

HELPING SICK AMERICANS NOW ACT

APRIL 19, 2013.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. UPTON, from the Committee on Energy and Commerce, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1549]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1549) to amend Public Law 111-148 to transfer fiscal year 2013 through fiscal year 2016 funds from the Prevention and Public Health Fund to carry out the temporary high risk health insurance pool program for individuals with preexisting conditions, and to extend access to such program to such individuals who have had creditable coverage during the 6 months prior to application for coverage through such program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Helping Sick Americans Now Act”.

SEC. 2. PRIORITIZING FUNDING FOR SICK AMERICANS.

Section 4002(c) of Public Law 111–148 (42 U.S.C. 300u–11(c)) is amended by adding at the end the following: “Notwithstanding any other provision of this section, the Secretary shall transfer amounts that are in the Fund that are attributable to fiscal year 2013 that are not otherwise obligated as of the date of the enactment of this sentence and funds that would otherwise be made available to the Fund for fiscal year 2014, fiscal year 2015, and fiscal year 2016 to the account within the Department of Health and Human Services that provides for funding to carry out the temporary high risk health insurance pool program under section 1101 and such funds shall become available for obligation under such section on such date of enactment and remain so available through December 31, 2013.”.

SEC. 3. IMMEDIATE ACCESS TO HEALTH CARE FOR SICK AMERICANS.

(a) **IN GENERAL.**—Section 1101(d) of Public Law 111–148 (42 U.S.C. 18001(d)) is amended—

- (1) in paragraph (1), by adding at the end “and”;
- (2) by striking paragraph (2); and
- (3) by redesignating paragraph (3) as paragraph (2).

(b) **EFFECTIVE DATE.**—The amendments made by subsection (a) shall apply with respect to individuals applying for coverage through the high risk insurance pool program on or after the date of the enactment of this Act.

SEC. 4. ENSURING AN ORDERLY REOPENING OF THE PROGRAM FOR SICK AMERICANS.

Section 1101(b) of Public Law 111–148 (42 U.S.C. 18001(b)) is amended by adding at the end the following new paragraph:

“(4) **ORDERLY REOPENING OF PROGRAM.**—The Secretary shall administer this section in accordance with the regulations under part 152 of title 45, Code of Federal Regulations, as in effect as of April 16, 2013, except as is necessary to reflect the amendments made by the Helping Sick Americans Now Act.”.

PURPOSE AND SUMMARY

H.R. 1549, the Helping Sick Americans Now Act, was introduced on April 15, 2013, by Rep. Joseph R. Pitts (R–PA) and subsequently referred to the Committee on Energy and Commerce.

The legislation would amend section 4002 of Public Law 111–148 to transfer fiscal year 2013 through fiscal year 2016 funds from the Prevention and Public Health Fund (“Fund”) to carry out the temporary high risk health insurance pool program for individuals with preexisting conditions, and to extend access to such program to such individuals who have had creditable coverage during the 6 months prior to application for coverage through such program.

BACKGROUND AND NEED FOR LEGISLATION

Section 1101 of the Patient Protection and Affordable Care Act (“PPACA”) established a \$5 billion program to provide health coverage for individuals with pre-existing conditions, otherwise known as the Pre-Existing Condition Insurance Plan (“PCIP”). Under PCIP, an individual is eligible to participate in the program if that individual:

- has been uninsured for at least six months;
- has a pre-existing condition or have been denied health coverage because of a health condition; and,
- is a United States citizen or legally resides in the United States.

Shortly after passage of PPACA, the Chief Actuary for the Centers for Medicare and Medicaid Services (“CMS” or “Agency”) estimated that the creation of PCIP would result in roughly 375,000 people gaining coverage in 2010. However, only 107,139 individuals were enrolled in the program as of January 1, 2013.

On February 15, 2013, CMS announced to States that the Agency was suspending enrollment in PCIP. This program was intended to help individuals with pre-existing conditions through December 31, 2013. Despite lower than expected enrollment, CMS announced that it would no longer enroll new individuals in the program and would bar States from accepting new applications because of financial constraints.

H.R. 1549, the “Helping Sick Americans Now Act,” addresses the financial constraints of the PCIP program by redirecting funds from the Fund toward helping sick patients. The Secretary of Health and Human Services has broad discretion on how to use the Fund. In past years, the Fund was spent on various projects, including public health surveillance, health workforce development, and prevention. Eliminating the Fund does not cut any specific program because the Fund was never directed at a specific program.

H.R. 1549 requires HHS to transfer approximately \$4 billion in fiscal year 2013 through fiscal year 2016 funding from the Fund to PCIP. This would allow CMS to enroll sick and chronically ill Americans who have been denied coverage due to the Administration’s suspension of PCIP.

H.R. 1549 also eliminates the statutory requirement for individuals to remain uninsured for six months as a condition of eligibility for the PCIP program.

HEARINGS

The Subcommittee on Health held a hearing on April 3, 2013, entitled “Protecting America’s Sick and Chronically Ill.” This hearing examined problems with the Patient Protection and Affordable Care Act’s Pre-Existing Condition Insurance Plan (PCIP) and explored ways to help Americans with pre-existing conditions obtain affordable health coverage.

COMMITTEE CONSIDERATION

On April 17, 2013, the full Committee met in open markup session and approved H.R. 1549, as amended, by a recorded vote of 27 yeas and 20 nays.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto. Ms. Capps offered an amendment to strike section 2, Prioritizing Funding for Sick Americans. The amendment was not agreed to by a roll call vote of 22 yeas and 27 nays. A motion by Mr. Upton to order H.R. 1549 reported to the House, as amended, was agreed to by a roll call vote of 27 yeas and 20 nays.

The following reflects the recorded votes taken during the Committee consideration:

**COMMITTEE ON ENERGY AND COMMERCE -- 113TH CONGRESS
ROLL CALL VOTE # 5**

BILL: H.R. 1549, the Helping Sick Americans Now Act

AMENDMENT: An amendment by Ms. Capps, No. 2, to strike section 2, Prioritizing Funding for Sick Americans.

DISPOSITION: NOT AGREED TO, by a roll call vote of 22 yeas and 27 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Hall		X		Mr. Dingell	X		
Mr. Barton		X		Mr. Markey			
Mr. Whitfield		X		Mr. Pallone	X		
Mr. Shimkus				Mr. Rush	X		
Mr. Pitts		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel	X		
Mr. Terry		X		Mr. Green	X		
Mr. Rogers				Ms. DeGette	X		
Mr. Murphy		X		Mrs. Capps	X		
Mr. Burgess		X		Mr. Doyle	X		
Mrs. Blackburn				Ms. Schakowsky	X		
Mr. Gingrey		X		Mr. Matheson	X		
Mr. Scalise		X		Mr. Butterfield	X		
Mr. Latta		X		Mr. Barrow	X		
Mrs. McMorris Rodgers		X		Ms. Matsui	X		
Mr. Harper		X		Ms. Christensen	X		
Mr. Lance		X		Ms. Castor			
Mr. Cassidy		X		Mr. Sarbanes	X		
Mr. Guthrie		X		Mr. McNerney	X		
Mr. Olson		X		Mr. Braley	X		
Mr. McKinley		X		Mr. Welch	X		
Mr. Gardner		X		Mr. Lujan	X		
Mr. Pompeo		X		Mr. Tonko	X		
Mr. Kinzinger		X					
Mr. Griffith		X					
Mr. Bilirakis		X					
Mr. Johnson		X					
Mr. Long		X					
Mrs. Ellmers		X					

04/17/2013

**COMMITTEE ON ENERGY AND COMMERCE -- 113TH CONGRESS
ROLL CALL VOTE # 6**

BILL: H.R. 1549, the Helping Sick Americans Now Act

AMENDMENT: A motion by Mr. Upton to order H.R. 1549 favorably reported to the House, as amended.
(Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 27 yeas and 20 nays

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Hall	X			Mr. Dingell		X	
Mr. Barton	X			Mr. Markey			
Mr. Whitfield	X			Mr. Pallone		X	
Mr. Shimkus				Mr. Rush			
Mr. Pitts	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel			
Mr. Terry	X			Mr. Green		X	
Mr. Rogers				Ms. DeGette		X	
Mr. Murphy	X			Mrs. Capps		X	
Mr. Burgess	X			Mr. Doyle		X	
Mrs. Blackburn				Ms. Schakowsky		X	
Mr. Gingrey	X			Mr. Matheson		X	
Mr. Scalise	X			Mr. Butterfield		X	
Mr. Latta	X			Mr. Barrow		X	
Mrs. McMorris Rodgers	X			Ms. Matsui			
Mr. Harper	X			Ms. Christensen		X	
Mr. Lance	X			Ms. Castor		X	
Mr. Cassidy	X			Mr. Sarbanes		X	
Mr. Guthrie	X			Mr. McNerney		X	
Mr. Olson	X			Mr. Braley		X	
Mr. McKinley	X			Mr. Welch		X	
Mr. Gardner	X			Mr. Lujan		X	
Mr. Pompeo	X			Mr. Tonko		X	
Mr. Kinzinger	X						
Mr. Griffith	X						
Mr. Bilirakis	X						
Mr. Johnson	X						
Mr. Long	X						
Mrs. Ellmers	X						

04/17/2013

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee has not held oversight or legislative hearings on this legislation.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

The goal of the legislation is to provide health insurance coverage for those with pre-existing conditions.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND
TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1549, would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK, LIMITED TAX BENEFITS, AND LIMITED TARIFF BENEFITS

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI of the Rules of the House of Representatives, the Committee finds that H.R. 1549, Helping Sick Americans Now Act, contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

APRIL 19, 2013.

Hon. FRED UPTON,
*Chairman, Committee on Energy and Commerce,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 1549, the Helping Sick Americans Now Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Lisa Ramirez-Branum.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure.

H.R. 1549—Helping Sick Americans Now Act

Summary: H.R. 1549 would amend the Public Health Service Act to direct the Secretary of the Department of Health and Human Services (HHS) to transfer unobligated amounts from the Prevention and Public Health Fund (PPHF) for fiscal years 2013 through 2016 to help carry out a program that provides temporary health insurance for qualified individuals with pre-existing health conditions.

Based on the historical spending patterns of both the PPHF and the Pre-Existing Condition Insurance Plan (PCIP), CBO estimates that enacting the legislation would result in a decrease in net direct spending of \$840 million over the 2013–2023 period; therefore, pay-as-you-go procedures apply. Enacting H.R. 1549 would not affect revenues.

H.R. 1549 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1549 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in Millions of Dollars—												
	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2013– 2018	2013– 2023
CHANGES IN DIRECT SPENDING													
Prevention and Public Health Funds:													
Estimated Budget Authority	— 840	— 930	— 930	— 930	0	0	0	0	0	0	0	— 3,630	— 3,630
Estimated Outlays	— 180	— 430	— 740	— 900	— 720	— 470	— 160	— 10	0	0	0	— 3,440	— 3,610
Pre-Existing Insurance Program:													
Estimated Budget Authority	3,630	0	0	0	0	0	0	0	0	0	0	3,630	3,630
Estimated Outlays	2,350	430	0	0	0	0	0	0	0	0	0	2,780	2,780
Net Impact:													
Estimated Budget Authority	2,780	— 930	— 930	— 930	0	0	0	0	0	0	0	0	0
Estimated Outlays	2,160	0	— 740	— 900	— 720	— 470	— 160	— 10	0	0	0	— 670	— 840

Note: Components may not sum to total because of rounding.

Basis of estimate: Under current law, \$1 billion per year has been provided to the PPHF for fiscal years 2013 through 2017. (In later years, that amount increases gradually to \$2 billion per year.) H.R. 1549 would direct the Secretary of HHS to transfer any unobligated amounts from that fund for fiscal years 2013 through 2016 to help carry out the PCIP program. CBO estimates that about \$3.7 billion of those funds would be available after accounting for the effects of sequestration under the Budget Control Act of 2011. (Following procedures under that act, \$51 million of the funds for the PPHF were cancelled in 2013, and CBO estimates that an additional \$210 million will be cancelled in fiscal years 2014 through 2016.) In addition, assuming enactment of H.R. 1549 in the spring of 2013, an estimated \$0.1 billion of 2013 funds will already be obligated before such enactment.¹ Thus, CBO estimates that enacting the legislation would transfer a total of \$3.6 billion out of the fund, and thus decrease direct spending under the PPHF by \$3.6 billion over the 2013–2023 period.

CBO estimates that the availability of an additional \$3.6 billion for the PCIP program would result in an increase in direct spending for that program of about \$2.8 billion; that amount is less than the amount of transferred funds in part because the authority for PCIP terminates in early 2014. Combining the decreased spending from the PPHF and the increased spending in the PCIP program, CBO estimates that enacting H.R. 1549 would, on net, reduce direct spending by \$840 million over the 2013–2023 period.

Prevention and Public Health Fund: As established, the PPHF provides grant assistance to entities to carry out prevention, wellness, and public health activities. Taking into account the expected reductions in the PPHF due to the sequestration under the Budget Control Act (about \$260 million over the 2013–2016 period), CBO estimates that \$3.7 billion would be available for such grants over the 2013–2016 period. Historically, several agencies within the Department of Health and Human Services award those grants in the last quarter of each fiscal year. CBO estimates that approximately \$100 million will be obligated via grant and contract agreements and thus will be unavailable to transfer to the PCIP program by the time H.R. 1549 is assumed to be enacted. As a result, CBO estimates that enacting H.R. 1549 would reduce direct spending under the PPHF by \$3.6 billion over the 2013–2023 period.

Pre-Existing Condition Insurance Plan: The Patient Protection and Affordable Care Act (ACA) appropriated \$5 billion for the creation of the PCIP program to provide access to health insurance to qualified individuals who were unable to acquire coverage because of a pre-existing condition. The temporary program is set to end on January 1, 2014, when broader reforms enacted under the ACA go into effect. The ACA also required the Secretary of HHS to make adjustments to the PCIP program if in any fiscal year the estimated aggregate spending would exceed the amount appropriated. To ensure that aggregate spending would not exceed those

¹ If H.R. 1549 were to be enacted later in fiscal year 2013, CBO would expect that more of the balance of funds in the PPHF for 2013 would be obligated and thereby unavailable to transfer to the PCIP program. In addition, enacting the bill later in the year would reduce the number of months remaining between the enactment date and before January 1, 2014, when the PCIP program is set to expire. As a result, it would cost less to fund that program. Therefore, a later enactment could result in lower estimated savings.

amounts, the Secretary announced in February that the PCIP program would suspend enrollment.

H.R. 1549 would provide funding to re-open enrollment for the PCIP program. In addition, the bill would remove a provision of the ACA that requires qualified individuals to be uninsured for six months prior to the date on which such individuals apply for coverage through PCIP. Based on enrollment trends and reported denial rates due to prior insurance coverage, CBO estimates that H.R. 1549 would increase direct spending under the PCIP program by \$2.8 billion over the 2013–2023 period.

Pay-As-You-Go Considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

Intergovernmental and private-sector impact: H.R. 1549 contains no intergovernmental or private-sector mandates as defined in UMRA. By transferring funds from PPHF to the PCIP program, the bill would provide additional funds to the 27 states that chose to operate the PCIP program. Nonetheless, the bill would decrease the amount of resources that state, local, and tribal governments receive to conduct prevention, wellness, and public health activities.

Estimate prepared by: Federal Costs: Lisa Ramirez-Branum; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Michael Levine.

Estimated approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

DUPLICATION OF FEDERAL PROGRAMS

No provision of H.R. 1549 establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULE MAKINGS

The Committee estimates that enacting H.R. 1549 would not direct specific rule making within the meaning of 5 U.S.C. 551.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act were created by this legislation.

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that the legislation does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 provides the short title of the “Helping Sick Americans Now Act.”

Section 2. Prioritizing funding for sick Americans

Section 2 requires the Secretary to transfer fiscal years 2013, 2014, 2015, and 2016 funds from the Fund to support the temporary high risk health insurance pool program to help Americans with pre-existing conditions.

Section 3. Immediate access to health care for sick Americans

Section 3 eliminates the requirement for individuals to go without coverage for six months in order to gain eligibility for the program.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

PATIENT PROTECTION AND AFFORDABLE CARE ACT

(Public Law 111-148)

* * * * *

**TITLE I—QUALITY, AFFORDABLE
HEALTH CARE FOR ALL AMERICANS**

* * * * *

**Subtitle B—Immediate Actions to Preserve
and Expand Coverage**

SEC. 1101. IMMEDIATE ACCESS TO INSURANCE FOR UNINSURED INDIVIDUALS WITH A PREEXISTING CONDITION.

(a) * * *

(b) ADMINISTRATION.—

(1) * * *

* * * * *

(4) *ORDERLY REOPENING OF PROGRAM.*—*The Secretary shall administer this section in accordance with the regulations under part 152 of title 45, Code of Federal Regulations, as in effect as of April 16, 2013, except as is necessary to reflect the amendments made by the Helping Sick Americans Now Act.*

* * * * *

(d) ELIGIBLE INDIVIDUAL.—An individual shall be deemed to be an eligible individual for purposes of this section if such individual—

(1) is a citizen or national of the United States or is lawfully present in the United States (as determined in accordance with section 1411); *and*

[(2) has not been covered under creditable coverage (as defined in section 2701(c)(1) of the Public Health Service Act as in effect on the date of enactment of this Act) during the 6-month period prior to the date on which such individual is applying for coverage through the high risk pool; and]

[(3)] (2) has a pre-existing condition, as determined in a manner consistent with guidance issued by the Secretary.

* * * * *

TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH

Subtitle A—Modernizing Disease Prevention and Public Health Systems

* * * * *

SEC. 4002. PREVENTION AND PUBLIC HEALTH FUND.

(a) * * *

* * * * *

(c) USE OF FUND.—The Secretary shall transfer amounts in the Fund to accounts within the Department of Health and Human Services to increase funding, over the fiscal year 2008 level, for programs authorized by the Public Health Service Act, for prevention, wellness, and public health activities including prevention research, health screenings, and initiatives, such as the Community Transformation grant program, the Education and Outreach Campaign Regarding Preventive Benefits, and immunization programs. *Notwithstanding any other provision of this section, the Secretary shall transfer amounts that are in the Fund that are attributable to fiscal year 2013 that are not otherwise obligated as of the date of the enactment of this sentence and funds that would otherwise be made available to the Fund for fiscal year 2014, fiscal year 2015, and fiscal year 2016 to the account within the Department of Health and Human Services that provides for funding to carry out the temporary high risk health insurance pool program under section 1101 and such funds shall become available for obligation under such section on such date of enactment and remain so available through December 31, 2013.*

* * * * *

DISSENTING VIEWS

We, the undersigned members of the Committee on Energy and Commerce, oppose the passage of H.R. 1549, the *Helping Sick Americans Now Act*, a bill to extend the *Affordable Care Act* (ACA)'s temporary high-risk insurance pool program for individuals with pre-existing conditions through the depletion of funds from the ACA's Prevention and Public Health Fund. Accordingly, we submit the following comments to express our concerns about this legislation.

INTRODUCTION

Prior to the enactment of the ACA,¹ insurers regularly denied health care coverage to people with chronic or life-threatening diseases such as diabetes, asthma, cancer, and HIV/AIDS or offered them coverage at prices so high as to make it effectively unavailable.² As a result, many of the people most in need of access to medical care found that they could not obtain insurance to cover the cost of that care.

When the ACA is fully implemented in 2014, insurers will be prohibited from discriminating against individuals with pre-existing conditions, and those individuals will be able to choose from a variety of health insurance coverage options. In the immediate term, the ACA banned discrimination against children with pre-existing conditions as of plan years beginning on or after September 23, 2010. As a bridge to 2014 for adults with pre-existing conditions, the ACA created a temporary high-risk pool known as the Pre-Existing Condition Insurance Plan (PCIP) and provided \$5 billion to cover the program's costs.³

The PCIP program is authorized under the ACA as a temporary, transitional program to provide health insurance coverage to individuals who have been diagnosed with a pre-existing condition and have been without health coverage for at least six months.⁴ The ACA authorized to be appropriated and appropriated \$5 billion to pay beneficiary claims and cover administrative costs that exceeded premiums collected from enrollees in PCIP. The law also gave the Secretary of the Department of Health and Human Services (HHS) authority to stop accepting applications before the program's termination date of December 31, 2013, and make other adjustments in order to ensure that program costs did not exceed the \$5 billion in available funding.

¹The ACA is comprised of two public laws, Pub. L. No. 111-148 (2010) and Pub. L. No. 111-152 (2010).

²House Committee on Energy and Commerce, *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance Market*, 111th Cong. (2010).

³ACA, Section 1101.

⁴*Id.*

PCIP PROGRAM

Background

The ACA makes PCIP coverage available to U.S. citizens and legal residents who have a pre-existing medical condition or have been denied health insurance coverage because of their health status and have been without health insurance for at least six months. To extend coverage to those eligible, states may either create their own programs or allow the federal government to manage their programs. Twenty-seven states have elected to run their own programs; the Center for Consumer Information and Insurance Oversight (CCIIO) (within the Centers for Medicare and Medicaid Services (CMS)) administers a single insurance program covering eligible citizens and legal residents of the remaining 23 states and the District of Columbia (D.C.).⁵

The federally-administered PCIP program began accepting applications for enrollment on July 1, 2010. The state-administered programs began accepting applications between August and October of 2010. Over the past three years, PCIP has provided coverage to 135,000 previously-uninsured Americans with severe and costly health care needs. CMS has closely monitored PCIP enrollment and costs since the program's inception and made adjustments to premiums and provider payment rates to ensure that the program's costs did not exceed the \$5 billion appropriation, while providing coverage that met the affordability requirements outlined in the ACA.⁶

Insuring a pool of policyholders with pre-existing conditions is costly. By definition, this population has a high-claims history, and the market rate for their coverage has made it unaffordable where it is even available. The purpose of PCIP is to offer coverage to these individuals at the same market-based premiums available to individuals without pre-existing conditions. As a result, the premiums PCIP enrollees pay were never expected to cover the entire cost of insuring them; the \$5 billion in federal subsidies were designed to make up the difference.⁷

The average cost per PCIP enrollee in 2012 was \$32,108 per year and varied widely by state, from a low of \$4,276 per enrollee to a high of \$171,909 per enrollee. Not only do costs vary by state, they also vary per enrollee. In one year, 4.4 percent of PCIP enrollees accounted for over 50% of claims paid.⁸

CMS has implemented several changes to manage the program's growth and its share of claims cost. In August 2012, CMS also reduced the negotiated and out-of-network payment rates for providers in the federally-administered PCIP, and negotiated additional discounts on reimbursement rates for hospitals that were treating a disproportionate number of PCIP enrollees. CMS changed the coverage of specialty drugs, requiring that only phar-

⁵ Center for Consumer Information and Insurance Oversight, *Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program* (Jan. 31, 2013) (online at http://cciio.cms.gov/resources/files/pcip_annual_report_01312013.pdf).

⁶*Id.*

⁷ HealthCare.gov, *State by State Enrollment in the Pre-Existing Condition Insurance Plan* (online at <http://www.healthcare.gov/news/factsheets/2012/11/pcip11162012a.html>) (accessed Apr. 19, 2013).

⁸ *Supra*, footnote 5.

macies and providers that are most cost effective be allowed to dispense specialty drugs. To help control costs for 2013, the three benefit plan options were merged into one, increasing the maximum out-of-pocket limit from \$4,000 to \$6,250. CMS is conducting clinical and non-clinical assessments to ensure that the 27 state-based and federally-administered PCIPs are abiding by all the program's regulations.⁹

On February 15, 2013, CMS announced that the PCIP program was temporarily suspending new enrollment in order to be certain that there would be sufficient resources to provide coverage for existing enrollees through the end of 2013. The federally-run PCIP program operating in 23 states and D.C. could accept and process all applications received on or before February 15, 2013. State-based PCIPs could continue accepting enrollment applications through March 2, 2013.¹⁰

PCIP Program Not a Long-Term Solution

While it is a welcome development that Republicans are now willing to join with Democrats to support the ACA's PCIP program, it is important to note that high-risk pools are not a long-term solution to reform the individual health insurance market.

Starting in the 1970s, states opened their own high-risk pools for individuals who were unable to get insurance or who were charged unaffordable premiums in the individual market. By 2011, 35 states were operating pools, yet only 226,000 people were covered nationwide. Enrollment, premiums, and deductibles vary drastically across the country. Thirty state high-risk pools have maximum lifetime benefit limits, five impose annual benefit limits, and all have waiting periods for individuals with pre-existing conditions. Many of these states have struggled to make up the difference between premiums and claims costs. Often costs are reduced by limiting enrollment; enforcing waiting periods for individuals with pre-existing conditions; and increasing premiums, deductibles, and co-payments.¹¹

Republicans have long been supporters of high-risk insurance pools like those created by PCIP and have advocated expanding high-risk pools as part of their plan to "repeal and replace" the ACA. Indeed, during consideration of the ACA, House Republicans proposed \$25 billion in funding to expand state high-risk pools and reinsurance programs.¹² Their legislation attempted to place some limits on premiums in high-risk pools and eliminate existing waiting lists but did not provide for a sustainable funding mechanism or premium assistance for enrollees. Furthermore, the legislation would have allowed widespread discrimination on the basis of pre-existing conditions to continue unabated in the private market and would have had little impact on the number of uninsured Americans.¹³

⁹ *Supra*, footnote 5.

¹⁰ HealthCare.gov, *PCIP—Enrollment Suspension* (Feb. 15, 2013) (online at www.pcip.gov/).

¹¹ National Association of State Comprehensive Health Insurance Plans (online at http://naschip.org/portal/index.php?option=com_content&view=article&id=230) (accessed Mar. 30, 2013).

¹² H.R. 4038, 111th Cong. (2009).

¹³ *Republicans Eye Costs, Not the Uninsured*, Politico (Jan. 24, 2011) (online at www.politico.com/news/stories/0111/48033.html).

The PCIP model was based on existing state high-risk pools but included key additional enrollee protections such as limits on out-of-pocket spending, protections against excessive premium rating, a guarantee that at least 65% of claims cost would be paid, immediate coverage for individuals with pre-existing conditions, and a broad range of health benefits. However, PCIP has experienced higher-than-expected claims cost per enrollee because most PCIP enrollees have serious health conditions and have gone untreated for a long period of time. Similar to the state high-risk pools, there is also a large gap between premiums and claims costs in PCIP. This difference between premiums and claims costs is a persistent problem for high-risk pools because they inherently lack a diverse group of enrollees.¹⁴

The “Marketplaces” (or Exchanges) that will be launched in 2014, combined with the Medicaid expansion and comprehensive ACA insurance market reforms, will offer a much more stable and affordable health insurance market. This is especially true for individuals with pre-existing conditions or serious health needs, who will no longer be denied coverage when they seek it on the open market. It is expected that within five years, 27 million people will gain coverage through Marketplaces, many of whom will be eligible for significant assistance with their premium costs.¹⁵ The broader risk pooling and premium assistance made possible through the Marketplaces will allow individuals with pre-existing conditions to access quality, affordable coverage at a lower cost than is available in high-risk pools. Spreading risk across the insurance market rather than concentrating it in high-risk pools will also lead to a far more efficient and sustainable use of resources than simply expanding funding for high-risk pools.¹⁶

PREVENTION AND PUBLIC HEALTH FUND

Background

The ACA is expected to expand affordable health insurance coverage to over 27 million Americans and to improve health benefits for millions more who are already insured.¹⁷

But as valuable as it is, health insurance cannot do everything necessary to render our nation healthy. Even if other parts of the ACA make it possible for virtually everyone to be insured, there will still be a major role for public health. Moreover, there will be an ongoing need for funding for these public health activities.

“Public health” includes many different things:

- It is working with groups and whole communities to improve health, often more effectively than could be done between an individual provider and patient. Fluoridation of water for a town is, for instance, vastly better than simply filling every

¹⁴J. Hall and J. Moore, The Commonwealth Fund, *Realizing Health Reform's Potential* (Sept. 2012) (online at www.commonwealthfund.org/-/media/Files/Publications/Issue%20Brief/2012/Sep/1627_Hall_PCIP_enrollment_costs_lessons_rb.pdf).

¹⁵Congressional Budget Office, CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage (online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf) (accessed Apr. 19, 2013).

¹⁶Testimony of Sara R. Collins, Ph.D., House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on Protecting America's Sick and Chronically Ill*, 113th Cong. (Apr. 3, 2013).

¹⁷*Supra* footnote 15.

citizen's cavities. Exercise programs to prevent obesity are better than having to treat diabetes among people who become morbidly overweight.

- It is tailoring health insurance and health care to prevent and diagnose disease early rather than simply treating it in its later stages. Immunizations are always better than outbreaks. Screening for hypertension is better than simply waiting for strokes.
- It is providing for safety-net services where the insurance market alone fails to do so. Community health centers, HIV-service providers, and breast and cervical cancer screening programs provide care to people who might not otherwise be able to find a provider. Health professions education programs can add to the primary care workforce when the market might produce only specialists. (Such programs will be even more necessary once the insurance expansion provisions of the ACA are fully implemented.)
- And, least glamorous but crucial, it is the infrastructure of daily disease control and health promotion. Closing down unsanitary restaurants is better than treating food poisoning. Compiling and studying epidemic trends can prevent major waves of disease.

The case might be made clearer by analogy: No community would be well-served if all its homeowners had fire insurance but there were no fire departments, firefighters, fire hydrants, smoke detectors, or indoor sprinklers. That very well-insured town would still burn to the ground. Insurance is necessary, but it is nowhere near sufficient.

The ACA addresses both approaches, with insurance and with public health. This required going beyond the investments in the law to provide health insurance to also include provisions to make significant public health commitments.

It would be insufficient simply to authorize future appropriations for these activities while providing mandatory spending for coverage initiatives. While the Committees on Appropriations of both the House and the Senate have shown ongoing and great leadership in these public health programs, the budget allocations for them have been too tight to allow significant new initiatives of these sorts. Consequently, the ACA provides as firm a funding and organizational base for these services as possible—mandatory spending—because they are essential in making insurance efficient and productive and in making the nation healthier.

Among those programs designated for mandatory spending in the ACA is the Prevention and Public Health Fund (the Prevention Fund). Its purpose is “to provide for expanded and sustained national investment in prevention and public health programs.”¹⁸ It is the first and only federal program with dedicated, ongoing resources specifically designed to improve the public's health, and in turn, to make the United States a healthier nation.

The Prevention Fund is administered by the HHS Secretary and may be used to support “programs authorized by the Public Health Service Act, for prevention, wellness, and public health activi-

¹⁸ACA, Section 4002.

ties.”¹⁹ When the Prevention Fund was initially created, it provided \$5 billion in mandatory spending for these activities over the period FY 2010 through FY 2014 and \$2 billion in mandatory spending each fiscal year thereafter (for a total of \$15 billion for FY 2010 through FY 2019, and \$18.75 billion for FY 2013 through FY 2022).

Legislation enacted in 2012 reduced these authorized funding levels by \$6.25 billion for FY 2013 through FY 2022.²⁰ More recently, the Prevention Fund lost dollars through the implementation of the so-called “sequester” that automatically chopped the Prevention Fund by some \$51 million.²¹ These cutbacks make it even more imperative to maintain both the Prevention Fund’s mandatory spending mechanism and its currently-authorized spending amounts. Such resources are necessary to address the perpetual underfunding of public health and prevention activities which, by some estimates, account for only 3% of national health expenditures.²² This view is supported by a recent Institute of Medicine report that reaffirms the importance of building upon existing streams of public health funding—including the Prevention Fund—to ensure our nation has an adequate infrastructure to improve health outcomes and to carry out other critical public health purposes.²³

Support for prevention has long been on a bipartisan basis. Members of this Committee from both sides of the aisle and across the political spectrum have spoken strongly in favor of this public health function.²⁴

Beyond the halls of Congress, this support is also widespread. A November 2009 public opinion survey by Trust for America’s Health and the Robert Wood Johnson Foundation found that 71% of Americans favored an increased investment in disease prevention.²⁵ And nearly 800 national, state, and local organizations support the Prevention Fund as a primary vehicle for making public health investments that would not only help to improve the public’s health, but also create jobs and lower long-term health care costs.²⁶

¹⁹ *Id.*

²⁰ *Middle Class Tax Relief and Job Creation Act of 2012*, Pub. L. No. 112–96.

²¹ Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Sequestration for Fiscal Year 2013* (online at www.whitehouse.gov/sites/default/files/omb/assets/legislative-reports/fy13ombjcssequestrationreport.pdf).

²² Center for Medicare & Medicaid Services, National Health Expenditure Data (online at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html?redirect=/NationalHealthExpendData/) (accessed Apr. 18, 2013).

²³ Institute of Medicine, *For the Public’s Health: Investing in a Healthier Future* (Apr. 10, 2012) (online at www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx).

²⁴ See, e.g., comments made by Reps. Pallone, Eshoo, and Walden during the Committee markup of H.R. 1549 (House Committee on Energy and Commerce, Markup on *H.R. 1549, the Helping Sick Americans Act et al.*, 113th Cong. (Apr. 17, 2013) (transcript of the proceeding)):

- Rep. Pallone: “. . . the fund was enacted as part of the ACA in response to overwhelming bipartisan support for prevention efforts . . .” (p. 17)
- Rep. Eshoo: “I don’t think there is a member here or a member in the Congress that doesn’t understand how important prevention is and the role of public health in that.” (p. 24)
- Rep. Walden: “. . . we are being asked to choose about prevention programs, which I am an advocate of . . .” (p. 98)

²⁵ See <http://healthyamericans.org/newsroom/releases/?releaseid=198> for a description of the poll’s complete findings.

²⁶ Letter from Jeffrey Levi, Ph.D., Executive Director, Trust for America’s Health (on behalf of 760 health-related organizations) to Chairman Fred Upton and Ranking Member Henry Waxman (Apr. 23, 2012) (online at <http://healthyamericans.org/health-issues/wp-content/uploads/2012/04/Fund-Reconciliation-EC-April2012.pdf>); Trust for America’s Health, State by State

Prevention Fund Dollars at Work

The Prevention Fund is one of a number of ACA initiatives that is already in place. Currently, all 50 states and the District of Columbia are receiving Prevention Fund support.²⁷

In general, the Prevention Fund is intended to provide support for programs generated at the local or community-based level. This is as it should be—communities know best what public health challenges they face and what interventions are most likely to work.

Currently, over 100 states and communities serving approximately 130 million Americans receive funding to implement evidence-based, community programs designed to reduce tobacco use, promote healthy living, prevent and control high blood pressure and high cholesterol, and address health disparities.²⁸ Twenty percent of funds go to support rural and frontier populations.

The Prevention Fund has also been used to provide flu shots and other immunizations; improve HIV/AIDS prevention through testing and linkages to care; expand mental health and injury prevention programs; train the public health workforce; and strengthen the public health infrastructure necessary to track and respond to disease outbreaks and disasters.²⁹ Recently, the Prevention Fund has supported the “Tips From Former Smokers” campaign, the first federally-funded, nationwide campaign focused on educating the public about the harms of smoking. This initiative has been credited with increasing the number of calls to state quitlines by 132% and generating a 428% increase in the number of unique visitors to an HHS smoking cessation website.³⁰

Prevention Dollars Produce High-Value Outcomes

Preventable diseases cost the United States significant resources—in terms of unnecessary deaths, lost productivity, and enormous amounts of money. Indeed, seven out of every ten deaths in this country are attributable to chronic diseases, where modifiable risk factors—such as lack of physical activity, poor nutrition, tobacco use, and excessive alcohol use—are responsible for much of the resulting illness and death.³¹ Chronic diseases consume an estimated 75% of the nation’s \$2 trillion health care spending each year.³² Obesity and related chronic diseases alone cost employers up to \$93 billion each year in health insurance claims.³³ A stable,

Groups Supporting ACA Prevention Fund (Apr. 8, 2013) (online at <http://healthyamericans.org/health-issues/wp-content/uploads/2013/04/Groups-Supporting-Prevention-Fund-State-by-State-List1.pdf>) (accessed Apr. 18, 2013).

²⁷ For a description of these activities and state-by-state information on the Prevention Fund, see HHS, *The Affordable Care Act’s Prevention and Public Health Fund in Your State* (online at www.hhs.gov/aca/prevention/ppht-map.html) (accessed Apr. 18, 2013).

²⁸ HHS, *The Community Transformation Grants Program* (online at www.healthcare.gov/news/factsheets/2011/09/community09272011a.html) (accessed Apr. 18, 2013).

²⁹ *Supra*, footnote 27.

³⁰ *Increases in Quitline Calls and Smoking Cessation Website Visitors During a National Tobacco Education Campaign—March 19–June 10, 2012*, *Morbidity and Mortality Weekly Report* (Aug. 31, 2012) (online at www.cdc.gov/mmwr/preview/mmwrhtml/mm6134a2.htm).

³¹ Centers for Disease Control and Prevention, *Chronic Diseases and Health Promotion* (online at <http://www.cdc.gov/chronicdisease/overview/index.htm>) (accessed Apr. 18, 2013).

³² Centers for Disease Control and Prevention, *Chronic Disease: The Power to Prevent, the Call to Control: At-A-Glance* (2009) (online at www.cdc.gov/chronicdisease/resources/publications/aag/chronic.htm).

³³ Centers for Disease Control and Prevention, *Worker Productivity* (online at www.cdc.gov/workplacehealthpromotion/businesscase/reasons/productivity.html) (accessed Apr. 18, 2013).

ongoing investment in prevention can help alleviate each of these burdens.

It is true that some life-saving prevention interventions actually involve expenditures. But so do most life-saving drugs and devices. We provide mandatory funding for drugs and devices through programs such as Medicare and Medicaid because steady and secure funding for these programs ensures that more Americans can live longer and healthier lives. Prevention efforts can also reduce the number of deaths and promote the health of Americans and should, therefore, also be supported through the mandatory spending mechanism.

Some forms of prevention do, of course, save money—immunizations, for example, are among our most cost-effective public health investments. Community-based interventions can be cost-effective as well. A 2009 Trust for America’s Health report concluded that an investment of \$10 per person per year in proven community-based interventions to increase physical activity, improve nutrition, and prevent smoking can save the country more than \$16 billion each year—a return of \$5.60 for every \$1 invested.³⁴ The Urban Institute estimates that certain proven community-based diabetes prevention programs can save as much as \$191 billion over 10 years.³⁵ A more recent Trust for America’s Health report concludes that a reduction of body mass index rates (the measure for obesity) nationwide that meets the HHS target of 5% would save over \$158 billion in 10 years.³⁶

Spending Authority

Despite the good and important work being done through the Prevention Fund, the health care savings it may help to produce, and the chronic underfunding of prevention activities in the past, Republicans are determined to bring the Prevention Fund to an end. They assert two principal arguments for their opposition to it: (1) the Prevention Fund’s funding mechanism—mandatory spending; and (2) the Secretary’s authority to determine how the Prevention Fund’s monies will be allocated. The two arguments are inter-related; taken together, they present a misleading analysis of how the Prevention Fund is intended to operate.

ACA Section 4002(b) provides for mandatory funding for the Prevention Fund. It authorizes to be appropriated and appropriates specified funding levels for FY 2010 and beyond. ACA Section 4002(d) addresses the role of the congressional appropriations committees in specifying how the appropriated funds are to be used. This section explicitly states that these committees have the authority to allocate monies from the Prevention Fund (in accordance with the Prevention Fund’s purpose to support prevention and other public health activities). Senator Harkin (author of ACA Section 4002) addressed this very issue in a 2011 letter to the Com-

³⁴J. Levi et al., Trust for America’s Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Feb. 2009) (online at: <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>).

³⁵R. Berenson et al., Urban Institute and Robert Wood Johnson Foundation, *How We Can Pay for Health Reform* (July 2009) (online at: http://urban.org/uploadedpdf/411932_howwecanpay.pdf).

³⁶Trust for America’s Health, *Bending the Obesity Cost Curve: Reducing Obesity Rates by Five Percent Could Lead to More Than \$29 Billion in Health Care Savings in Five Years* (Jan. 2012) (online at <http://healthyamericans.org/assets/files/TFAH%202012ObesityBrief06.pdf>).

mittee, making it clear that it is the responsibility of congressional appropriators to determine resource allocations.³⁷

Contrary to Republican belief, the Prevention Fund is not “a fund that the [HHS Secretary] can use at will.”³⁸ It is only when Congress fails to pass an HHS appropriations bill (or does not allocate the Prevention Fund in an appropriations bill) that the HHS Secretary has the authority to designate which public health programs or activities would receive Prevention Fund support. While it is true that the Secretary has already exercised this authority, it is also true that she has generally done so in a manner that is consistent with the overall purpose of the Prevention Fund.³⁹

The Secretary’s more recent actions to use the Prevention Fund to assist with the implementation of the ACA is a direct result of Republicans’ relentless defiance to provide such support through the appropriations process. In effect, Republicans continue to try to end the ACA by depriving it of the resources necessary to get it up and running, leaving the Secretary little recourse but to cobble together a patchwork of funding streams to help get the job done—and get it done on time. It is our expectation that such action will no longer be necessary if and when Congress adequately funds various implementation-related ACA activities.

H.R. 1549: RIGHT GOAL; WRONG FIX

Republicans and Democrats alike agree on the goal of H.R. 1549: “. . . to carry out the temporary high-risk insurance pool program for individuals with pre-existing conditions, and to extend access to such program to such individuals who have had creditable coverage during the 6 months prior to application for coverage through such program.”⁴⁰ Where they differ is with the means by which this goal can be achieved.

As has become their routine, Republicans have turned to the Prevention Fund for the \$2.8 billion the Congressional Budget Office estimates will be required to carry out the purpose of H.R. 1549. Section 2 of the bill would strip the Prevention Fund of virtually all of its monies for the next four fiscal years in order to continue the PCIP program for just another eight months—until those eligible for the program will be able to take full advantage of the insurance coverage provided under the ACA. Because of the purpose and overall track record of the Prevention Fund as described above, we believe this approach to “pay for” H.R. 1549’s expanded coverage is both ill-conceived and shortsighted.

But we also fully recognize the need to identify funding sources to finance this \$2.8 billion price tag. Democrats put forth two proposals in an attempt to do just that.

³⁷ Testimony of Senator Tom Harkin (submitted for the record), House Committee on Energy and Commerce, Subcommittee on Health, *Hearing on Setting Fiscal Priorities in Health Care Funding*, 112th Cong. (Mar. 9, 2011) (“Contrary to misperceptions that it evades the appropriations process, the Fund was established . . . in such a way that appropriators direct how monies from the Funds are spent”).

³⁸ Section on Background and Need for Legislation, Majority Views (Committee Report on H.R. 1549, the *Helping Sick Americans Now Act*).

³⁹ Republicans on the Committee support this view: “In past years, the [F]und was spent on various projects including public health surveillance, health workforce development, and prevention.” (Section on Background and Need for Legislation, Majority Views (Committee Report on H.R. 1549, the *Helping Sick Americans Now Act*)).

⁴⁰ H.R. 1549.

The first, an amendment offered by Rep. Pallone, would pay for the extension of the PCIP program with a small increase in the tax on cigarettes (four cents per pack).⁴¹ This approach not only would raise the funds necessary to extend the PCIP program; it is also supported by evidence showing tobacco taxes curb its use (especially among children)⁴² and, in turn, reduce the number of diagnoses of cancer and heart disease—some of the top pre-existing conditions covered through the PCIP program. The Pallone Amendment was ruled out of order.

The second, an amendment offered by Rep. Capps, would remove the Prevention Fund as the funding source for H.R. 1549 to allow the Committee to identify a different option—a bipartisan option—before the bill comes to the House floor.⁴³ Despite recognition that H.R. 1549 will not become law because of its Prevention Fund pay for, Republicans unanimously rejected the Capps Amendment; in effect, rejecting the opportunity to put the goal of H.R. 1549 on a fast track to success.⁴⁴

In light of both the Prevention Fund's purpose and track record to date, it comes as a great disappointment that Republicans continue to target this program for elimination.⁴⁵ Surely, this is not because of Republican assertions about the merits of the various initiatives supported by the Prevention Fund. And given traditional bi-partisan support for prevention activities, Republican opposition cannot be based on the substance of the program.

Pure and simple, Section 2 of H.R. 1549 represents the Republicans' unending attack to disrupt, dismantle, and ultimately destroy the ACA—even programs that have been funded and are up and running, including those that make good health policy sense, in or out of the health reform law.⁴⁶ And all this despite the Supreme Court's ruling upholding the constitutionality of the ACA.⁴⁷ What they have not been able to achieve whole cloth, Republicans

⁴¹ See debate on the amendment offered by Rep. Frank Pallone (House Committee on Energy and Commerce, Markup on *H.R. 1549, the Helping Sick Americans Act et al.*, 113th Cong., pp. 70–75 (Apr. 17, 2013) (transcript of the proceeding)).

⁴² Campaign for Tobacco-Free Kids, *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids (And the Cigarette Companies Know It)* (Oct. 11, 2012) (online at <http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf>); Congressional Budget Office, *Raising the Excise Tax on Cigarettes: Effects on Health and the Federal Budget* (June 2012) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/06-13-Smoking_Reduction.pdf).

⁴³ See debate on the amendment offered by Rep. Lois Capps (House Committee on Energy and Commerce, Markup on *H.R. 1549, the Helping Sick Americans Act et al.*, 113th Cong., pp. 75–111 (Apr. 17, 2013) (transcript of the proceeding)).

⁴⁴ *Id.*

⁴⁵ During the 112th Congress, House Republicans passed the following legislation designed to repeal or otherwise significantly change the Public Health and Prevention Fund:

- H.R. 1217, *To Repeal the Prevention and Public Health Fund* (eliminated the Prevention Fund (Congressional Record, H2633–2647 (Apr. 13, 2011))).
- H.R. 3630, *Middle Class Tax Relieve and Job Creation Act of 2012* (reduced authorized Fund amounts by \$11 billion over 10 years—more than 60% of its funding—as part of the original House payroll extenders legislation (Congressional Record, H8762–8824 (Dec. 13, 2011))).
- H.R. 4628, *Interest Rate Reduction Act* (eliminated the Prevention Fund (Congressional Record, H2228–2252 (Apr. 27, 2012))).
- H.R. 5652, *Sequester Replacement Reconciliation Act of 2012* (eliminated the Prevention Fund (Congressional Record, H2583–2633 (May 10, 2012))).

⁴⁶ During the 112th Congress, House Republicans voted over 30 times to repeal all or part of the ACA (*House Has Voted 32 Times to Repeal All or Part of Health-Care Reform Law*, Washington Post (July 11, 2012) (online at www.washingtonpost.com/blogs/2chambers/post/house-has-voted-32-to-repeal-all-or-part-of-health-care-reform-law-heres-the-full-list/2012/07/10/gJQAzoqgbW_blog.html)).

⁴⁷ *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.* 567 U.S. ____ (2012).

continue to attempt to do piece by piece.⁴⁸ Section 2 puts the Prevention Fund in the frontline of this ongoing assault yet again.

In our view, this is not where the Prevention Fund should be. Rather, it should remain exactly where it is—at the forefront of helping to realign the nation’s approach to health and health care, allowing Americans to become and remain healthier and more productive.

CONCLUSION

We wholeheartedly agree with the goal of H.R. 1549 and would very much welcome the opportunity to work with our Republican colleagues to make it happen. But with a pay for designed “to rob Peter to pay Paul” and to continue the Republican war on the ACA, we regrettably cannot support the legislation in its current form.

We stand ready to renew our efforts to find a pay-for solution that all Members can support. Unless and until that happens, we must oppose H.R. 1549.

HENRY A. WAXMAN.
 DORIS O. MATSUI.
 GENE GREEN.
 JOHN P. SARBANES.
 JAN SCHAKOWSKY.
 BOBBY L. RUSH.
 BRUCE BRALEY.
 EDWARD J. MARKEY.
 ELIOT L. ENGEL.
 PETER WELCH.
 G.K. BUTTERFIELD.
 JOHN D. DINGELL.
 FRANK PALLONE, Jr.
 ANNA ESHOO.
 DIANA DEGETTE.
 LOIS CAPPS.
 JIM MATHESON.
 KATHY CASTOR.
 MIKE DOYLE.
 BEN RAY LUJÁN.
 PAUL D. TONKO.

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⁴⁸ See, e.g., comments by Rep. Phil Gingrey: “A minority of our conference feels that the only vote that should be taken against ObamaCare is a repeal vote—all or nothing, to kill it dead . . . I’ve always felt that . . . if we see areas we can chip away at, that are the most egregious parts of the bill, we really should do that.” (*GOP Seeks \$4B for ObamaCare Program!*, The Hill (Apr. 17, 2013) (online at <http://thehill.com/homenews/house/294673-gop-seeks-4b-obamacare-increase>)).