current regulations to align with Executive Order 13559. This proposed rule will strengthen partnerships between HHS and faith-based and other community organizations to provide social services to those in need. We intend for the proposed rule to amend the existing regulations that address the equal treatment of faith-based

organizations. Beyond that, I cannot comment more on the content of the rule at this time but my staff will keep yours updated.

You are correct that once the rule is published for public comment and promulgated thereafter, it will impact programs. HHS will undergo a process for making sure that grantees know about the updated guidance put forward by the President in EO 13559 and the corresponding updated regulations. Furthermore, we will make sure that grantees are following all the appropriate rules and regulations, including those presented through this final rule. All these efforts represent our best efforts to ensure that beneficiaries are protected and provided the best care and service possible within the statutory and regulatory guidelines provided.

2. **Secretary Burwell, can you discuss the value of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit in Medicaid and why it is so important for children to have access to comprehensive health care services?**

Answer: The goal of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is to assure that individual children get the health care they need when they need it – the right care to the right child at the right time in the right setting. EPSDT entitles enrolled children under age 21 to any treatment or procedure that fits into any of the categories of Medicaid-coverable services listed in Section 1905(a) of the Social Security Act if that treatment or service is necessary to "correct or ameliorate" defects and physical and mental illnesses or conditions, even if the service is not covered for adults. This include physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance abuse disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high-quality health benefit for children under age 21 enrolled in Medicaid, keeping them healthy and preventing illness or disability.

3. **Secretary Burwell, can you please speak to the agency's actions to increase coordination between implementation of early learning programs under your jurisdiction and implementation of IDEA Part C funds for early intervention to ensure needs of children with disabilities are met?**

Answer: We are strongly committed to ensuring that the needs of children with disabilities are met in early learning settings.

As you know, under the Head Start Act, in both main Head Start (3-5 year olds) and Early Head Start (birth to three year olds), grantees must ensure that at least 10 percent of their funded enrollment slots are occupied by children with diagnosed disabilities that are IDEA eligible. The most current data shows nationally over 13 percent of children enrolled in Early Head Start (EHS) have disabilities for which they have an Individualized Family Services Plan through Part C of IDEA. These children receive early intervention services. Approximately 12% of preschool age children are diagnosed with disabilities under IDEA (Part B). The majority of these children receive special education and related services provided though IDEA at their Head Start programs.

About half the children enter Early Head Start with an existing diagnosis, while the other half are identified after they are enrolled- usually through developmental screening and referral conducted by the program. Head Start and Early Head Start programs participate in IEP and IFSP meetings at the parent's request. They are required to obtain copies of IFSPs and IEPs to ensure that they are able to individualize services and support progress toward each child's goals.

There are many children enrolled in Early and Preschool Head Start who have delays or diagnoses but are not eligible for services under local IDEA criteria. Programs must individualize for these children using all available information, including input from parents, screening and ongoing assessment, observation and any formal evaluation. The newly *published Head Start Early Learning Outcomes Framework: Ages Birth to Five* provides specific indicators of what children should know and be able to do as they progress toward kindergarten. The Framework must be used by programs in planning for all children, including children with disabilities. Increasingly, children who are not eligible under IDEA have plans under Part 504 of the Rehabilitation Act. These plans require specific accommodations to program services, but do not include special education and related services.

We have taken a number of steps to strengthen coordination between implementation of early learning programs at HHS and across the federal government, including at the Department of Education. Last year, HHS and the Department of Education released Birth to Five: Watch Me Thrive!,an initiative to promote universal developmental and behavioral screening and appropriate follow-up. The initiative included guidance on establishing formal collaborations between early learning programs and other community partners, including early interventionists, the medical home, and special educators, to ensure a smooth and timely referral process for all children suspected of having a disability and eligible to receive Part C services.

4. **Over half of all hospital costs are incurred by Medicare and Medicaid beneficiaries. Insofar as hospitals are therefore receiving the bulk of their revenue from the federal government, what actions is the department taking to ensure that hospitals are engaging with minority-owned, women-owned, and disadvantaged businesses in the provision of contracted services in hospitals?**

Answer: HHS appreciates the importance of encouraging the participation of minority-owned, women-owned, and disadvantaged businesses in federal contracting. The HHS Office of Small and Disadvantaged Business Utilization manages and develops appropriate outreach programs to promote the participation of these businesses in HHS contracts and to ensure that these businesses compete for and receive a fair share of the Department's expenditures. CMS has consistently exceeded its goal of awarding 5% of its contracts to small disadvantaged businesses, and in FY 2015, awarded the largest small disadvantaged contract in the history of the Medicare program, worth over $400 million. CMS frequently meets with interested small disadvantaged businesses to help them understand our programs, opportunities, and how they can do business with CMS.

Hospitals that participate in Medicare and Medicaid must meet a variety of conditions of coverage and conditions of participation. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. These conditions do

not require hospitals to adhere to the same contracting rules and regulations as the federal government.

Questions Submitted by Representative Fudge (OH)

1. **Secretary Burwell, as I am sure you know, heroin and opioid use is growing rapidly in this country. No one is immune; this increase touches both men and women and reaches across all demographics. In Ohio alone, more than 980 people died in 2013 from overdose. In an effort to combat this growing epidemic I introduced the *Breaking Addiction Act of 2015*, a bill that would increase our nation's dangerously inadequate capacity for substance use disorder (SUD) services and expand access to treatment through selective waiver of the IMD exclusion. This exclusion forbids federal Medicaid matching payments to certain facilities that primarily serve individuals with mental illness, including those with substance use disorders. While I applaud CMS's recent announcement allowing states to develop and test innovative treatment delivery programs, does HHS have any plans to further address the issue of IMD exclusions and increase the utilization of waivers? What other action is the department taking to reduce the abuse of heroin and opioids and increase access to treatment?**

Answer: Thank you for raising the critical issue of substance abuse prevention. As you note, we recently issued a letter to State Medicaid Directors describing opportunities and federal authorities offering states flexibility to implement system reforms that provide a continuum of care for beneficiaries with substance use disorders (SUDs) including access to acute inpatient care and short-term residential care, as well as community-based outpatient care and recovery supports. This letter offered a new opportunity for states to use section 1115 waiver demonstration authority to provide Medicaid coverage for a full array of SUD treatment services, including coverage of services for inpatients in institutions for mental diseases (IMDs), whose services have traditionally not been eligible for Medicaid reimbursement, to support state efforts to introduce SUD system reforms. This letter also referenced a recent initiative by the Centers for Medicare and Medicaid Services (CMS), called the Innovation Accelerator Program (IAP), to support states in improving their delivery systems with technical assistance at varied levels of intensity depending on the level of interest and commitment of each state. The first phase of the IAP initiative is focused on helping states transform their SUD delivery systems, and, as part of their SUD system transformation efforts, helping the states assess how they may take advantage of the new opportunities outlined in the letter. In addition, CMS recently issued a notice of proposed rulemaking revising our regulations on Medicaid managed care arrangements to clarify that states may include coverage of short-term stays in IMDs in their contracts with managed care plans to manage care for their Medicaid beneficiaries. Last year, HHS, with CMS as lead, developed and disseminated specific information to state Medicaid directors regarding the coverage of Medication Assisted Treatment for substance use disorders.

In terms of addressing the overall issue of heroin and prescription drug abuse, HHS has undertaken a multipronged initiative that incorporates a broad effort at reducing opioid mortality and morbidity that includes a specific emphasis on increasing access to care. The initiative focuses on three priority areas:

1. **Providing training and educational resources, including updated prescriber guidelines, to assist health professionals in making informed prescribing decisions** and address the over-prescribing of opioids.
2. **Expanding the use of Medication-Assisted Treatment (MAT)**, a comprehensive way to address the needs of individuals that combines the use of medication with counseling and behavioral therapies to treat substance use disorders. I recently announced a rulemaking effort aimed at expanding access to MAT using buprenorphine that is currently underway.
3. **Increasing use of naloxone**, as well as continuing to support the development and distribution of the life-saving drug, to help reduce the number of deaths associated with prescription opioid and heroin overdose.

The initiative consists of actions across multiple HHS operating divisions and includes new investments in the FY 2016 President's Budget that are critical to addressing the crisis. Initiative efforts also include reviewing HHS policy to identify ways to provide more access to treatment. For example, HHS is currently working on revising regulations related to buprenorphine. A detailed description of the Secretary's Opioid Initiative can be found at: http://aspe.hhs.gov/sites/default/files/pdf/107956/ib_OpioidInitiative.pdf . We look forward to your input and partnership on this important issue.

2. **Childhood obesity has increased by over 400 percent over the past 40 years. A study by University Hospital in Cleveland found the obesity rate for children in Ohio ages 10-17 is 36 percent. If we do not find a way to curb this epidemic, 23 million children are at risk of being the first generation to live shorter lives than their parents. What is the department doing to combat this growing public health epidemic and ensure our nation's children grow up to lead healthy, full lives?**

Answer: I appreciate you raising this critical issue. The Department of Health and Human Services is engaged in the areas of research and surveillance, prevention, and treatment to address childhood obesity and ensure our children can lead healthy, full lives. Recently we have seen declines in obesity among preschool-age children, and leveling of obesity rates among children 6 to 19 years after decades of unprecedented increases. The Department also works closely with First Lady Michelle Obama's *Let's Move!* Initiative. The goal of *Let's Move!* is to end childhood obesity within a generation by encouraging physical activity and making healthy choices easier for families.

The Centers for Disease Control and Prevention (CDC) collects data on childhood obesity and leading risk factors to help states, schools and decision makers develop and implement programs to improve student health including weight status. We know that diet plays a critical role in disease prevention and in both individual and public health—a good diet can help prevent diabetes, high blood pressure, and cardiovascular disease. The Department is working to help American consumers make informed dietary decisions for themselves and their families. The Food and Drug Administration (FDA) issued a proposed rule to ensure the Nutrition Facts Label displays caloric, nutritional, and serving-size information for pre-packaged foods. We are also working to ensure that Americans eating away from home have accurate and easy-to-see calorie information available for these foods.

CDC is also supporting efforts to help the entire U.S. population eat healthy, be more active, and avoid obesity – with a focus on helping young children establish healthy habits that can last a lifetime. A healthy start is critical, as half of all children who are obese in elementary school were overweight or obese by the time they entered kindergarten. CDC invests resources in state health departments, universities, and non-governmental organizations to work in communities, hospitals, childcare centers, and schools to prevent childhood obesity through a number of public health efforts. For example:

- CDC investments have assisted 190 hospitals across 45 states (reaching 2 million babies) to increase support for mothers who breastfeed.
- CDC's Healthy Schools Program provides tools, resources and training to all 50 states to improve the nutrition environment and increase opportunities for quality physical activity and physical education in U.S. elementary and secondary schools.
- Through the Childhood Obesity Research Demonstration and High Obesity Counties Initiative, CDC investments have connected low-income children with obesity to integrated primary care and community weight management initiatives. Early results of the work over the past four years show BMI reductions for children 6–12 years. Additionally, since 2014, CDC has reached over 2 million residents through investments in over 50 counties with the highest obesity rates.

Because most children in the United States are cared for in early care and education facilities prior to starting kindergarten, CDC and the Administration for Children and Families promote adoption of obesity prevention standards and best practices in the areas of nutrition, physical activity, breastfeeding support, and screen time reductions. Finally, through the Affordable Care Act, most health plans must provide screening for obesity in children, as well as behavioral intervention for children who are obese at no out-of-pocket charge.

For children enrolled in Medicaid, the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit covers all medically necessary services which can include obesity-related services. A number of states have efforts underway to improve awareness and use of obesity-related services by Medicaid-eligible individuals. Additionally, several states are working with their managed care organizations to implement performance improvement projects focused on body-mass index screening and referral for healthy weight and physical activity counseling.

3. As we celebrate the 50th anniversary of Medicare and Medicaid, what action points are departmental priorities for protecting and improving these vital programs? As some states have chosen not to expand Medicaid coverage under the ACA, what is the department doing on its own to improve and increase coverage to those Americans who need it the most?

Answer: Since they began 50 years ago, the Medicare and Medicaid programs have provided health benefits coverage for millions of Americans, playing a particularly important role in providing essential health coverage for seniors and low-income children, adults, pregnant women, and people with disabilities. These programs have greatly reduced the number of uninsured people and have helped create a health care system that is better, smarter, and more comprehensive.

Medicare is making progress as a leader in the health care system, pioneering ways to reward quality over quantity, coordinate services across settings, and provide better value for seniors and taxpayers. We are focused on delivering better care to beneficiaries and putting patients at the center of their care. This includes quality improvements that have reduced hospital readmissions, saved thousands of lives by reducing hospital acquired conditions, and lowered health spending by billions of dollars as compared to where it would have been under previous trends. . CMS will continue to build on this progress. The Center for Medicare and Medicaid Innovation (Innovation Center) is testing innovative payment and service delivery models that reduce spending while maintaining or improving quality of care. The Innovation Center has over 20 models engaging more the 60,000 health care providers[3] and more than 2.5 million Medicare, Medicaid, and CHIP beneficiaries are or soon will be receiving care through these initiatives. CMS is also creating alternative payment models to deliver better care at better value. For example, Accountable Care Organizations (ACOs) and the Medicare Shared Savings Program have already resulted in $417 million in savings[4] for Medicare; over 400 ACOs are participating in the Medicare Shared Savings Program, serving over 7 million beneficiaries. The Comprehensive Primary Care Initiative, a multi-payer initiative involving nearly 500 practices serving 2.5 million patients, has already resulted in decreased hospital admissions and emergency department visits at some sites.

Medicaid has produced significant benefits to people of all ages and in all stages of their lives. Through continual innovation and improvement, Medicaid has been taking steps to deliver better care, spend health care dollars more wisely, and provide better access. CMS is modernizing the eligibility and enrollment process for Medicaid and CHIP to support a strong consumer experience. As a result of the ACA, the process to gain coverage through Medicaid has been streamlined, so individuals can apply online, by telephone, by mail, or in person, and can get help from application assisters in their communities or by calling a toll-free number. States now rely on available electronic data sources to confirm information on the application, facilitating faster eligibility decisions. States are making substantial progress processing Medicaid and CHIP applications more efficiently for people whose eligibility is based on modified adjusted gross income, often in real or near real-time. For example, in Washington, 92 percent of applications are processed in under 24 hours; in New York, 80 percent of applications are processed in one session; and in Rhode Island, 66 percent of applications are processed without manual intervention or the requirement of additional information.[5]

Promoting the expansion of Medicaid is also a key priority. States that have expanded their Medicaid programs are documenting significant reductions in uncompensated care and the uninsured rate. Hospitals provided over $50 billion in uncompensated care in 2013; in 2014, there was a $7.4 billion reduction in uncompensated care costs, and with 68 percent of the reduction coming from states expanding Medicaid. And of the 11 states with the greatest reductions in uninsured rates in 2015, 10 had expanded Medicaid eligibility. This coverage is translating into tangible improvements in population health. Nearly one-third of the cases of diabetes in the United States have not been diagnosed; however, in states that expanded Medicaid, the number of beneficiaries with newly identified diabetes rose by 23 percent, compared to 0.4 percent in states that did not expand Medicaid, in the first six months of 2014.

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[3] CMS Fact Sheet: "Better Care, Smarter Spending, Healthier People: Improving Our Health Care Delivery System"

[5] CMS Fact Sheet: "Medicaid Moving Forward"

HHS is committed to working with states to expand Medicaid in ways that work for them, while protecting the integrity of the program and those it serves. For example, in Arkansas, under section 1115(a) demonstrations, some new Medicaid enrollees receive their coverage from Qualified Health Plans offered in the individual market through the Marketplace. Michigan's Health and Wellness Plan promotes healthy behaviors through education and engagement of beneficiaries and providers. Iowa has a demonstration that includes a Healthy Behaviors program under which a beneficiary is eligible to reduce his/her premium payment amount by engaging in health improvement activities.

With all of these efforts, HHS will continue to strengthen Medicare and Medicaid for the beneficiaries served by these programs.

Questions Submitted by Representative Polis (CO)

1. **Back in April, I had the opportunity to visit the Head Start program at the Wilderness Early Learning Center in Boulder, and I've seen firsthand the benefits Head Start can have for its kids and the community it serves. I'm also a strong advocate for high-quality charter schools. Charter schools, which are public schools, have the autonomy to offer a unique curriculum for students, and many students and parents choose to take advantage of that.**

   As you know, Head Start grants are given to non-profits, community centers, and sometimes traditional public schools, but to my knowledge, no charter schools have received Head Start grants, and very few have applied. Can you talk about what your agency is doing to clarify guidance so that high-quality charter schools know they are eligible to apply for Head Start grants and understand how to meet Head Start requirements?

Answer: The Office of Head Start (OHS) informs all interested parties about funding opportunities by posting them on the HHS Grants Forecast website and the ACF website. Head Start funding opportunities only occur as the result of terminations or relinquishments of Head Start grants or as the result of the Head Start Designation Renewal System (DRS). In accordance with HHS grants policy, OHS ensures that the broad scope of interested and eligible applicants are aware of opportunities through webinars describing the opportunities and the vehicles mentioned earlier. When DRS was implemented, OHS did extensive outreach to ensure robust competition.

In 2014, with the implementation of the new Early Head Start Expansion and Early Head Start-Child Care Partnership grant opportunities, ACF further engaged in outreach efforts to disseminate information about the opportunities to interested groups. Our outreach included 14 webinars for stakeholders, including education organizations, such as the American Federation of Teachers, Council for Chief State School Officers, National Education Association, American Association of School Administrators, which encompass charter schools. The outreach aimed to inform a broad audience about the opportunity and their eligibility to apply. These webinars

reached 7,200 individuals and organizations. In addition, ACF sent multiple messages to email contact lists that reached 27,000 recipients.

In 2011, OHS began asking grantees to identify if they are a charter school in their annual data reporting. One delegate agency (subgrantee) has identified as a charter school and 271 grantees identify as schools systems.

We would welcome any suggestions you might have to ensure that charter schools are included in our broad outreach efforts moving forward.

2. **Earlier this year, the FDA published revised recommendations pertaining to blood donations by men who have had sex with men. The policy change would eliminate the outdated lifetime ban for gay and bisexual men and instead institute a one-year deferral policy from the date of the last sexual contact with a man. This is a positive step forward, and will indeed allow more lives to be saved, but can you speak about your opinion on whether the new policy reflects the most up-to-date science on this issue? The large majority of gay men do not engage in risky behavior and are not at higher risk of contracting HIV than the general population.**

   In fact, the FDA's own BloodDROPS survey has found that the prevalence of HIV in male blood donors who reported that they have had sexual relations with men is just .25 percent – lower than the overall prevalence in the total U.S. population, which is .38 percent. In your opinion, does the one-year deferral policy reflect the most scientifically sound policy to save as many lives as possible, or do you view the one-year deferral as just a first step toward modernizing the FDA's policy with respect to donations by gay and bisexual men? Would the FDA consider a policy that screens for specific risky behavior rather than grouping all men who have had sexual relations with men into one blanket, high-risk category?

Answer: The Food and Drug Administration (FDA) takes its responsibility to regulate the blood supply and to ensure its continued safety for patients who receive potentially lifesaving blood products very seriously, and also understands the need to update the policies regarding blood donors to reflect current science. In collaboration with other government agencies, and considering input from external advisory committees, the FDA has carefully examined the available scientific evidence relevant to the blood donor deferral policy for men who have sex with men (MSM) and has recommended a change in the blood donor deferral period for MSM from indefinite deferral to one year since the last sexual contact with another man. FDA has released a draft guidance document outlining these changes and the final guidance is under development, with consideration to comments received during the public comment period.

The deferral policy is not one based upon sexual orientation. According to the Centers for Disease Control and Prevention, about two-thirds of all new HIV infections in the United States occur in MSM, who make up 2% of the total U.S. population. Although the prevalence of HIV in blood donors who reported MSM behavior is reported to be 0.25%, this is 40-fold higher than the prevalence of HIV in blood donors who do not report this behavior.

FDA carefully considered alternative deferral criteria, such as individual risk assessment for HIV, prior to recommending a time-based deferral. However, evidence shows that self-reporting of risk behaviors presents significant issues for a number of reasons, including lack of sufficient data on the effectiveness of donor educational questionnaires and lack of reliability in self-reports of monogamy by partners in any type of sexual relationship. On the other hand, a 12-month deferral has been well studied and found to maintain the safety of the blood supply in Australia, a country with HIV epidemiology and blood screening systems similar to the United States.

FDA's proposed revision to the policy for MSM donor deferral recommends a deferral period that aligns with the donor deferral period for certain other groups of other men and women at increased risk for HIV infection.

In addition, FDA has already taken steps to implement a national blood surveillance system that will help the agency monitor the effect of a policy change and further help ensure the continued safety of the blood supply. While the implementation of this system is not contingent upon changing FDA's blood donor deferral policy for men who have sex with men, the system will monitor a majority of the blood collected in the United States for a number of different transfusion-transmitted viral infections, including HIV. We anticipate that the surveillance system will provide important information that will help FDA maintain and possibly further enhance the high level of safety of the U.S. blood supply. FDA is committed to the further evaluation of its blood donor deferral policies as additional scientific information becomes available.

[Whereupon, at 12:08 p.m., the committee was adjourned.]

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