

# POLICIES AND PROCEDURES OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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## HEARING

BEFORE THE

COMMITTEE ON EDUCATION  
AND THE WORKFORCE

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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HEARING HELD IN WASHINGTON, DC, MAY 5, 2011

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# **POLICIES AND PROCEDURES OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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**Thursday, May 5, 2011  
U.S. House of Representatives  
Committee on Education and the Workforce  
Washington, DC**

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

Present: Representatives Kline, Petri, Biggert, Foxx, Roe, Walberg, DesJarlais, Hanna, Rokita, Bucshon, Gowdy, Barletta, Ross, Kelly, Miller, Kildee, Payne, Andrews, Scott, Woolsey, Hinojosa, McCarthy, Tierney, Kucinich, Wu, Davis, Grijalva, and Hirono.

Staff Present: Andrew Banducci, Professional Staff Member; Katherine Bathgate, Press Assistant/New Media Coordinator; James Bergeron, Director of Education and Human Services Policy; Casey Buboltz, Coalitions and Member Services Coordinator; Heather Couri, Deputy Director of Education and Human Services Policy; Daniela Garcia, Professional Staff Member; Ed Gilroy, Director of Workforce Policy; Benjamin Hoog, Legislative Assistant; Amy Raaf Jones, Education Policy Counsel and Senior Advisor; Marvin Kaplan, Professional Staff Member; Barrett Karr, Staff Director; Ryan Kearney, Legislative Assistant; Brian Newell, Deputy Communications Director; Krisann Pearce, General Counsel; Molly McLaughlin Salmi, Deputy Director of Workforce Policy; Ken Serafin, Workforce Policy Counsel; Linda Stevens, Chief Clerk/Assistant to the General Counsel; Alissa Strawcutter, Deputy Clerk; Loren Sweatt, Professional Staff Member; Joseph Wheeler, Professional Staff Member; Aaron Albright, Minority Communications Director for Labor; Tylease Alli, Minority Hearing Clerk; Jody Calemine, Minority Staff Director; Ruth Friedman, Minority Director of Education Policy; Brian Levin, Minority New Media Press Assistant; Jerrica Mathis, Minority Legislative Fellow, Labor; Megan O'Reilly, Minority General Counsel; Julie Peller, Minority Deputy Staff Director; Meredith Regine, Minority Labor Policy Associate; Laura Shifter, Minority Senior Education and Disability Advisor; and Michele Varnhagen, Minority Chief Policy Advisor and Labor Policy Director.

Chairman KLINE. A quorum being present, the committee will come to order.

Well, good morning, everybody.

Good morning, Madam Secretary, welcome. We are delighted that you are here. I believe this is your first appearance before the committee, and we certainly appreciate the opportunity to meet with you today.

I realize your time is valuable, and we only have a small window to discuss a small range of topics. As we discussed earlier, it is likely that we will be interrupted by votes pretty quickly, so an administrative comment for all of my colleagues: Mr. Miller and I and the Secretary are going to all try to get our opening statements done, and at least Mr. Miller and I, depending upon how quickly they call votes.

By any definition, the Department of Health and Human Services is a massive Federal agency. It employs nearly 76,000 workers and maintains an annual operating budget in excess of \$800 billion, the largest of any agency in the Federal Government.

While a great deal of the Department's resources is directed to Medicare and Medicaid, more than \$100 billion in taxpayer money is spent on various social service programs. Many of these programs fall within the jurisdiction of this committee, such as welfare, the Community Services Block Grant, and provisions of the Child Abuse Prevention and Treatment Act.

No doubt these programs are well intended. They reflect our Nation's ongoing commitment to serving those in need. In recent years, however, the Federal budget has been placed on an unsustainable path taxpayers can no longer afford. This growth has forced us to take a hard look at every facet of the Federal Government as we consider how to reign in spending.

I realize the administration has offered some modest proposals for scaling back the cost of your Department, Madam Secretary. However, these proposals fail to rise to the challenges we face. If we adopt the President's plan, the Congressional Budget Office reports the Federal Government will spend \$46.2 trillion, impose \$1.5 trillion in new taxes, and add roughly \$9 trillion to the national debt over the next decade.

This is unacceptable.

In health care, the news is just as disappointing. It has been a little more than a year since the President signed his health care bill into law, yet already the price tag for the new law has increased by more than 50 percent. A plan that supporters promised would reduce costs, will instead charge taxpayers more than \$2.6 trillion when fully implemented, and add more than \$700 billion to the deficit.

Our national conversation has become so consumed by trillions and billions, that it is almost impossible to comprehend the magnitude of the crisis we face. These reckless policies affect not only the Nation's bottom line, they undermine confidence in our economy and harm job creators' ability to expand businesses or hire new workers.

The current fiscal crisis demands we examine every program to ensure every taxpayer dollar is spent efficiently and effectively. Every Federal agency must be part of that effort. If we fail to promote responsible reforms and make tough choices, our Nation will no longer be able to provide assistance to those who need it most.

Those who argue for a timid response threaten the very safety net many Americans rely upon.

We know many of the decisions we must make will be unpopular. Writing about the spending cuts in the final appropriations bill, the President's communications director noted "Many will be painful, and are to programs that we support, but the fiscal situation is such that we have to act. "And I couldn't agree more.

The Nation faces an historic moment: We can continue the status quo of more spending, more taxes, and more debt that will ultimately lead to our Nation's decline, or we can make the tough, yet necessary, choices to preserve the promise of our country and the prosperity of our children. That is the course the majority of this House has supported and one that I believe an overwhelming majority of the American people expect us to take.

[The statement of Chairman Kline follows:]

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

A quorum being present, the committee will come to order.

Good morning and welcome Madam Secretary. I believe this is your first appearance before the Committee, and we certainly appreciate the opportunity to meet with you today. I realize your time is valuable and we only have a small window to discuss a wide range of topics. I will keep my opening remarks brief to help ensure all members have ample opportunity to discuss with you the department's policies and priorities.

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Our national conversation has become so consumed by "trillions" and "billions" that it's almost impossible to comprehend the magnitude of the crisis we face. These reckless policies affect not only the nation's bottom line, they undermine confidence in our economy and harm job-creators' ability to expand businesses or hire new workers.

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director noted, "Many will be painful, and are to programs that we support, but the fiscal situation is such that we have to act." I couldn't agree more.

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Chairman KLINE. At this time I would like to recognize Mr. Miller, the senior Democratic member of the committee, for his opening remarks.

Mr. MILLER. Thank you, Mr. Chairman. Thank you for having this hearing. I want join you in welcoming Secretary Sebelius to the committee.

From educating our youngest children in Head Start to ensuring seniors' access to health care and Medicare, your Department administers programs that have unquestionably made our families and communities healthier and our country stronger. In recent months, we have seen an unprecedented attack on these programs that help millions of American families.

While we must address our Nation's long-term deficits, the budget priorities pursued by the Republican majority have put much of the sacrifice directly on the backs of children and seniors. Cutting 130,000 children from Head Start isn't about rebuilding our economy. The repealing of the historic health care reform law won't help families and businesses get costs under control.

You and your Agency, Madam Secretary, have primary responsibility for the implementation of the Affordable Care Act. A year after its enactment, the reform bill is still doing the right thing. It is the right thing to do to help families struggling with affordable coverage; it is the right thing to do for businesses crushed by skyrocketing premiums over the last decade; and it was the right thing to do to finally end the worst abuses of the insurance industry.

The Affordable Care Act also makes significant strides in combating fraud and abuse in the Medicare and Medicaid system, and it includes key health care cost controllers, identified by top experts, as critical to getting costs under control without rationing care.

And this is part of keeping the bargain, the bargain and the promise that this country made to our Nation's seniors, and it is a promise and a bargain that this Nation must keep to our seniors. However, the same cannot be said about the Republicans' budget. They achieved savings not by making Medicare work better, but by shifting costs onto seniors.

In fact, according to the report we released this morning, seniors would have to shoulder approximately \$6,400 more in health care costs in 2022. The typical 65-year-old in 2022 will spend half of their Social Security on health insurance premiums under the Republican budget plan, and that cost increases with each passing year.

Using the CBO numbers, the Center for Economic Policy and Research has found that to buy a Medicare-equivalent policy under the Republican plan, the median 85-year-old in 2050 would have to spend twice their annual income.



In this committee, we should be concerned about what this means for workers today. Based upon further analysis by the Center, which I submit for the record, the 54-year-old today would have to save an additional—an additional \$182,000 over the next 11 years just to pay for the increased health care costs under the Republican budget.

This is over and above what they are already putting away every month in their savings, in their 401(k)s and in their retirement plans. So these workers will have to find around an extra \$1,000 to \$1,300 a month to put in their IRAs or their 401(k) plans, and that is contingent on the market not crashing right before they retire.

This committee has been concerned for years about the sufficiency of workers' retirement plans. In 2007, before the recent crisis, the Census Bureau found that half of all the workers had no retirement savings. In 2010, the Employee Benefit Research Institute found that the average retirement savings shortfall was over \$47,000 per individual, and all of that was counting on Medicare.

So how do these workers find another \$182,000, especially since for middle-class workers in this country, wages have essentially been stagnant since the 1970s and labor protections for workers who try to organize and do better on the job for their families and for their communities, their ability to organize is now under attack. Under the Republican plan, seniors will go into debt and they will be forced to sell their homes that they have spent a lifetime paying off, and they will have to rely on their children just to pay basic medical care.

This is not what anyone envisioned as a dignified retirement. This was not the bargain. This was not the promise that this Nation made with its seniors. And I say that, clearly understanding the need for additional reforms to make sure that Medicare is sustainable for seniors in the future and sustainable for taxpayers.

I am very encouraged to see that as the Republican negotiators go to the White House today, they are reconsidering the idea that they would split Medicare, that they would put the 65-year-old in the jeopardy that I outlined under the economic policy study, and they would put this burden on the savings of middle-class Americans today. And they also have the ability, as they go to the White House, to think about whether or not Medicare is going to be included in the discussions around the debt limit. It sounds like they are reconsidering that. I hope they are.

They can also understand that they can build on the trillion, about 700, or is it—a little over \$700 billion that they have adopted in Medicare savings for their budget that are in the Affordable Care Act. And so hopefully we can continue to build on those kinds of savings that come from bending the cost curve for health care for seniors in this country and for the cost of the Medicare program.

Again, I welcome you to the committee and thank you so much for your service to our country.

Chairman KLINE. I thank the gentleman.

[The statement of Mr. Miller follows:]

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

I am pleased that we are having a hearing on the critically important work of our nation's employment and workforce training programs. I would like to thank our distinguished panel of witnesses for joining us today.

While our economy is moving in the right direction, in my congressional district and across our nation, millions of American workers continue to struggle to find good jobs and make ends meet.

In order to thrive in today's workforce, American workers, particularly those adults and youth who are unemployed, dislocated, or disadvantaged, need education and training, counseling, guidance, and support to secure family-sustaining jobs, achieve their educational goals, and improve their lives.

In part, today's hearing will focus on recent reports released by GAO on federal programs that provide some form of employment and training services. In these reports, GAO has recommended co-locating and consolidating administrative structures to avoid duplicating services.

In addition, the GAO recommended that the Secretaries of Labor and HHS work together to develop and disseminate information to encourage such efforts.

While my colleagues on the other side of the aisle support the consolidation of administrative structures and funding streams and argue that any savings should be applied to the deficit, I believe that consolidation should be used to improve the quality and accessibility of employment and job training services.

If the process of co-locating or consolidating programs leads to a savings, I strongly believe that these resources should be reinvested into our public workforce and adult education system and be used to address the needs of those workers who are hardest to serve. Those who are jobless desperately need our help to improve their lives.

In the Rio Grande Valley of South Texas, we have waiting lists for adult education and employment and training services and are unable to meet the needs of our most vulnerable workers and youth due to limited resources.

As Ranking Member of the Subcommittee on Higher Education and Workforce Training, reauthorizing and improving the Workforce Investment Act (WIA) and adequately funding our nation's public workforce and adult education system are top priorities for me. In my view, our public workforce and adult education system has been starved for far too long.

It is my hope that we, the members of this committee, can identify areas of common ground and work in a bipartisan manner to reauthorize WIA in the 112th Congress.

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Chairman KLINE. Pursuant to committee rule 7(c) all committee members will be permitted to submit written statements to be included in the permanent hearing record.

Without objection, the hearing record will remain open for 14 days to allow statements, questions to the record, and other extraneous material referenced during the hearing to be submitted in the official hearing record.

[The information follows:]

U.S. CONGRESS,  
*Washington, DC, June 28, 2011.*

Hon. KATHLEEN G. SEBELIUS, *Secretary,*  
*U.S. Department of Health and Human Services, 200 Independence Ave., SW, Wash-*  
*ington, DC 20201.*

DEAR SECRETARY SEBELIUS: Thank you for testifying at the Committee on Education and the Workforce's May 5, hearing on "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 that answer the questions posed no later than July 12, 2011, for inclusion in the official hearing record. Responses should be sent to Benjamin Hoog of the Committee staff, who can be contacted at (202) 225-4527.

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

JOHN KLINE,  
*Chairman*

QUESTIONS FROM REPRESENTATIVE KLINE

1. **HEAD START FRAUD AND ABUSE.** Last year, the U.S. Government Accountability Office (GAO) conducted an undercover investigation of 15 Head Start programs, acting in response to tips from former and current employees at two separate Head Start centers. Undercover GAO applicants tried to enroll children in these programs and presented the centers with pay stub data that demonstrated they were above income eligibility requirements. Nine of the 15 sites enrolled the students by encouraging applicants not to submit the pay stubs that would put them over the income threshold. Some of the programs continued to count the students as enrolled, even though the students never actually participated in the program. At a May 2010 hearing before this Committee, the Assistant Secretary for Children and Families stated that the Department was taking immediate corrective action and was undertaking a “top-to-bottom” review of its program oversight responsibilities. Can you give us an update on the Department’s effort to combat waste, fraud, and abuse in the Head Start program? How many unannounced monitoring visits has the Department conducted since the release of the GAO report?<sup>1</sup>

2. **RECOMPETITION OF HEAD START GRANTEES.** In 2007, Congress passed the Improving Head Start for School Readiness Act, which requires the Secretary of Health and Human Services to establish a new, comprehensive system to re-compete Head Start and Early Start grants. The Department is currently in the process of finalizing regulations on recompetition to ensure that Head Start grantees are meeting the requirements of the law and preparing pre-school-aged children for entry into kindergarten. Please provide us with an update on this process. When will the first grantees be re-evaluated?

3. **EFFECTIVENESS OF THE COMMUNITY SERVICES BLOCK GRANT PROGRAM.** The President’s FY2012 budget request includes a \$388 million cut to the Community Services Block Grant program, which is geared toward anti-poverty activities. Over the last 10 years, a number of independent studies and research activities, including those conducted by the U.S. Government Accountability Office (GAO), have questioned the program’s effectiveness in combating poverty in local communities. What changes do you think the Committee should make to the program to make it more effective? When was the last time the program was evaluated and what were the results?

4. **HEALTH INSURANCE EXCHANGES:** You claim in your testimony that in 2014, state health insurance exchanges will provide new options for consumers. However, it has been reported that several governors have vetoed bills intended to implement the new law’s requirement for state-based Health Insurance Exchanges, and many states are not working toward establishing such exchanges. Also, one governor rejected a \$54 million “early innovator” grant for an exchange partly on the basis that states do not want to be subjected to federal regulation. Assuming some states will not create health insurance exchanges by 2014, at what point will HHS develop the federal insurance exchange option that would be available to consumers in those states? Can you elaborate on the structure of this option?

QUESTIONS FROM REPRESENTATIVE WALBERG

For nearly 20 years, the National Institute for Occupational Safety and Health (NIOSH) along with the National Cancer Institute (NCI) conducted a study on the potential effects of diesel exhaust in underground mines. The Mining Awareness Resources Group (MARG) voluntarily participated in the study by providing access and information for NIOSH to conduct the study; however this was done with the understanding that NIOSH would be providing the study data to the group in order to review the studies. Two federal court orders have ordered NIOSH to provide the data to MARG and the Committee on Education and the Workforce, yet the institute has not fully complied.

1. Why has NIOSH not complied with the court orders of two federal judges?
2. When will the data be made available to all parties involved?

<sup>1</sup><http://www.gao.gov/new.items/d10733t.pdf>.

## QUESTION FROM REPRESENTATIVE BARLETTA

1. A number of smaller pharmacies in my district in Northeastern Pennsylvania have raised concerns regarding the impact of “rapid refills” on patient care. As you know, an increasing number of doctors are issuing prescriptions for 90 day supplies of medication. However, the patient’s condition may change, forcing a doctor to modify the prescription prior to the patient exhausting the huge supply. Additionally, the patient loses out on valuable and more frequent in-person counseling offered by local brick and mortar pharmacies. Can you give the Agency’s perspective on the challenges to patient care associated with so-called “rapid refills”? How has the Patient Protection and Affordable Care Act interfered with this process?

## QUESTION FROM REPRESENTATIVE ROE

1. During our dialogue at the May 5, 2011, hearing of the Education and the Workforce Committee, you stated that of the 30 million to 35 million Americans who will receive coverage as a result of PPACA, “\* \* \* about 15 million are likely to be Medicaid-eligible.” However Medicare’s chief actuary has indicated that the number of new Medicaid enrollees could rise as high as 25 million given that Social Security benefits will not be counted as income for the purpose of determining Medicaid eligibility.<sup>2</sup> How then, is PPACA not just a massive expansion of Medicaid?

## QUESTIONS FROM REPRESENTATIVE WOOLSEY

1. The HHS FY 12 budget proposes to zero out two programs in the National Institute for Occupational Safety and Health (NIOSH): the Education & Research Center (ERC) program and the Agriculture, Fishing and Forestry (AFF) program. Combined, these two programs total less than \$50 million. The ERCs were established to implement Section 21 of the Occupational Safety and Health Act’s (OSHAct) requirement to train “an adequate supply” of occupational safety and health professionals to implement the law.

A. With regard to the AFF program, fatality rates in agriculture, fishing and forestry are more than seven times the average—and cost our economy \$4 billion per year. NIOSH has developed technology to save lives and property in these industries. The National Academy of Sciences (NAS) found this program conducts high priority, sound research, but indicated that there were opportunities for improvement. The HHS FY 12 budget request zeroes out the program, claiming the program was ineffective, and asserts that the Agriculture Department and the Labor Department can pick up the slack when this program is zeroed out. The NAS panel members have written to Congress contending that the HHS budget justification misrepresents their 2007 report.

i. What specific authorization and funding is available in the Labor Department or Agriculture Department in the President’s FY 12 budget to replace the NIOSH AFF research program?

ii. Will you be willing to review the budget justification for the AFF program to determine if it is valid and factually supported?

iii. Would you be willing to work with the Committee to identify funds within HHS’s operating divisions that could be reallocated to allow this priority NIOSH work to continue?

B. With regards to the ERC program, the HHS FY 12 budget request justifies termination on the grounds that NIOSH had planned to sunset funding after 5 years; however, neither the Centers for Disease Control nor OMB can find any documents to back this up. Congress never intended to sunset this program after 5 years, and the Institute of Medicine recommended continuing this program.

i. Has HHS conducted a recent assessment of whether the ERC program has fulfilled its mission pursuant to Section 21 of the OSHAct? If so, has such assessment determined that there is an adequate supply of occupational safety and health professionals?

ii. If such study had not been done, why would HHS terminate this program before such assessment has been completed?

iii. Will you be willing to undertake a review to determine if the budget justification for the ERC program is valid and fully supported?

iv. Would you be willing to work with the Committee to identify funds within HHS’s operating divisions that could be reallocated to allow this priority NIOSH work to continue?

<sup>2</sup> See <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Foster.pdf>.

## QUESTION FROM REPRESENTATIVE MCCARTHY

1. Congress included a provision in the Patient Protection and Affordable Care Act requiring that patients receiving Medicare home health services have a face-to-face encounter with a referring physician prior to certification for home health services.

Having heard from both home health care providers and physician groups alike, I am concerned that in implementing the provision, CMS has gone beyond Congressional intent. In doing so, the agency has created significant additional administrative paperwork and documentation burdens on physicians for which they are not reimbursed. The requirement also creates obstacles to care for patients, who are by definition homebound, and may not have convenient access to physician offices.

I am very concerned that the outcome of this will be that patients are denied access to the care they need, and that is provided in both the lowest cost and most desired setting—one's own home.

We will continue to work with the agency, but would appreciate your attention and thoughts on this matter as well. Would you support efforts to streamline and simplify the process for documenting the face to face encounter so that we address concerns of referring physicians, home health providers, and the patients they serve?

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[Additional submission of Mr. Miller follows:]

CENTER FOR ECONOMIC AND POLICY RESEARCH,  
*Washington, DC.*

Hon. GEORGE MILLER, *2205 Rayburn House Office Building Washington, DC.*

DEAR REPRESENTATIVE MILLER: Thank you for your interest in our report "Representative Ryan's \$30 Trillion Medicare Waste Tax."

According to Figure 1 of the Congressional Budget Office's letter to Paul Ryan, the cost of purchasing private health insurance equivalent to that which Medicare provides is 12 percent higher than the cost to Medicare in 2011. CBO projects that the additional cost from providing care through private insurers will grow to 67 percent of the total cost of Medicare by 2030.

Consequently, under the Ryan plan, a person born in 1957 must spend approximately \$16,900 (in today's dollars) to purchase Medicare-equivalent insurance in 2022. Through Medicare, the insurance would cost only \$11,200. This implies \$5,700 of waste.

As this beneficiary ages, both the general increase in health care prices and the increased burden of providing health care with age will conspire to raise this person's cost of insurance. At age 65, a person born in 1957 will require an additional \$182,000 in retirement savings—earning 3 percent real interest—in order to purchase private insurance rather than accept coverage through Medicare through age 84.

In part, this \$182,000 reflects additional sharing of costs imposed the Ryan plan. The Ryan plan would shift approximately \$20,800 in costs from the government to this beneficiary between 2022 and 2041. Thus, the shift requires the beneficiary to set aside \$14,000 in retirement savings by age 65 as well as \$6,800 in interest income in order to make up for the reduced support from the government.

The remaining \$168,000 in required retirement savings—again generating annual interest at a rate 3 percentage points above inflation—reflects the additional cost of private insurance. The total cost of private insurance would be \$557,300, compared to \$322,200 through Medicare. The principal and interest on \$168,000 would suffice to cover this \$235,100 difference in insurance costs from age 65 through age 84.

Please do not hesitate to contact me if you have further questions.

DAVID ROSNICK,  
*Center for Economic and Policy Research.*

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Chairman KLINE. Again, before I introduce our distinguished witness, I want to make an administrative announcement. The Secretary has a hard stop time at 12:30. I want to encourage my colleagues, when we get into questions and answers, that you try to abide by the 5-minute clock so that everybody has a chance. And, again, we expect to be called to votes momentarily.

So let me move to the introduction. The Honorable Kathleen Sebelius was sworn in as the 21st Secretary of the Department of Health and Human Services on April 28, 2009.

I got the wave down here. Everybody knows who the Secretary is. So in the interest of time, Madam Secretary, you are recognized.

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

Secretary SEBELIUS. Chairman Kline and Ranking Member Miller, members of the committee, thank you for inviting me here to discuss the President's 2012 budget for HHS.

The President's budget ensures Americans live within our means. As a lead-up to the budget, we looked at all of our programs, cut waste, eliminated programs that weren't working well enough, re-designed our programs to put a new focus on result. In some cases, we cut programs we would have kept in place in better fiscal times.

At the same time, our budget protects the investments we need to keep Americans prosperous in the years to come, from investments in Head Start so our kids can compete with those in any nation, to investments in biomedical research that allows the U.S. to continue to lead the world in discoveries of breakthrough cures and treatments.

Today I want to focus my oral testimony on some of the provisions in our budget that will benefit the youngest and the oldest Americans.

But first a quick update on the implementation of the the Affordable Care Act. Thanks to the steps we have taken so far, children can no longer be denied coverage because of their preexisting health conditions. Families have new protections with the Patient's Bill of Rights. Businesses are getting some initial relief from the soaring health care costs, and seniors have better access to prescription drugs and preventive care.

Tomorrow we will announce that more than 18,000 Americans who have been shut out of the insurance market are now taking advantage of the preexisting insurance plans in their States. Some States are still reporting figures, so those numbers could go higher, but that is about a 50 percent increase in the last couple of months as people begin to learn about the program.

It is encouraging to see that more people who need health insurance are getting it, but we know that is not enough, and that is why we are continuing to work with States and national advocates to reach eligible people and let them know coverage is available. We are also working with insurers that have chosen to notify people about the preexisting insurance plan when their applications are denied, and we are evaluating ways to reduce premiums and ease eligibility standards to expand access to the plans. For many, these plans provide access to lifesaving treatment, so it is vital we continue to find those who are eligible and get them enrolled.

Our budget builds on the momentum of the the Affordable Care Act with critical investments that provide for and protect our most vulnerable citizens. We know there is nothing more important to our future than the healthy development of all of our children.

Science continues to show that success in school is significantly enhanced by higher-quality early learning opportunities. Earlier

this year, we got the results of the latest study to look at value of early education. Researchers followed children from low-income families enrolled in Chicago's early education programs until they turned 26, and found that over that child's lifetime the program generated as much as \$11 in economic benefits for every dollar spent. Now, that is a huge payoff. So even in tight budget times, our budget makes room for new investments in child care and Head Start, which have a long history of bipartisan support.

But the budget does more than provide additional resources. It aims to raise the bar on quality in child care and early education by supporting key reforms to transform the Nation's early childhood system into one that fosters healthy development and gets children ready for school.

Quality child care is more than just providing baby sitting. It supports healthy child development and school readiness, and that is why our budget puts forward principles for legislation reauthorizing the main child care program, the Child Care and Development Block Grant. These include promoting better health and safety standards, putting more information about the quality of different child care options into parents' hands and improving workforce training to make sure that the people caring for our kids have the skills they need.

We look forward to working with this committee, Mr. Chairman, as you consider these issues. We are also promoting better quality in Head Start, using new evidence-based evaluations in classrooms, including a tool that will help Head Start programs see what is working and improve what isn't.

In addition, we have revamped the training we provide to Head Start directors and teachers to make sure best practices actually reach the classroom. We are proposing new rules to require the lowest performing programs, the bottom 25 percent, to compete for funding. By giving programs incentives to raise the quality of their services and removing the weaker programs, we want to ensure that the best programs are the ones serving our children.

Finally, we are pleased that the fiscal year 2011 budget included funding to allow States to fund innovation in early education, and our 2012 request includes \$350 million to continue this key investment.

Taken together, these initiatives are designed to create an early learning system that gets every child ready for school, supports healthy child development and features high standards, whether the child is in a pre-K program, a Head Start center, a child care center, or a family day-care home. They will help ensure that American children start school as prepared as any in the world.

Our budget also focuses on creating safe environments for children and families. We thank the committee for reauthorizing the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act last year, and our budget includes more than \$200 million for the child abuse and domestic violence programs authorized by these laws.

The budget also provides critical support for seniors. It invests in the care and services seniors need to stay active and engaged in their communities, and it addresses the terrible problem of elder

abuse and provides funding for caregiver services that give families the peace of mind and enable them to care for near relatives.

These goals guide our Department's work on the reauthorization of the Older Americans Act coming up later this year.

For more than 45 years, the Older Americans Act has enjoyed broad bipartisan support. In the past year alone, the law's comprehensive home and community-based system has supported nearly 11 million seniors and their family caregivers, but the need for this kind of support continues to grow rapidly.

Every day, more than 9,000 baby boomers turn 65. That is nearly 3.3 million a year, many of whom will be ultimately cared for by their family members. We need to do all we can to help families caring for their loved ones, and the Older Americans Act gives us the tool to do just that.

We look forward to working with this committee to reauthorize the Older Americans Act and build upon the law's long record of success in serving our families and our communities.

The 2012 budget makes tough choices and smart target investments today so we can have a healthy, stronger, and more competitive America tomorrow. That is what it takes to win the future and that is what we are determined to do.

Thank you, Mr. Chairman, and I look forward to our discussion. Chairman KLINE. Thank you, Madam Secretary.  
[The statement of Secretary Sebelius follows:]

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

Chairman Kline, Ranking Member Miller, and Members of the Committee, thank you for the invitation to discuss the policies and priorities of the Department of Health and Human Services (HHS).

In President Obama's State of the Union address he outlined his vision for how the United States can win the future by out-educating, out-building and out-innovating the world so that we give every family and business the chance to thrive. His 2012 budget is the blueprint for putting that vision into action and making the investments that will grow our economy and create jobs.

At the Department of Health and Human Services this means giving families and business owners better access to health care and more freedom from rising health care costs and insurance abuses. It means keeping America at the cutting edge of new cures, treatments and health information technology. It means helping our children get a healthy start in life and preparing them for academic success. It means promoting prevention and wellness to make it easier for families to make healthy choices. It means building a health care workforce that is ready for the 21st century health needs of our country. And it means attacking waste and fraud throughout our department to increase efficiency, transparency and accountability.

Our 2012 budget does all of this.

At the same time, we know that we cannot build lasting prosperity on a mountain of debt. And we cannot win the future if we pass on massive debts to our children and grandchildren. We have a responsibility to the American people to live within our means so we can invest in our future.

For every program we invest in, we know we need to cut somewhere else. So in developing this budget, we took a magnifying glass to every program in our department and made tough choices. When we found waste, we cut it. When we found duplication, we eliminated it. When programs weren't working well enough, we reorganized and streamlined them to put a new focus on results. When they weren't working at all, we ended them. In some cases, we cut programs that we wouldn't cut in better fiscal times.

This Budget contributes to deficit reduction and meets the President's freeze to non-security programs by offsetting critical investments with over \$5 billion in targeted reductions. These reductions are to real programs and reflect tough choices. In some cases the reductions are to ineffective or outdated programs and in other areas they are cuts we would not have made absent the fiscal situation.



The Budget proposes a number of reductions and terminations in HHS.

- The Budget cuts the Community Services Block Grant in half (by \$329 million) and injects competition into grant awards.
- The Budget cuts the Low Income Home Energy Assistance Program by \$2.5 billion bringing it back to the 2008 level appropriated prior to the spike in energy prices.

The Budget also stretches existing resources through better targeting.

- The Budget redirects and increases funding in CDC to reduce chronic disease. Rather than splitting funding and making separate grants for heart disease, diabetes, and other chronic diseases, the Budget proposes one comprehensive grant that will allow States to address chronic disease more effectively.

- The Budget proposes refocusing the Senior Community Services Employment program to better integrate unemployed seniors into their communities through community service employment assisting other seniors to stay in their homes.

- The Budget redirects prevention resources in SAMHSA to fund evidence-based interventions and better respond to evolving needs. States and local communities will benefit from the additional flexibility while funds will still be competed and directed toward proven interventions.

These are the two goals that run throughout this budget: making the smart investments for the future that will help build a stronger, healthier, more competitive, and more prosperous America, and making the tough choices to ensure we are building on a solid fiscal foundation.

This Committee has jurisdiction over several important parts of HHS, including child care and Head Start, which focus on our youngest citizens, programs under the Older Americans Act, which focus on our oldest citizens, and certain child abuse, runaway and homeless youth, and family violence programs, which focus on some of our most vulnerable citizens.

The budget documents are available on our website. But for now, I want to share an outline of the budget, including the areas of most interest to this Committee, and how it will help our country invest in, and win, the future.

#### *Advance the Health, Safety, and Well-Being of the American People*

**Enhancing the Quality of Early Education:** The Budget provides \$6.3 billion in combined discretionary and mandatory funding for child care, which is a \$1.2 billion increase above the FY 2011 funding level. These resources will provide child care subsidies to 1.7 million low-income children so that their parents can work or attend training or education. The funding also supports activities to improve the quality of child care to support learning and success for all 12 million young children who are in out-of-home care each week.

The Administration also supports critical reforms to the child care program with the goal of helping more children access high quality child care, through higher health and safety and quality standards, development of the early childhood workforce, increased continuity of care, and quality rating improvement systems that provide parents with critical information about the quality of their care choices and assist providers in reaching higher levels of quality. The Budget also supports improvements to program integrity and accountability initiatives. Taken together, these reforms will help transform the nation's child care system into one that provides safe, nurturing care that fosters healthy child development, promotes future academic success, and supports parental employment.

Additionally, the President's Budget includes \$8.1 billion for Head Start, which will allow us to continue to serve 968,000 children in 2012. The budget request supports the critical reforms underway to raise the bar on quality in the Head Start program, including requiring grantees not meeting the standard for automatic non-competitive renewal under the Head Start Act to compete for funding to ensure that children and families are served by the most capable providers. The budget also supports the redesigned training and technical assistance system which would bring current research and the best evidence-informed practice into Head Start classrooms, including best practices for local programs to work with their local school systems to ensure that children start school with the skills they need and that the gains children achieve in Head Start are sustained as the children leave Head Start and move on to public schools.

The Administration is engaged in a multi-faceted effort to raise the bar on quality in Head Start. The training and technical assistance system has been revamped and now features six national centers that focus on different elements of quality early education, including parent engagement, quality teaching, and financial management. In addition, we now have 10 "Centers of Excellence" and 130 Head Start programs participating in a mentoring program designed to pair programs with dedi-

cated mentors who can help them examine their programs and implement changes that improve quality.

Another key element of our efforts to improve quality is the creation of a robust re-designation renewal system, called for in the most recent Head Start reauthorization legislation. This system will inject competition into the Head Start program and require low performing programs to compete against other entities for continued funding. We issued the proposed rule in September 2010 and received many comments from around the country. We are in the process of reviewing those comments and writing a final rule. We believe that a strong re-competition system will promote quality in two important ways. First, it provides new incentives for all Head Start programs to improve their programs because programs found to be low performing will have to compete for continued funding. Second, it provides a way to replace low-performing programs with entities that are able to provide higher quality early education to children.

As we work to finalize the rules for this competitive process, we are guided by the goal of the bipartisan reauthorization legislation—to ensure that children served in Head Start have access to high quality early education that promotes healthy child development and school readiness.

In fact, all of our work in early education is devoted to the goals of fostering healthy development and school success for children. Regardless of whether a child is in a Head Start Center, a family child care home, a public pre-K program, or a private preschool, that child needs quality teachers, a safe environment, healthy food, and activities that fosters her social, emotional, physical, and cognitive development. That is why the Administration has proposed the creation of the Early Learning Challenge Fund. This proposed competitive grant program would be jointly administered by the Departments of Education and Health and Human Services and would challenge States to establish model, coordinated, Statewide systems of early learning and development for children from birth to kindergarten entry by raising program standards, forging better linkages between early education programs and elementary schools, and improving early learning workforce training so that teachers have the skills they need. The overall program goal would be to improve health, social, emotional, and educational outcomes for young children so that they develop the skills and abilities necessary to succeed in school and in life.

The Administration's agenda on early education—including both investments and the focus on quality—are key elements of the broader education agenda designed to help every child reach his or her academic potential and improve our nation's competitiveness.

#### *Child Abuse Prevention*

The Budget request for child abuse prevention efforts includes \$26.5 million for grants to States and \$41.7 million for grants to community-based organizations. The request supports the reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA). This Committee played a leading role in the successful and bipartisan reauthorization effort last year and I appreciate your efforts. Reauthorization included new State plan assurances and a focus on collaboration and linkages between domestic violence and child abuse and neglect. Reauthorization also included a new funding formula adjustment should appropriations exceed FY 2009 amounts by more than \$1 million. These funds will continue to help support improved child protection systems, including prevention services for families. Child abuse and neglect continues to be a significant problem in the United States. CAPTA funds support the efforts in establishing and maintaining effective systems of child protection, a critical element in eliminating the tragedy of child abuse and neglect, and support direct services to families.

#### *Preventing Domestic Violence*

The President's FY 2012 Budget provides \$140 million to shelter and serve victims of domestic violence and their children, as well as prevent domestic abuse before it starts. The request supports the newly reauthorized Family Violence Prevention and Services Act, and funds over 1,300 battered women's shelters, evidence-based prevention strategies, and the National Domestic Violence Hotline. The Hotline receives over 24,000 calls per month, with most callers reporting it is their first request for help. Again, I would like to thank this Committee for its bipartisan work to reauthorize these important programs last year.

**Child Support and Fatherhood Initiative:** The Budget includes \$305 million in FY 2012 and \$2.4 billion over 10 years for the Child Support and Fatherhood Initiative. This initiative is designed to promote strong family relationships by encouraging fathers to take responsibility for their children, changing policies so that more of fathers' support reaches their children, and continuing a commitment to vigorous en-

forcement. The Budget increases support for States to pass through child support payments to families, rather than retaining those payments, and requires States to establish safe access and visitation arrangements as a means of promoting father engagement in their children's lives. The Budget also provides a temporary increase in incentive payments to States based on performance, which continues an emphasis on program outcomes and will foster enforcement efforts when state budgets are stretched.

**Reform and Reauthorize the Foster Care Financing System:** The Budget includes an additional \$250 million in mandatory funds in FY 2012 and a total of \$2.9 billion over 10 years to align financial incentives with improved outcomes for children in foster care and those who are receiving in-home services from the child welfare system in order to prevent entry or re-entry into foster care. We look forward to working with the Committee to improve outcomes for vulnerable children in our child welfare system.

#### *Domestic Sex Trafficking*

Contrary to a common assumption, human trafficking is not just a problem in other countries. Cases of human trafficking have been reported in all 50 States, Washington D.C., and U.S. territories. Victims of human trafficking can be children or adults, U.S. citizens or foreign nationals, male or female. The President's FY 2012 budget proposed \$5 million for training to address sex trafficking of runaway and homeless youth and supports for those working with U.S. domestic victims in the runaway and homeless youth population (in addition to funding currently provided through the Office of Refugee Resettlement for foreign trafficking victims in the United States). The Administration's proposal would train and support those who work with the runaway and homeless youth population to identify, prevent, and address sex trafficking of minors in this population. These funds will support the training and outreach for a broad range of those who work with runaway and homeless youth, including program staff, caseworkers and parents. Through collaboration, funds also may support partnerships with law enforcement, attorneys, and judges to train individuals on how to recognize and address sex trafficking among youth.

**TANF Reauthorization:** The President's Budget continues existing funding for the TANF program in FY 2012. When TANF reauthorization is considered, the Administration would be interested in exploring with Congress a variety of strategies to strengthen the program's ability to improve outcomes for families and children, including helping more parents succeed as workers by building on the recent successes with subsidized employment. One area in which HHS is already working to improve employment opportunities is by partnering with the Department of Labor (DOL). HHS and DOL are exploring a variety of efforts in the employment and training area which are aimed at addressing the challenges, strategies, incentives, and results for States and localities to undertake collaborative initiatives. These collaborative efforts include developing joint administrative guidance, providing technical assistance and outreach, and leveraging research resources.

**Supporting Older Adults and their Caregivers:** The Budget includes \$60 million, an increase of \$21 million over FY 2010, to help seniors live in their communities without fear of abuse, and includes an increase of \$96 million for caregiver services, like counseling, training, and respite care, to enable families to better care for their relatives in the community. The Budget also proposes to transfer to the Administration on Aging (AoA) a Department of Labor program that provides community service opportunities and job training to unemployed older adults. As part of this move, a new focus will be placed on developing professional skills that will enable participants to provide services that allow fellow seniors to live in their communities as long as possible.

**Reauthorizing the Older Americans Act:** For more than 45 years, the Older Americans Act (OAA) has enjoyed broad, bipartisan support. The programs supported by the Act provide community-based supports that assist families caring for their loved ones and help seniors stay in their homes for as long as possible. Over the past year, nearly 11 million seniors and their family caregivers have been supported through the OAA's comprehensive home and community-based system. Most funding under the Older Americans Act is directed to State units on aging which, in turn, send funding to local area agencies on aging. Funding is also provided by formula to tribal organizations. These local agencies partner with service providers and volunteers in their communities to provide services to seniors. These services complement the health care system by helping to prevent hospital readmissions, providing transportation to doctors appointments, and supporting some of life's most basic functions, such as assistance to elders in their homes including delivering or preparing meals and helping them with bathing. These services are especially crit-

ical for the nearly three million seniors who receive intensive in-home services, half a million of whom meet the disability criteria for nursing home admission but are able to remain in their homes, in part, due to these community supports.

The reauthorization of the Older Americans Act provides us with the opportunity to work with this Committee to strengthen and build upon a long record of success in serving our families and communities. To support this process, over the past year the Administration on Aging conducted the most open system for providing input on recommendations for reauthorizing the Older Americans Act in its history, convening and receiving reports from more than 60 reauthorization listening sessions held throughout the country, and receiving online input from interested individuals and organizations, as well as from seniors and their caregivers. This input represented the interests of thousands of consumers of the OAA's services.

Based in part upon this extensive public input process, we think that reauthorization can strengthen the Older Americans Act and put it on a solid footing to meet the challenges of a growing population of seniors. We look forward to working with the Committee on bipartisan reauthorization legislation. The following are some examples of areas that we would like to discuss with the Committee as you consider legislation:

- Ensuring that the best evidence-based interventions for helping older individuals manage chronic diseases are utilized. A number of evidence-based programs have been shown to be effective in helping participants adopt healthy behaviors, improve their health status, and reduce their use of hospital services and emergency room visits.
- Improving the Senior Community Service Employment Program (SCSEP) by integrating it with other seniors programs. The President's budget proposes to move this program from the Department of Labor to the Administration on Aging within HHS. The goal of this move is to better integrate this program with other senior services provided by the Older Americans Act. We would like to discuss adopting new models of community service for this program with you, including refocusing the program to better integrate seniors into their communities through real community service employment serving other seniors, which enables both to stay in the community longer.
- Combating fraud and abuse in Medicare and Medicaid by embedding the Senior Medicare Patrol Program (SMP) in the OAA as an ongoing consumer-based fraud prevention and detection program. The SMP program serves a unique role in the Department's fight to identify and prevent healthcare fraud by using the skills of retired professionals as volunteers to conduct community outreach and education so that seniors and families are better able to recognize and report suspected cases of Medicare and Medicaid fraud and abuse. In FY 2009, the program educated over 215,000 beneficiaries in over 40,000 group education sessions and one-on-one counseling sessions, resolving or referring for further investigation over 4,000 complaints of potential fraud, error, or abuse.

#### *Transform Health Care*

The 2012 budget gives Americans more and control over their health care choices, so they can get affordable, high-quality care when they need it.

**Expanding Access to Coverage and Making Coverage More Secure:** The Affordable Care Act expands access to affordable coverage to millions of Americans, strengthens consumer protections and ends some of the worst insurance company abuses. These reforms create an important foundation of patients' rights in the private health insurance market and put Americans in charge of their own health care. As a result, we have already implemented important private market reforms including eliminating pre-existing condition exclusions for children; prohibiting insurance companies from rescinding coverage and imposing lifetime dollar limits on coverage; and enabling many adult children to stay on their parent's insurance plan up to age 26. The Affordable Care Act also established new programs to lower premiums and support coverage options, such as the Pre-Existing Condition Insurance Plans Program and the Early Retiree Reinsurance Program. The Act provides Medicare beneficiaries and enrollees in private plans access to certain covered preventative services free of charge. Medicare beneficiaries also have increased access to prescription drugs under Medicare Part D through provisions in the Act that close the coverage gap, known as the "donut hole," by 2020 so that seniors no longer have to fear being unable to afford their prescriptions. Medicare beneficiaries are also eligible to receive an annual wellness visit free of charge.

Beginning in 2014, State-based health insurance Exchanges will create affordable, quality insurance options for many Americans who previously did not have health insurance coverage, had inadequate coverage, or were vulnerable to losing the coverage they had. Exchanges will make purchasing private health coverage easier by

providing eligible consumers and small businesses with “one-stop-shopping” where they can compare a range of plans. New premium tax credits and cost-sharing reductions will also increase the affordability of coverage and care. The Affordable Care Act will also extend Medicaid coverage to millions of low-income individuals who were previously not eligible for coverage, granting them access to affordable health care.

**Ensuring Access to Quality, Culturally Competent Care for Vulnerable Populations:** The Budget includes \$3.3 billion for the Health Centers Program, including \$1.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund, to expand the capacity of existing health center services and create new access points.

**Improving Health Care Quality:** The Affordable Care Act contains numerous provisions designed to ensure that patients receive safe, high quality care. Innovative payment and delivery reforms such as bundled payments for a single episode of care and the formation of Accountable Care Organizations will promote better coordinated and more efficient care. New value-based purchasing programs for hospitals and other health providers will reward those who deliver high quality care, rather than simply encouraging a high volume of services. The new Center for Medicare and Medicaid Innovation (“Innovation Center”) will design, test, and evaluate new models of payment and delivery that seek to promote higher quality and lower costs. Similarly, the new Centers for Medicare & Medicaid Services’ (CMS) Federal Coordinated Health Care Office will complement these efforts to provide higher quality and better integrated care for those who are eligible for both Medicare and Medicaid. **Reducing Health Care Costs:** New innovative delivery and payment approaches will lead to both more efficient and higher quality care. For example, provisions in the Affordable Care Act designed to reduce health care acquired conditions and preventable readmissions will both improve patient outcomes and reduce unnecessary health spending. The Innovation Center, in coordination with private sector partners whenever possible, will pursue new approaches that not only improve quality of care, but also lead to cost savings for Medicare and Medicaid. Rate adjustments for insurers participating in Medicare Advantage will promote greater efficiency in the delivery of care. Meanwhile, new rules for private insurers, such as medical loss ratio standards and enhanced review of premium increases, will lead to greater value and affordability for consumers.

**Combating Healthcare Associated Infections:** HHS will address healthcare associated infections through the hospital value-based purchasing program, as called for in the Affordable Care Act. In addition, the FY 2012 Budget includes \$86 million—of which \$20 million is funded through the Prevention and Public Health fund—to the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), and the Office of the Secretary to reduce healthcare-associated infections. In FY 2012, HHS will continue research on health-care associated infections and tracking infections through the National Healthcare Safety Network. HHS will also identify and respond to new healthcare-associated infections by conducting outbreak and epidemiological investigations. In addition, HHS will implement, and ensure adherence to, evidence-based prevention practices to eliminate healthcare-associated infections. HHS activities, including those that the Innovation Center sponsors and hospital value-based purchasing, as called for in the Affordable Care Act, will further the infection reduction goals of the Department’s Action Plan to Prevent Healthcare-Associated Infections.

**Health Services for 9/11 World Trade Center Attacks:** To implement the James Zadroga 9/11 Health and Compensation Act, the FY 2012 Budget includes \$313 million in mandatory funding to provide medical monitoring and treatment to responders of the September 11, 2001 World Trade Center attacks and initial health evaluations, monitoring, and treatment to others directly affected by the attacks. In addition to supporting medical monitoring and treatment, HHS will use funds to establish an outreach program for potentially eligible individuals, collect health data on individuals receiving benefits, and establish a research program on health conditions resulting from the World Trade Center attacks.

**Stabilizing Medicare Physician Payments:** In December, the Administration worked with Congress to offset the cost of legislation preventing an imminent decrease in physician payment rates due to the Medicare Sustainable Growth Rate (SGR) formula. The Budget goes further and proposes to continue the current level of payment, and offset the increase above current law for the next two years with specific savings. Beyond the next two years, I am determined to work with you to put in place a long-term plan to reform physician payment rates in a fiscally responsible way, and to craft a reimbursement system that gives physicians incentives to improve quality and efficiency, while providing predictable payments for care furnished to Medicare beneficiaries.

*Advance Scientific Knowledge and Innovation*

**Accelerating Scientific Discovery to Improve Patient Care:** The Budget includes \$32.0 billion for the National Institutes of Health (NIH), an increased investment of \$745 million over the FY 2010 enacted level, to support innovative basic and clinical research that promises to deliver better health and drive future economic growth. In FY 2012, NIH estimates it will support a total of 36,852 research project grants, including 9,158 new and competing awards.

Recent advances in the biomedical field, including genomics, high-throughput biotechnologies, and stem cell biology, are shortening the pathway from discovery to revolutionary treatments for a wide range of diseases, such as Alzheimer's, cancer, autism, diabetes, and obesity. The dramatic acceleration of our basic understanding of hundreds of diseases; the establishment of NIH-supported centers that can screen thousands of chemicals for potential drug candidates; and the emergence of public-private partnerships to aid the movement of drug candidates into the commercial development pipeline are fueling expectations that an era of personalized medicine is emerging where prevention, diagnosis, and treatment of disease can be tailored to the individual and targeted to be more effective. To help bridge the divide between basic science and therapeutic applications, NIH plans to establish in FY 2012 the National Center for Advancing Translational Sciences (NCATS), of which one component would be the new Cures Acceleration Network. With the creation of NCATS, the National Center for Research Resources will be abolished and its programs transferred to the new Center or other parts of NIH.

**Advancing Patient-Centered Health Research:** The Affordable Care Act created the Patient-Centered Outcomes Research Institute to fund research and get relevant, high quality information to patients, clinicians and policy-makers so that they can make informed health care decisions. The Patient-Centered Outcomes Research Trust Fund will fund this independent Institute, and related activities within HHS. In FY 2012, the Budget includes \$620 million in AHRQ, NIH and the Office of the Secretary, including \$30 million from the Trust Fund, to invest in core patient-centered health research activities and to disseminate research findings, train the next generation of patient-centered outcomes researchers, and improve data capacity.

**Advancing Health Information Technology:** The Budget includes \$78 million, an increase of \$17 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate health information technology (health IT) adoption and promote electronic health records (EHRs) as tools to improve the health of individuals and transform the health care system. The increase will allow ONC to assist health care providers in becoming meaningful users of health IT.

**Improving Health Outcomes of American Indians and Alaska Natives:** The President is committed to improving health outcomes and providing health care for American Indian and Alaska Native communities. The Budget includes nearly \$5.7 billion, an increase of \$589 million over FY 2010, which will enable the Indian Health Service (IHS) to focus on reducing health disparities, ensuring that IHS services can be supplemented by care purchased outside the Indian health system where necessary, supporting Tribal efforts to deliver quality care, and funding health facility and medical equipment upgrades. These investments will ensure continued improvement to support the Administration's goal of significantly reducing health disparities for American Indians and Alaska Natives. **Transforming Food Safety:** The Administration is committed to transforming our nation's food safety system to one that is stronger and more reliable for American consumers. This Budget reflects the President's vision of a safer food safety system by including \$1.4 billion, an increase of \$333 million over FY 2010 for the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) food safety activities. Coupled with the enactment of the FDA Food Safety Modernization Act (the Act), which was signed into law on January 4, 2011, HHS will continue to modernize and implement an integrated national food safety system. HHS plans to work with Congress to enact additional food safety fees to support the full implementation of the Act. CDC will improve the speed and accuracy of food borne illness outbreak detection and investigation and FDA will focus on establishing preventive controls for facilities and produce safety standards for farms in an effort to avoid an outbreak of tainted food.

**Preventing and Treating HIV/AIDS:** The Budget supports the goals of the National HIV/AIDS Strategy to reduce HIV incidence, increase access to care and optimize health outcomes for people living with HIV, and reduce HIV-related health disparities. The request focuses resources on high-risk populations and allocates funds to State and local health departments to align resources to the burden of the epidemic across the United States. The Budget includes \$2.4 billion, an increase of \$85 million, for HRSA's Ryan White program to expand access to care for persons living

with HIV/AIDS who are otherwise unable to afford health care and related support services. The Budget also includes \$858 million for domestic HIV/AIDS Prevention in CDC, an increase of \$58 million, which will help CDC decrease the HIV transmission rate; decrease risk behaviors among persons at risk for acquiring HIV; increase the proportion of HIV infected people who know they are infected; and integrate services for populations most at risk of HIV, sexually transmitted diseases, and viral hepatitis. In addition, the Budget proposes that up to one percent of HHS discretionary funds appropriated for domestic HIV/AIDS activities, or approximately \$60 million, be provided to the Office of the Assistant Secretary for Health to foster collaborations across HHS agencies and finance high priority initiatives in support of the National HIV/AIDS Strategy. Such initiatives would focus on improving linkages between prevention and care, coordinating Federal resources within targeted high-risk populations, enhancing provider capacity to care for persons living with HIV/AIDS, and monitoring key Strategy targets.

**Addressing the Leading Causes of Death and Disability:** Chronic diseases and injuries represent the major causes of morbidity, disability, and premature death and contribute to the growth in health care costs. The Budget aims to improve the health of individuals by focusing on prevention of chronic diseases and injuries rather than focusing solely on treating conditions that could have been prevented. Specifically, the Budget includes \$705 million for a new competitive grant program in CDC that refocuses targeted disease-specific grants into a comprehensive program that will enable health departments to implement the most effective strategies to address the leading causes of death. Because many chronic disease conditions share common risk factors, the new program will improve health outcomes by coordinating the interventions that can reduce the burden of chronic disease. In addition, the allocation of the \$1 billion available in the Prevention Fund will improve health and restrain the growth of health care costs through a balanced portfolio of investments. The FY 2012 allocation of the Fund builds on existing investments and will align with the vision and goals of the National Prevention and Health Promotion Strategy under development. For instance, the CDC Community Transformation Grants create and sustain communities that support prevention and wellness where people live, learn, work and play through the implementation, evaluation, and dissemination of evidence-based community preventive health activities.

**Preventing Substance Abuse and Mental Illness:** The Budget includes \$535 million within the Substance Abuse and Mental Health Services Administration (SAMHSA) for new, expanded, and refocused substance abuse prevention and mental health promotion grants to States and Tribes. To maximize the effectiveness and efficiency of its resources, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more thoughtfully and strategically. SAMHSA will use competitive grants to identify and test innovative prevention practices and will leverage State and Tribal investments to foster the widespread implementation of evidence-based prevention strategies through data driven planning and resource dissemination.

**Ensuring Safety and Improving Access to Medical Products:** FDA is charged with a significant task: to protect and promote the health of the American public. To succeed, they must ensure the safety and effectiveness of the medical products that Americans rely on every day, and also facilitate the scientific innovations that make these products safer and more effective. The Administration is dedicated to this critical mission and the Budget provides \$1.4 billion for FDA to enhance the safety oversight of medical products, facilitate the development of innovative products, and establish a pathway for the approval of generic biologics thus allowing greater access to life saving biological products that are safe and effective.

**Pandemic and Emergency Preparedness:** While responding to the 2009 H1N1 influenza pandemic has been the focus of the most recent pandemic investments, the threat of a pandemic caused by H5N1 or other strains has not diminished. HHS is currently implementing pandemic preparedness activities in response to lessons learned from the H1N1 pandemic in order to strengthen the nation's ability to respond to future health threats. Balances from the FY 2009 supplemental appropriations are being used to support recommendations from the HHS Medical Countermeasure Review and the President's Council of Advisors on Science and Technology. These multi-year activities include advanced development of influenza vaccines and the construction of a new cell-based vaccine facility in order to quickly produce vaccine in the U.S., as well as development of next generation antivirals, rapid diagnostics, and maintenance of the H5N1 vaccine stockpile.

The HHS Medical Countermeasure Review described a new strategy focused on forging partnerships, minimizing constraints, modernizing regulatory oversight, and supporting transformational technologies. The request includes \$665 million for the Biomedical Advanced Research and Development Authority, to improve existing and

develop new next-generation medical countermeasures and \$100 million to establish a strategic investment corporation that would improve the chances of successful development of new medical countermeasure technologies and products by small and new companies. The Budget includes \$70 million for FDA to establish teams of public health experts to support the review of medical countermeasures and novel manufacturing approaches. Additionally, NIH will dedicate \$55 million to help shepherd investigators who have promising, early-stage, medical countermeasure products. Finally, the Budget includes \$655 million for the Strategic National Stockpile to replace expiring products, support BioShield acquisitions, and fill gaps in the stockpile inventory. Strengthen the Nation's Health and Human Service Infrastructure and Workforce

**Strengthening the Health Workforce:** A strong health care workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes \$1.3 billion, including \$315 million in mandatory funding, within HRSA, to support a strategy which aims to promote a sufficient health workforce that is deployed effectively and efficiently and trained to meet the changing needs of the American people. The Budget will initiate investments that will expand the capacity of institutions to train over 4,000 new primary care providers over five years.

**Expanding Public Health Infrastructure:** The FY 2012 Budget supports State and local capacity so that health departments are not left behind. Specifically, the Budget requests \$73 million, of which \$25 million is funded through the Prevention Fund, for the CDC public health workforce to increase the number of trained public health professionals in the field. CDC's experiential fellowships and training programs create an effective, prepared, and sustainable health workforce to meet emerging public health challenges. In addition, the Budget requests \$40 million from the Prevention Fund to support CDC's Public Health Infrastructure Program. This program will increase the capacity and ability of health departments to meet national public health standards in areas such as information technology and data systems, workforce training, and regulation and policy development.

*Increase Efficiency, Transparency, and Accountability of HHS Programs*

**Strengthening Program Integrity:** Strengthening program integrity is a priority for both the President and me. The Budget includes \$581 million in discretionary funding, a \$270 million increase over FY 2010, to expand prevention-focused, data-driven, and innovative initiatives to improve CMS program integrity. The Budget request also supports the expansion of additional Strike Force cities to target Medicare fraud in high risk areas, enhanced efforts to achieve the President's goal of cutting the Medicare fee-for-service error rate in half by 2012, and funding to support implementation of a robust set of legislative proposals to expand HHS program integrity efforts. The legislative proposals are estimated to produce \$32.3 billion in savings over ten years.

In addition, the Affordable Care Act provides unprecedented tools to CMS and law enforcement to enhance Medicare, Medicaid, and Children's Health Insurance Program (CHIP) program integrity. The Act enhances provider screening to stop fraudsters from participating in these programs in the first place, gives the Secretary the authority to implement temporary moratoria on enrolling new providers or suppliers in fraud hot spots, and increases law enforcement penalties. Additionally, the continued implementation of the Secretary's Program Integrity Initiative seeks to ensure that every program and office in HHS prioritizes the identification of systemic vulnerabilities and opportunities for waste and abuse, and implements heightened oversight.

**Implementing the Recovery Act:** The American Recovery and Reinvestment Act provides \$138 billion to HHS programs as part of a government-wide response to the economic downturn. HHS-funded projects around the country are working to achieve the goals of the Recovery Act by helping State Medicaid programs meet increasing demand for health services; supporting struggling families through expanded child care services and subsidized employment opportunities; and by making long-term investments in health information technology (IT), biomedical research and prevention and wellness efforts. HHS made available a total of \$118 billion to States and local communities through December 31, 2010; recipients of these funds have in turn spent \$100 billion by the same date. Most of the remaining funds will support a signature Recovery Act program to provide Medicare and Medicaid incentive payments to hospitals and eligible health care providers as they demonstrate the adoption and meaningful use of electronic health records. The first of these Medicaid incentive payments were made January 5, 2011. As of March 31, 2011, 660 providers received \$64 million in Medicaid incentives. More than 23,000 grantees and contractors of HHS discretionary programs have to submit reports on the status



of their projects each calendar quarter. These reports are available to the public on Recovery.gov. For the quarter ending December 31, 2010, 99.6 percent of the required recipient reports were filed timely. Recipients that do not comply with reporting requirements are subject to sanction.

*Conclusion*

This Budget is about investing our resources in a way that pays off again and again. By making smart investments and tough choices today, we can have a stronger, healthier, more competitive America tomorrow.

This testimony reflects just some of the ways that HHS programs improve the everyday lives of Americans.

Under this Budget, we will continue to work to make sure every American child, family, and senior has the opportunity to thrive.

And we will take responsibility for our deficits by cutting programs that were outdated, ineffective, or that we simply could not afford.

But, we need to make sure we're cutting waste and excess, not making across the board, deep cuts in programs that are helping our economy grow and making a difference for families and businesses.

We need to move forward responsibly, by investing in what helps us grow and cutting what doesn't.

My department can't accomplish any of these goals alone. It will require all of us to work together.

I look forward to working with you to advance the health, safety, and well-being of the American people. Thank you for this opportunity to speak with you today. I look forward to our conversation.

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Chairman KLINE. We are getting updates on votes every few minutes. It looks like the latest guess is around 10:30, so we will start with questions and go until we get called to vote.

I know there are going to be a lot of questions about health care, and I am tempted to jump in and start asking those, but I want to go in a little bit different direction, Madam Secretary. The most recent Head Start impact study says that "the advantages children gain during their Head Start, and age 4 years, yielded only a few statistically different differences in outcomes at the end of first grade for the sample as a whole."

Can you expand that at all? Have you been looking into that?

And then, as a follow-on, I will just get them both out there—again, the latest Head Start impact study states that there was no strong evidence of impact on children's language, literacy, or math measures at the end of kindergarten or at the end of the first grade.

Can you tell us what you are doing to get at that? It is a vexing problem we have been looking at for a long time.

Secretary SEBELIUS. Well, Mr. Chairman, I think that we certainly share the goal of making sure that both the child development and the early learning skills are focused on in all of our child care and early education programs, and Head Start is key among them. Early Head Start and Head Start continue to show improvements in child development and in learning skills. But how long they last into the school life continues to be determined.

So we are continuing to take that information very seriously, as I said in my opening statement, to revamp both teacher training, to upgrade the quality standards, to make sure that we are reanalyzing the curriculum, the core curriculum in child care. But I think studies continue to show that early learning programs do make a significant difference, and 3-year-olds who spend a year in Head Start have a significantly different impact when they go into

grade school than those who don't. What we need to do is continue that progress once they hit school.

Chairman KLINE. Let me follow up just a little bit. I think that probably everybody on this committee has observed and would agree that early learning is helpful.

But my question is specifically talking about Head Start where the quote was, "there was no strong evidence of impact on children's language, literacy, or math measures at the end of kindergarten or at the end of the first grade." So those efforts that you are undertaking, I hope are focused and will prove to be fruitful in Head Start, because I think we have been disappointed many times that the Head Start program is not really helping that many kids be ready for first grade.

Secretary SEBELIUS. Well, I would say, Mr. Chairman, we have an unprecedented effort underway right now with the Department of Education, where we are working closely with them to kind of align standards to make sure that the early childhood programs run by the education system have the developmental aspects that I think have been a component of Head Start, and that the Head Start programs have the curriculum-based component that often were more focused on in the education programs.

We think that regardless of where a parent chooses as an appropriate out-of-home placement for their child, whether it is child care or Head Start or Early Head Start or a public pre-K program, we should have the same goals and the same alignment of initiatives.

So we are taking those issues very seriously. We think school readiness has to be an important component of Head Start, and we continue to upgrade the programs.

We are also recompeting programs that have the lowest 25 percent of the impact on children. We think that is an important aspect, to make sure that we continue to drive improvements and not just continue to fund programs because they have historically had funding.

Chairman KLINE. Thank you.

I am going to move to another subject quickly. Your Agency administers the early retiree insurance program, which provides money to employment-related retiree benefit plans. An HHS report dated March 31, 2011, said the program which was supposed to last until 2014 had already spent \$1.8 billion and is not accepting new applications as of the end of April.

This is troubling on a number of levels. I would like to know if it is true that one plan sponsor, the United Auto Workers Retiree Medical Benefits Trust, received \$207 million, or 11.5 percent of the total amount paid by the program?

During the plan approval process, did this plan have to demonstrate or prove that it needed taxpayer funding to pay claims to maintain solvency? I have another number of questions relating to this, but I think you can see the point; we are concerned how the decisions are made or how this money is awarded. Can you address that specific question?

Secretary SEBELIUS. I would be glad to, Mr. Chairman. I can't answer with specificity about the UAW plan. I will be glad to give you the written answer to that.

Chairman KLINE. Would you, please?

Secretary SEBELIUS. I just don't have those facts off the top of my head. But this program has been enormously both popular and helpful, I think, to those companies and programs who wanted to continue their early retiree coverage. We have seen employers consistently dropping that coverage over a period of time and, in fact, one of the largest growing groups of uninsured in America were the 55 to 65 years old who had retired early, and they and their spouses often lost that employer-based coverage when those plans got too expensive.

This program was widely advertised, announced. There was a process where applications were accepted universally. They had to present documentation to our office. It wasn't our office picking and choosing who got in. The programs qualified if they met the statutory qualifications. And the way this works, Mr. Chairman, is individual claims are presented that rise above the threshold. So it is a stop-loss policy, if you will, for early retiree programs.

The most expensive claims are presented and they are paid. We share 80 percent of those costs. So we give employers some ability to predict their costs going forward, and that has actually stabilized the early retiree plan. So plans are not being paid from a presumptive pipeline; we are actually paying after the fact, as claims are being presented. And we would be happy, again, to share the documentation of how that is working. It is paid at 6 months. After the claim is made, they come in and the money goes out the door.

Chairman KLINE. Okay. I will present some questions for the record.

Secretary SEBELIUS. Sure, be glad to.

Chairman KLINE. The example looks like we are going to run out of money. And have you requested that money in the Presidents's budget and so forth? I will present those for the record.

Secretary SEBELIUS. I would be glad to answer that.

Chairman KLINE. I recognize Mr. Miller.

Mr. MILLER. Thank you very much. Just on the chairman's earlier discussion on Head Start, I don't know the study he is referring to, but I know on previous studies the question that had to be requested was what was the quality of the program the child was entering into in kindergarten or first grade?

We know that many of these children and, unfortunately, the poor performing schools, the poorer schools in our country, they can lose a whole year over the summer. And so the idea that—you know, it is what do you follow on with after Head Start that has to be determined. But I would be glad to look at the studies. But I know in the past that has been a significant impact on what happens to children afterwards.

I want to turn to part of the the Affordable Care Act that I had a chance to participate in in my district last month, and that was the Partnership For Patients Initiative, which is really about, as I witness this, is this is an effort to try to reduce medical errors to improve care, to stop the accidents that take place, improve the sanitary nature of a hospital, from washing your hands to a whole range of things that were popularized, I think to some extent, by

Gawande, and making of the list before surgery and what you should be thinking about when you are doing that.

I was quite surprised at the range of support for this program from the Chamber of Commerce, the Business Roundtable, that after the event the profits, the nonprofits, and public facilities all wanted to say how do we get to participate in this? And in the San Francisco Bay area, it is quite an array of hospitals, from the most successful nonprofits to a Kaiser system of a prepaid nature and then the public facilities.

My understanding is that there is about 90—somewhere, 95-98,000 people who die in the care of hospitals or shortly, thereafter as a result of errors and mistakes that are made; in the facility that we visited, a question of hand-washing all of the time as you move from room to room and from facility to facility.

They had a simple plan of putting bright red tape behind the head of the bed so that those who are on respiratory assistance, or the bed is kept at 30 degrees, a dramatic reduction in pneumonias in that facility. People who are susceptible to slips and falls now have to wear very bright red socks and slippers so that people are aware of that. Slips and falls have gone down about 50 percent. It has just ricocheted through the system in terms of the improvement in the outcomes in that facility.

I think your Agency has said that we look for a savings down the road of about \$50 billion under this initiative, but it is very clear from people who are paying the bill, the employers and others who are participating in this, that there is a pretty big bet being placed on improving these outcomes. There was a piece in the Wall Street Journal last week that, even with all of the admonishment, as medical staff moves from space to space, there is—over a vast majority of them are still not washing their hands.

Those of us who have visited the veterans facility know every time you move between one space to another, whether you have touched anything, you have to go through the sanitizing of your hands as you move around that facility.

And I would just like your comments on this because this seems to me, given the people who are rushing forward to say we haven't yet been able to participate, who want to participate in this program.

Secretary SEBELIUS. Well, Congressman Miller, we have had enormous enthusiasm and excitement, as you have indicated, across the range of not only health care providers but employers, business groups, patient advocates. We do have about 100 deaths a year, but hundreds and hundreds of thousands of people are injured. And, in fact, the most recent study said that one out of every three Americans who goes into a hospital is injured by care that they receive in the hospital.

That is a very large number and it not only causes enormous injury and death, but it costs an enormous amount of money that we shouldn't be spending.

In the past, Medicare has been a volume purchaser. So whether the hospital had a 60 percent infection rate or 0 percent infection rate, you basically got paid the same way.

The Affordable Care Act gives us a framework to actually begin to head in a very different direction, to use the enormous payment

system of Medicare and Medicaid to be a cost-driver to encourage value instead of volume. And we are taking that very, very seriously. So the Partnership for Patients has two very, very aggressive goals. Reduce hospital-based infections by 40 percent over the next 3 years. The ultimate goal is zero. We shouldn't be hurting people when they have to go to the hospital. That has to be our goal.

Also, reducing unnecessary hospital readmissions by 20 percent over the next 3 years. And those goals are achievable because there are pockets of that care going on right now in the country. So we are going to be providing technical assistance, be sharing best practices, helping to encourage.

But, as you say, we currently have over a thousand hospitals who have signed up. We have employer groups, we have patient advocate groups, a range of partners. And, frankly, the private sector is enormously enthusiastic. They have been trying to do this for years, but they don't have enough juice in the system. They can't touch every hospital with their purchases.

So joining together on quality outcomes not only improves care for Americans, but dramatically lowers cost and it—you know, we have two ways to lower the rising costs in Medicare. It is improving care and getting a better bang for our buck and lowering costs that way, or just cutting off benefits. And I think the Partnership for Patients gives us a real pathway to a new kind of delivery system change.

Mr. MILLER. Thank you. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman. Dr. Foxx, you are recognized.

Ms. FOXX. Thank you, Mr. Chairman. Thank you, Secretary Sebelius, for being with us.

I was interested in hearing what Mr. Miller was saying, and talking about all these wonderful things that have happened over using common sense. Just what is astonishing to me is that it has taken so long for the Department to be able to put in commonsense issues like this.

It seems the Federal Government doesn't often care about costs until our backs are against the wall, and we ought to be caring about costs every day in every program. There should be accountability in every program every day, and it is disappointing to someone like me who cherishes common sense, that it has taken so long to get to this point.

But let me get to my question now. I find it really interesting, Madam Secretary, that you and the President said over and over and over and over again that if you like it, you can keep it. You promised the American people that if they had health care, health insurance, that they could keep what they had.

But we now know that, although you promised people to be able to be grandfathered in, the regulation that you published last year found that 60 percent of employers and 80 percent of small employers will lose their grandfather status by 2014. So what you said wasn't true because you have established regulations that were not in the law to guarantee that people can't keep their health insurance.

So how do you reconcile what you promised with what you have put into effect, and the fact that that is going to cost so much more money as a result of it?

Secretary SEBELIUS. Well, Congresswoman, I first of all share your concern that common sense doesn't always drive policy.

The error report came out 10 years ago indicating we had a serious safety problem and, frankly, no one paid a lot of attention to it in the Medicare agency. And I am pleased that finally the Affordable Care Act presented the platform to allow us to have the kind of regulation in place that moves in a brand-new direction.

In terms of the insurance market, as you know, employer participation in the market is voluntary, and small business owners, and particularly individuals, move in and out on an individual basis. And you are absolutely right; the law doesn't mandate that employers who had a policy in place in 2010, when the bill was signed, must keep that policy in place. That is not part of the law, so they still have free will and free choice.

What we did do was create a platform that said basically if you keep essentially the same kind of benefit package, if you don't shift a huge amount of costs onto your employees, if you don't dramatically cut the kinds of benefits that your employees now are able to access, then you are grandfathered in under the plan.

And so it is really an employer choice whether or not the grandfather status is going to meet them on into the future or not. That is really the way the private market works. The employers come in voluntarily. They may or may not provide coverage.

We are seeing actually, I think, some good news where small employers are beginning to reenter the market for the first time in a very long time. We were on a trajectory where if you work for a small company—and I certainly saw this as an insurance commissioner in Kansas, and I heard about it over and over again when I was Governor of Kansas—that the most vulnerable people in the marketplace were folks buying individual coverage and folks, farm families, and small mom-and-pop shops who were in the small group market. And that market is beginning to stabilize, and I think that is very good news.

Ms. FOXX. But, Madam Secretary, why don't you just leave free choice out there, period? It would be up to the employers to decide what they can afford to do and it would be up to the employees to decide whether they want to go on the private market themselves. Why not allow that free choice?

You all on your side of the aisle have very limited issues on free choice.

Secretary SEBELIUS. Well, I think, again, the platform of the Affordable Care Act, Congresswoman, is that employers, particularly in the small market, have to look forward to a new, competitive, lower-cost marketplace. According to the Congressional Budget Office, they will have choices and the costs for those premiums will go down. They currently have very limited choices in the marketplace and often pay 18 percent to 20 percent more than their large competitors just because of the size of their companies. So they will be in a large pool, they will have some choices.

Individuals also will be able to purchase coverage and have some assistance purchasing that coverage if they are lower-wage workers if they don't have access to employee coverage.

So we have a market that will be framed by States around the country. That doesn't exist right now and gives a lot more choice and a lot of cost relief to the most vulnerable folks in the marketplace.

Chairman KLINE. Thank you. Mr. Kildee.

Mr. KILDEE. Thank you very much.

Madam Secretary, Head Start, when it was first authorized in 1965, placed the program in HHS rather than the Department of Education, because it was more comprehensive than just education, to include health and other social skills, among others. I was chief sponsor of the 2007 reauthorization of Head Start and we tried to enhance those purposes that we first put in in 1965.

How has the fiscal year 2012 budget helped you in your efforts to bring these programs, integrate them together, the various purposes, beyond the purpose of education in the Head Start program?

Secretary SEBELIUS. Well, Congressman, I think that the President certainly shares your belief that Head Start is a very important component of an early childhood framework for America, and that is why he has proposed an increase in Head Start funding as we move forward and the ability to serve additional children.

I think also the notion that we have a very exciting opportunity with the passage of the 2011 framework, the Early Learning Challenge Fund, which will be housed in the Department of Education but participated in by HHS and Education, which actually is a kind of a mirror of "Race to the Top" for early childhood education, driving quality initiatives, aligning the kinds of standards and giving States the opportunity to really innovate in early childhood education.

And what we are seeing around the country is that Head Start is no longer operating in a silo, but many Governors have put together broad-based early education Cabinets where the Head Start folks are very much at the table with the early childhood education folks, with the child care folks, which was almost unprecedented. And I know I did that, again, when I was in Kansas, but that is a mirror of what is happening.

I think the integration of developmental skills, one of the features of Head Start that I think is very critical, that again needs to be incorporated into a lot of early childhood programs, is involvement of parents. There is a significant parental aspect to Head Start, where they participate in a child's education at the earliest point and hopefully that continues on.

So there are a number of components which not only look at school readiness, but look at the whole developmental readiness of the child, that we are trying to improve and actually share with our partners in the education system.

Mr. KILDEE. Thank you very much, and I encourage you to encourage the Governors and those in the States to continue to do that. Thank you very much.

Chairman KLINE. The gentleman yields back.

I am going to recognize Dr. Roe in about 3 seconds. And for everybody's information, his will be the last question as we head

for the floor to vote. I am just alerting all the members of the committee.

Dr. Roe, you are recognized.

Mr. ROE. Thank you, Madam Secretary, for being here today and to let you know that my background is a physician practicing in Tennessee where we had an experiment with an expansion of our Medicaid program.

And the first question I have is how many people will the Affordable Care Act cover, do you estimate right now, it will cover?

Secretary SEBELIUS. How many new people?

Mr. ROE. Yes.

Secretary SEBELIUS. The estimates are in the 30 to 35 million range.

Mr. ROE. And it looks like that most of this expansion of coverage is just an expansion of Medicaid.

Secretary SEBELIUS. Doctor, the data that I have seen, it is estimated about half and half. About half will be exchange-eligible and about half will be Medicaid-eligible. So about 15 million are likely to be Medicaid-eligible.

Mr. ROE. Well, what CMS says is that 24.7 million will be added, an increase of 5 million, and these are Medicaid. And this is not me, this is CMS.

And CBO estimates 8 million more than we had thought. Do you agree with those numbers, what CMS said, or what the CBO said about their estimates?

Secretary SEBELIUS. Again, the numbers that I am familiar with are about half and half. So I am not quite sure what you are looking at or quoting.

Mr. ROE. I will send some—

Secretary SEBELIUS. Maybe who is uninsured; and there are a portion of uninsured that aren't assumed to be fully insured. I mean, I don't know.

Mr. ROE. Well, I will get those in written form to you.

Secretary SEBELIUS. Okay, thank you.

Mr. ROE. Do you think this bill is simple or is it complex to understand, and have you read the whole bill?

Secretary SEBELIUS. I have read the bill. I think it is very comprehensive because it deals with all aspects of the health care system.

Mr. ROE. Let me get down to just some practical aspects of it.

I have a practice that has about 350 employees, primary care doctors. We insure about 300 of them, and everybody is eligible, and we have done that for 40 years in our practice, very proudly have provided health insurance coverage, retirement, and so forth. Right now we pay about \$5,500 per employee, or somewhere—it may be up to 6,000, I haven't seen the numbers for this year.

If someone goes to the exchange and we decide to pay the \$2,000 penalty, we save ourselves and our practice a million dollars. That is one little business.

Another business in Tennessee that I have seen and talked to those folks, because we don't know what—I know someone, and this is another question I am going to have, is who defines what affordable care is, what is that, and what is in the package? This company will spend, they think, 40 million more dollars in their



business, complying with these new regulations, or they can save \$40 million by having those folks get their health insurance through the exchange.

Now, we had a very good presentation—and you probably should read this from the Lofton Group. Mr. Brewer came in, the president of Lofton Group, and went over case example after example about why that will happen. So why wouldn't I do that under this situation? And like he said, most of his clients told him, I am not going to be the first to do this, but I am not going to be third.

And, finally, what is going to happen is, you are going to have a debate between the chief financial officer and the HR people. I have done it around the table and find the chief financial people win.

So tell me why that is not going to happen?

Secretary SEBELIUS. Well, I think, Congressman, one of the things that assumes is that there is no advantage to a business owner for keeping great employees and tying those employees to the health insurance plan. And what we see right now is a voluntary marketplace where people have entered voluntarily. Your premise is based on the fact that that employer, you in this instance, or someone else, drops all employer coverage.

Mr. ROE. But if you had—if you were over 200 employees now, which we are, almost all of them provide health insurance coverage right now. And as you see reimbursements, especially in our business with Medicaid going down and with Medicare—I hope I have time to get into Medicare—why wouldn't I do that?

Secretary SEBELIUS. Well, again, I think that the exchanges are particularly being designed for small employers. You, in the instance of having the number of employees that you are talking about, are likely to be banned from initially entering the exchange because of the—

Mr. ROE. With all due respect, they can.

Secretary SEBELIUS. Pardon me?

Mr. ROE. They can. I mean, I have read this. We can do that. If one person goes in there and we decide to drop—anyway, that is fine. I am not going to get an answer.

The other question I have is Medicare I am particularly worried about because health care decisions, I believe, Madam Secretary, shouldn't be made here in Washington, D.C. They should be made between patients and their families and their doctors, not by insurance companies and not the Federal Government.

Secretary SEBELIUS. I absolutely agree.

Mr. ROE. And my concern is we have just taken \$500 billion out of an already underfunded Medicare plan, and your number is 3.5, 3.3 million people we are adding per year, that is another 30, 35 million in the next 10 years, with \$500 billion less. How does that math work?

Secretary SEBELIUS. Well, Congressman, as you have probably recognized, the \$500 billion is a reduction in the growth rate of Medicare from what is estimated to be about 7.8 percent to closer—to over 6 percent. So it is not taking money out of the program, it actually is trying to slow down the cost growth without changing any of the guaranteed benefits. And, indeed, there are additional guaranteed benefits.

I would suggest that the House-passed budget, the House Republican budget that suggested that vouchers are the appropriate goal for Medicare, and turning over Medicare patients to the private insurance market does nothing but shift enormous cost onto seniors in this country. You put an insurance company between them and their doctor.

Chairman KLINE. Madam Secretary, I hate to interrupt. Dr. Roe, the clock is demanding here. We—the committee is in recess.

[Recess.]

Chairman KLINE. The committee is called back to order.

By agreement with my colleagues, we are going to resume. I understand Mr. Miller will be joining us shortly, but I recognize Mr. Andrews for 5 minutes.

Mr. ANDREWS. Thank you, Mr. Chairman, and welcome, Madam Secretary, to the committee. It is very, very wise, Madam Secretary, to be listening to Chiquita. I would too. She is a very able and wise young lady; and from the right State, I might add.

Madam Secretary, one of the topics of the moment for the country is Medicare and how we should respond to the long-term bargain our country made with our seniors and persons with a disability in 1965. And that bargain, of course, was when the person retires or is adjudicated to have a disability, they will be guaranteed medical benefits, they will be guaranteed the choice of their own physician, and Medicare will pick up the lion's share of that bill.

And that is a system that I think has worked very well for this country for a very long period of time.

As you know, there are proposals that would, in my view, end that system. It would say to people 55 years and under that they are going to be into a very different system that is essentially a subsidy, an inadequate subsidy to buy private health insurance.

A report that Mr. Miller spoke of earlier indicates that if one takes the gap which the Congressional Budget Office has identified between the premium support that the Republican plan would offer and the real out-of-pocket costs for health care for retirees and seniors, it would be about \$6,000 a year; and for a senior to have enough money to cover that gap he or she would have to save nearly \$200,000 out of their pocket before they retire.

One interesting point of reference is that the average 401(k) balance for a person when they retire in this country is a little less than \$100,000 a year. So what that means is if you are a senior under the Republican Medicare plan, at least the one that existed until yesterday, and you emptied your 401(k), it would only make up about half of what you need to pay your out-of-pocket health care bills, additional out-of-pocket health care bills because of the Republican plan.

Now I know that before you came here your experience as Governor back in Kansas generally gave you the opportunity to be an insurance market regulator. I wonder if you could tell us what you think would happen—in addition to this financial disaster, what you think would happen to people 65 and over and people with a disability if they were thrown into the private insurance market with this kind of inadequate subsidy? What would that mean to a senior citizen or a person with a disability?

Secretary SEBELIUS. Well, Congressman, I have seen the same analysis that you have.

First of all, Medicare as a program has one of the lowest administrative costs of any health program I would suggest in the world. So we know that, according to CBO, according to any economist, that the administrative costs of an average health insurer are significantly higher. So you take the same amount of dollars and you have less buying power if you are doing it through the private market than you do through Medicare.

Secondly, to have a fixed dollar amount, as opposed to guaranteed benefits, I think is, as you suggest, a very different kind of commitment to seniors and leaves an enormous cost shift on to seniors and those with disabilities.

Mr. ANDREWS. If I could just interrupt for a minute, what might that cost shift and lack of guaranteed benefit mean for an oncology patient or a person with cancer? Give me an example of what it might do there.

Secretary SEBELIUS. Well, I think there is no question, if you take a snapshot, people will run out of money very quickly. And if you run out of the government voucher and then you run out of your own money, you are really left to scrape together charity care, go without care, die sooner. There aren't really a lot of options.

But it is estimated according to the CBO analysis that by I think it is 2030 you would have about 70 percent of the cost of medical care shifted onto individuals. A pretty dramatic—right now, it is about 25/75, and that would flip pretty dramatically. And most people—a number of people, working families and others, don't have the wherewithal to come up with that kind of cash, particularly in their later years when they are likely to have more serious and more expensive care.

Mr. ANDREWS. It is true, isn't it, that the Republican plan that was adopted by the House majority about 2 weeks ago really isn't a cost reduction plan, it is a cost shifting plan, that as health care costs go up, seniors pay more and Medicare goes away?

Secretary SEBELIUS. I think the combination of the votes on repealing the Affordable Care Act, which would not only get rid of the new tools we have to crack down on fraud and abuse but limit the closure—eliminate the closing of the donut hole, go after some of the new guaranteed benefits, combined with the voucher program, would basically destroy the commitment to ongoing health care.

As you say, one of the promises made in 1965—and a little personal anecdote—my father was actually on the Energy and Commerce Committee serving in Congress and helped write the Medicare law. He just had his 90th birthday, and he is pretty happy with those benefits right now.

Mr. ANDREWS. We will tell Mr. Dingell that.

Secretary SEBELIUS. Well, he served with Mr. Dingell, and he knows Mr. Dingell.

Chairman KLINE. So do we all.

Secretary SEBELIUS. Indeed. But I think it is a very different kind of commitment that we would be making to 55-year-olds about their future in the United States.

Mr. ANDREWS. Thank you, Madam Secretary.

Chairman KLINE. I thank the gentleman.

Mr. Walberg, you are recognized.

Mr. WALBERG. Thank you, Mr. Chairman; and thank you for joining us, Madam Secretary.

As you may probably may already know, since 1992 the National Institute for Occupational Safety and Health and National Cancer Institute have been working on a study that determined the potential health affects of diesel exhaust on miners. Members of the mining industry voluntarily provide NIOSH with access and information to conduct this study.

Initially, NIOSH agreed to share data with the companies and volunteered access and information. However, since that time, NIOSH has not honored that agreement on more than one occasion. As a result, Federal judges twice ordered NIOSH to share these materials with the concerned parties, which include this committee. Yet full compliance has yet to be seen. And so the questions I would ask, I would like to know why NIOSH has not complied with these orders of two Federal judges and would also like to know what assurances you can give me that the data will be released as required by the courts. In other words, basically, do you want NIOSH to comply?

Secretary SEBELIUS. Well, Congressman, I must confess I am not familiar with either the studies that were done or the Federal cases, but I will commit to you that I will learn about them quickly and work with you to get you the information that you have requested. I just can't respond about why they haven't done it. I am not—I wasn't aware that they had not, but it will be something that I will—

Mr. WALBERG. But if the court has ordered this, I would hope I could conclude that you would want them to comply.

Secretary SEBELIUS. Well, as I say, Congressman, I am not familiar with the situation. I will get very familiar with the situation, and I will get an answer back to you quickly.

Mr. WALBERG. I appreciate that.

Secretary SEBELIUS. Yes.

Mr. WALBERG. Moving back to the Chairman's lead-off questions with Head Start, last year, the U.S. Government Accountability Office conducted an undercover investigation of 15 Head Start programs, acting in response to tips from former and current employees at two separate Head Start centers. Undercover GAO applicants tried to enroll children in these programs and presented the centers with pay stub data that demonstrated they were above income eligibility requirements. Nine of the 15 sites enrolled the students anyway by encouraging applicants not to submit the pay stubs that would put them over the income threshold. Some of the programs continued to count students as enrolled, even though the students never actually participated in the program.

At a May, 2010, hearing before this very committee, the Assistant Secretary for Children and Family stated that the Department was taking immediate corrective action and was undertaking a top-to-bottom review of its program oversight responsibilities. So the questions I would ask are these: Can, first, you give us an update on the Department's effort to combat waste, fraud, and abuse in the Head Start program? And, secondly, how many unannounced

monitoring visits has the Department conducted since the release of the GAO report?

Secretary SEBELIUS. Congressman, I, first of all, want to tell you that I share your dismay at the GAO report and, more than the GAO report, the practices that were under way; and we do take program integrity very seriously. In fact, I have for the first time created a Secretary's Program Integrity Council which operates across all of our agencies and departments to try and actually get out ahead of any practices, any lax oversight, any issues that we should know about.

We did very quickly go into—first of all, we have had, I think I was told yesterday, 160 unannounced visits, to answer your question with some specificity; and those are ongoing efforts to make sure we are complying with that. We have conducted retraining of Head Start directors, we have issued new guidance on compliance with program integrity and guidelines, and reminded people about their legal responsibilities.

We are recompeting, as I say, the—we put out a rule about recompeting the lowest 25 percent of the program. We are conducting overall reviews and ongoing training initiatives. But we are taking this very seriously, reminding people that these are taxpayers' dollars and being used to educate some of our most vulnerable children, and we want to make sure that that is exactly where the dollars go.

Mr. WALBERG. I appreciate that, and we will look forward to receiving fuller information on that. In a time of vanishing dollars for our education systems in my State as well as your State we can't suffer this to take place, so thank you.

Secretary SEBELIUS. I agree.

Mr. WALBERG. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Mr. Payne.

Mr. PAYNE. Thank you.

Let me commend you on the outstanding job you are doing.

I think one thing we need to keep in mind is that it is great that the United States of America has moved into the nations around the world of developed countries to provide universal health care. As you know, we were one of the only developed countries in the world that did not provide it.

Let me just say about Head Start, we know it is a vital program. It helps to level the playing field for low-income preschoolers and improve academic outcomes. We know there are some problems striving towards a more perfect union, so to speak.

In your testimony, you mentioned the Department's endeavor to strengthen the Head Start program, and I commend you for efforts as well as your continued support of childhood education in fiscal year 2012 requests.

Our Republican colleagues propose a \$690 million cut to Head Start this year, as you know, which would have removed 130,000 low-income children and families from the program, closed 10,000 Head Start classrooms, and laid off 33,000 teachers and related staff. This measure is contrary to our goals of increasing employment and strengthening educational outcomes. Thankfully, this measure did not become law.

And our children, like a little fellow named Matthew in my district, sent me a constituent letter saying, Dear Congressman, it's my future, hands off Head Start funding. As a matter of fact, little Matthew had his little hand print to just keep your hands off our funding, so I have to have a meeting with him. I hope he doesn't come to a town hall meeting to run me out of the place.

So we know that it is a very important, and so I really commend the administration and support your fiscal year 2012 budget.

Let me just say, in addition to proposing cuts for Medicaid, my Republican colleagues supported a spending plan that would turn Medicaid into a block grant program. Medicaid provides health care for the most vulnerable population—the elderly, disabled, children, low-income adults. Madam Secretary, can you explain the impact of this action? Would it have become—had other beneficiaries in the States if it had gone into effect?

Secretary SEBELIUS. Well, Congressman, our analysis of the budget proposal is that, as you know, not only does it propose a block grant but there is a significant and very dramatic decrease in the funding level. So it is a fixed cap that decreases over time. And, frankly, again as a former Governor who administered a Medicaid program, one of the things that you can't anticipate is 2 years out what the economic downturn is going to do.

So just a little bit of hindsight, if we had had a block grant in place for Medicaid recipients over the last number of years and the increase in services needed based on the number of people who lost their jobs, lost their health care, needed reliance on that, I think most States would have been in a very—a more dire situation than they are right now.

As you know, the vast majority of the Medicaid population are children. The most expensive part of the population are older Americans who are poor enough to qualify for Medicare but often are in nursing homes. And you don't have a lot of—the people don't go away when the money goes away.

So I have met with mayors and some governors and county supervisors and others who find this proposal to be very alarming, because they will still deal with folks coming through the doors of emergency rooms without care. They would be dealing with people in nursing homes without the support that Medicaid currently provides for that very critical nursing home care.

What we think is a much more strategic way to deal with this is 5 percent of the Medicaid beneficiaries account for about 50 percent of the cost. They are the most chronically ill, often disabled. Many of them are getting very erratic care. They are often in two systems, Medicare and Medicaid, at the same time. And we are working very closely with States and with a proposal that is going to come out of our new center for innovations that will focus on the so-called dual eligibles and give States a lot of flexibility of using the best possible practices to coordinate care and actually drive those costs down. If we can cut those costs by 10 to 15 percent, States will save billions of dollars; and the Federal Government, frankly, will save billions of dollars.

Mr. PAYNE. Thank you very much. I don't know if I have time for another question. It is still on yellow.

Well, during the debate on H.R. 1, Republicans adopted nine riders intended to block implementation of all or components of ACA. If enacted, these amendments would have brought implementation of the ACA to a halt, eliminated benefits that people throughout the Nation are already enjoying, including many of my Republican colleagues and constituents. Can you quickly mention some of the benefits that already have been experienced as a result of ACA?

Secretary SEBELIUS. Certainly, Congressman. I mentioned the children with pre-existing health conditions, which I think is a huge step forward for families who have been struggling with that, being locked out of the insurance market for years. We have already seen the reports of just the last month are that hundreds of thousands of young adults are now covered. One of the most uninsured populations in the United States is now coming into the marketplace, thanks to the provision that allowed young adults to stay on a family policy for an extended period of time.

We know that seniors are beginning to get relief from their prescription drug benefits. A number of them got the one-time \$250 check, but this year they will have a 50 percent decrease that is going into affect; and, at the same time, they are experiencing lower rates on Medicare Advantage plans, thanks to the negotiating power that the ACA provided for us.

There is a new bill of rights for patients that ensures that new plans have preventive health care, that new oversight powers for State insurance departments to do rate reviews, the medical loss ratio goes into effect this year. So \$0.80 of every health care dollar has to be spent on health costs and not overhead and CEO salaries. Those are just kind of snapshots of what is beginning to be under way. The preexisting condition plan, where we now have 18,000 Americans who had been locked out of the market are now able to buy market-based coverage and really often in life-saving situations.

Mr. PAYNE. Thank you.

Chairman KLINE. The gentleman's time has expired.

Dr. DesJarlais, you are recognized.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

Secretary Sebelius, thank you for being here today.

Like my colleague from Tennessee, I am also a physician. Prior to coming to Congress in January, I practiced primary care medicine for the past 18 years in Tennessee and was also witness to the failed attempt at a government-run model in the State or Medicaid program, was known as TennCare. I would love to discuss that, but I think right now what is on a lot of people's minds is the issues with Medicare. So I would like to start with that.

Would you agree that Medicare is an example of government-run health care?

Secretary SEBELIUS. Congressman, Medicare provides for—

Mr. DESJARLAIS. Yes or no on that one. Is it run by the government?

Secretary SEBELIUS. Yes.

Mr. DESJARLAIS. Okay. Are you in agreement with my colleague across the aisle that said Medicare has been doing a great job for many years now, 40 plus years?

Secretary SEBELIUS. I think it has delivered essential benefits to seniors for 40 plus years, yes, sir.

Mr. DESJARLAIS. I just want to share a few concerns that have been brought forth to us in the past few months.

One of great concern is that the CBO has estimated that the program will be bankrupt in 9 years if left unchanged. So when we get challenged that our attempts to make changes to this program to secure it and protect it for future generations, sometimes I take issue with that.

Also—

Secretary SEBELIUS. You know, Congressman, the slowdown and the cost grow was estimated to add a number of additional years onto the Medicare trust fund. That was provided by the ACA.

Mr. DESJARLAIS. We are going to get into that, because we are going to talk about slowdown and cost grow. But, also, as you stated, we are entering 9,000 new members into the Medicare program each day or roughly 3.3 million per year. So we are greatly expanding the program, and we are talking about bringing down costs. And it is obvious this is a great thing. Just back from the '70s you all remember the average life expectancy was much less. We are all living 10 years longer than we were just a few years ago. But that also has to be accounted for. We have to pay for that. That has been occurring. Baby boomers, as we mentioned, are coming through the program now. So we have huge volume issues.

Also, it is noted that right now that an average family, average couple that makes about 43,000 a year per person has a Medicare tax liability over a lifetime of approximately \$100,000. But yet the average utilization for the same couple is about \$300,000, so we have a 3 to 1 ratio there. And all those things kind of point towards disaster, especially when we talk about bringing more people in, yet we are going to reduce cost and somehow we are going to maintain quality of care.

What would be your concerns, based on those facts I just gave you.

Secretary SEBELIUS. Well, I think that there are ways that certainly health care providers have suggested that we can reduce costs, not tamper with the guaranteed benefits, and deliver better care at the same time. And that is really the strategy of looking at the underlying rise in health care costs. Whether it is Medicare or the private insurance market or somebody whose paying out-of-pocket, the trajectory of health care costs, paying more for everything that we are doing, continues to rise at well above the rate of inflation. And yet, as you know, Doctor, in the United States our health results don't show that kind of expenditure. We are not getting the kind of health results we should get. So I think there are all the kinds of delivery systems.

Congressman Miller mentioned just one—

Mr. DESJARLAIS. I don't mean to interrupt, but we have so little time.

One of the things that was—

Secretary SEBELIUS. I would like to get you that answer in writing.

Mr. DESJARLAIS. Thank you, ma'am. I would appreciate that.



One of the plans when ObamaCare was passed on Christmas Eve in the middle of the night was that physicians were going to assume a 21 percent cut in Medicare. Is that still your intent?

Secretary SEBELIUS. As you know, the President has suggested since he came into office that the SGR has to be fixed permanently. He has proposed again in the 2012 budget that it be fixed. He has got 2-and-a-half years of offset and looks forward to working with Congress to fix it.

The SGR I think remains as a major barrier to Medicare beneficiaries, predated the Affordable Care Act, continues to be an issue that I look forward to working with Congress to fixing.

Mr. DESJARLAIS. In your testimony, I am reducing health care costs and increasing quality—you mention several times these innovation centers. You are going to pursue whenever possible new approaches that will improve quality of care and lead to savings. As I read through this, I see a lot of assumptions and theories, but I don't see anything based on fact.

What exactly are innovation centers and how can you assure the American people when the health care system as we know now is going bankrupt that we should just take a blind leap of faith is that these things are going to work?

Secretary SEBELIUS. Well, there is one innovation center umbrella, and there are already some programs that have been put out in terms of regulation. So the accountable care organizations is an opportunity for health care providers to voluntarily come together around the care delivery system focused on Medicare beneficiaries. And if indeed there are savings achieved, they get to share in those savings. If there are no savings, it is a net wash. We don't expend additional funding. There is enormous enthusiasm among hospital systems and providers groups for doing just that.

Mr. DESJARLAIS. You agree these are unproven, untested theories?

Secretary SEBELIUS. They have never existed before.

Chairman KLINE. The gentleman's time has expired. I thank the gentleman.

I am looking at the clock, and we have less than an hour before the Secretary has to leave, so I am going to be a little bit more stringent on the 5-minute clock in order to give all of our colleagues a chance to ask questions.

Mr. Grijalva, you are recognized.

Mr. GRIJALVA. Thank you, Mr. Chairman; and thank you, Madam Secretary, for being with us.

First, an acknowledgement. Then I will raise a request and just one question.

The acknowledgment is to your staff. They have been very attentive to our office, and we appreciate that very much. Some of the questions that came up regarding the waiver process in Arizona, they have been very diligent about communicating with us and giving us the information. We are very appreciative of that. We have been persistent, and they have been equally gracious, and so I appreciate that.

The concern I have is some of the proposed regulatory changes to Head Start and early Head Start. I am concerned there could be an impact on dual-language children. As you know, this group of

children, Latinos in particular, have a proportionately low enrollment in Head Start and early Head Start. As you work through those regulatory changes to diminish fraud and abuse within those programs that should be eliminated—my office looks forward to working with you so there is no unintended consequences relative to the participation of those children that desperately need to be part of that program.

Secretary SEBELIUS. We would look forward to that.

Mr. GRIJALVA. A question just for historical purposes. Talk about, if you would, talk about what you perceive to be the original objectives of the Medicaid Act.

Secretary SEBELIUS. The Medicaid Act was clearly aimed at providing health care services for some of the most vulnerable Americans. Those who are the lowest income, children, pregnant women, the disabled who qualify for Medicaid are primarily the beneficiaries of that program.

Mr. GRIJALVA. Thank you—

Secretary SEBELIUS. And a partnership with State and local government to deliver those services.

Mr. GRIJALVA. And I ask that question because those objectives continue to be I think the guiding principle behind Medicaid. But do you feel that some of the current attempts by the majority in the House to change the program by rolling back eligibility, the block grant process, making it more difficult for those vulnerable populations to get access to health care both at the State level and at the Federal level, how do they match up with those objectives?

Secretary SEBELIUS. Well, Congressman, I am very sympathetic to my former colleagues who are governors around this country and are in very tough budget times. And balancing a budget is never easy. Medicaid nationally is about 16 percent of State budgets, and it is always something to look at.

We have been very diligent, working with States, around giving maximum flexibility within the law, working on sharing the best practices. We have got a lot of new governors who have not been in that office before, and we have sent teams into 20 different States to work on what their snapshot looks like in ways to save dollars.

I think the administration is continuously committed to providing health care services to those very vulnerable populations. We want to do it in the most cost-effective and, frankly, the most high-value method possible, and that isn't going on in every State around the country. So what we can do is work with States to try and figure out ways to stretch those dollars but provide those essential services.

Because the folks aren't going to go away. If the Federal Government decides to shift costs, they just shift on to States, to local governments, and, ultimately, on to people who end up on the streets or in a jail or under a bridge because they don't have the support system that they need to stay healthy and stay productive.

Mr. GRIJALVA. Thank you.

In the collaboration with the Education Department around Head Start—because Head Start is more than education. It is a whole child program. And one of the discussions I think is important, if I may suggest, is programs like Even Start that extends

that literacy to the whole family. One of the programs that Education has indicated that they want to eliminate is part of a component that I think merits discussion.

And thank you very much. I yield back.

Chairman KLINE. I thank the gentleman.

Dr. Bucshon, you are recognized.

Mr. BUCSHON. Thank you, Mr. Chairman; and thank you, Secretary Sebelius, for being here today.

I am also a physician, cardiothoracic surgeon for the last 15 years. I have a bunch of questions, so I will try to brief.

You stated that Congressman Ryan's plan puts seniors on the open market. Are you aware that it is designed after the same type of health care plan that Members of Congress currently have? And would you call that the government putting Members of Congress onto the wide-open private health care market?

Secretary SEBELIUS. Yes. I mean, you are in a negotiated Federal Employee Health Benefit Plan—

Mr. BUCSHON. What I am saying is—

Secretary SEBELIUS. You don't have a fixed amount of money—

Mr. BUCSHON. Do I have to go to my local insurance agent with government money and pick my health care plan? Or do I have a book about this thick with a multitude of options from which I can choose that have had—let me finish—that have had negotiated rates that are competitive because to participate in a program as a health insurer you have to be competitive?

This is the same proposal that Chairman Ryan has for seniors, and it is clearly deceptive to say to the American people that this is putting seniors into an open health care market when in fact you know that that is not true.

Secretary SEBELIUS. Well, I do think it is putting seniors—right now, they can choose a doctor, they can choose a program—

Mr. BUCSHON. So can I, actually.

Secretary SEBELIUS. And do multiple—in an insurance plan, often the doctor is chosen for you, the health plan is chosen for you.

I would suggest also, though, Congressman, one of the key differences is the Federal Government is a much more generous partner to Members of Congress in the Federal employee health plan than Congressman Ryan suggests to be the seniors in the plan that they would go into. Their voucher system has a much lower buying power that the Federal employees do right now. It in fact decreases over time, according to the Congressional Budget Office. So rather than having the lion's share of the program paid for by the Federal Government, you would actually have the lion's share of the program paid for by seniors.

Mr. BUCSHON. Well, I think that is still to be elucidated, and I disagree with that premise.

Secretary SEBELIUS. That is not my analysis. That is the Congressional Budget's analysis.

Mr. BUCSHON. Let's move on.

You talk about Medicare savings and the Affordable Care Act being against future growth. And you are aware that the Medicaid proposal to the States for block granting, that what you are calling cuts is actually also savings against an unsustainable growth rate and has actually what you describe as not cuts to Medicare but

preventing further growth and that the block grants are the same thing and that it would be deceptive to say that this is actually a cut in the Medicaid program if you are calling it savings in the Medicare program under the Affordable Care Act. It is the same thing, right?

Secretary SEBELIUS. Well, the block grant is really the administration of the program which, if I understand it correctly, would get rid of the direction to protect vulnerable populations. So States basically could pick and choose who to cover and who not to cover. The fixed—

Mr. BUCSHON. Excuse me, they have that ability now, don't they?

Secretary SEBELIUS. No, sir. There are some mandatory populations in Medicaid that they cannot drop.

Mr. BUCSHON. Okay. I want to move on to is a different subject.

NIOSH is under your jurisdiction in HHS, and under certain responsibilities to the Federal Mine Safety and Health Act of 1977 they are the technical advisor to MSHA, mine safety. Recently, MSHA has proposed a new rule on coal dust limitations within underground coal mines. And my dad, by the way, was a United Mine Worker for 37 years. We have asked for the background medical information from MSHA and from others, and they have said that that is being denied by Health and Human Services because of patient privacy regulations.

And, first of all, is that true? Is that the reason why this committee—

Secretary SEBELIUS. Congressman, I really have no—you are saying this is a mine safety standard?

Mr. BUCSHON. It is a coal dust mine safety standard. They are trying to cut the standard down under MSHA.

Secretary SEBELIUS. I would be delighted to get you a full and complete answer. I really have no idea.

Mr. BUCSHON. Mr. Main also told me he would give us the medical background information on that, and we haven't seen it yet.

Secretary SEBELIUS. Mr. Who?

Mr. BUCSHON. And he is saying that that is because Health and Human Services with NIOSH is denying that because it is private health information that you can't give under HIPPA regulation. But we publish medical studies every day with groups of patients.

Secretary SEBELIUS. As I say, Congressman, I will talk to Dr. John Howard, who heads NIOSH, and get you a full answer. I don't know about the mine safety regulation.

Mr. BUCSHON. What I would appreciate is if we could get the information from NIOSH, giving all of the background on the proposed rule that they submitted to MSHA that justifies this change in a long-standing regulation which in my view has as a physician has no medical solid information that is necessary. And let me say in my district in Indiana would be devastating because of the many coal mines and others in my State would likely not be able to comply and may have to close, again resulting in a significant amount of job loss. I would appreciate that information.

Chairman KLINE. The gentleman's time has expired.

We can take that for the record. It is a follow-on question.

Secretary SEBELIUS. I would be glad to. Thank you.

Chairman KLINE. Ms. Woolsey.

Ms. WOOLSEY. Thank you, Mr. Chairman.

I thought I would take the opportunity before I ask our wonderful Secretary a question to respond to the gentleman from Tennessee in his question of how the Republicans could be challenged over their proposal to privatize Medicare.

The answer is simple. And the answer is, when their plan increases the tax cuts for the wealthiest Americans, when oil companies continue to get tax breaks and subsidies, when corporations, successful corporations, pay absolutely no taxes, they are proposing to privatize Medicare and at the same time asking seniors to take a blind leap of faith that, by privatizing Medicare, the private insurers will actually take care of the senior citizens in this country. And that is why there is so much pushback to their proposal.

So now I want to go to my question which has to do with—you mentioned, Secretary Sebelius, a healthy development of all of our children, which of course I support 100 percent. And I think part of that healthy development is ensuring that when they enter the classroom they are well, their mental and physical health is being cared for. Otherwise, these kids can't learn. They can't succeed.

Well, last week, the House voted to eliminate funding for the construction of school health centers, under the pretense of the Republican bill that there are other sources of funding laying around this country that could pay for these school health centers. So you know better than I do that 8 million children lack access to any primary health care, and they need this in order to get through school. So could you expand on the value of investing in school health systems and what that means to the future of our children and our country?

Secretary SEBELIUS. Well, Congresswoman, we are doing two things right now to expand access to coverage for children. One is to take advantage of the opportunity given by the CHIP reauthorization of 2009 to do some very extensive outreach. We think there are likely still about 5 million children who are eligible but not enrolled. So we have a very robust outreach effort going on with school districts and health care providers, using sport stars and coaches, others, to try and reach the parents and enroll those kids.

But there is no question I think that one of the most effective strategies is actually, since schools are often in the hearts of neighborhoods, that a school-based clinic not only deals with the children's health needs but often the family health needs of the neighborhood. So the Affordable Care Act designated as one of the sites for expansion of community health centers school-based clinics, which was a recognition that moving into underserved areas, outreach in a very easy way for people to access health services was often very productive and certainly for parents and children to access services together is very effective.

So I think that the funding goal of expanding the school-based health clinic footprint was a wise strategy to make sure that we are reaching into many of these underserved communities and figuring out ways to have accessible health care during the time that families would most likely be able to access health care providers.

Ms. WOOLSEY. So can you think of any pockets of funding where there are excess monies that could be—without our funding these school-based health centers?

Secretary SEBELIUS. Well, we are embarked on an expansion of the community health center footprint. Unfortunately, that got decreased a bit by the CR 2011, but we will continue I think to do that. Because community health centers actually have been proven over and over again to be enormously effective in lower-cost, high-quality preventive care. And if we want to stop paying \$0.70 out of every health dollar on chronic disease, getting to conditions very early and certainly getting to kids very early. You don't learn well if you are not healthy. You can't study in school if you are not well. So getting a productive workforce starts with having highly educated kids, and kids won't be well educated unless they are healthy.

Ms. WOOLSEY. Thank you.

Chairman KLINE. The gentlelady's time has expired, and I was so hoping the Secretary could identify one of those untouched pots of money.

Secretary SEBELIUS. If I find it, I will tell you, Mr. Chairman.

Chairman KLINE. I will hold you to it.

Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Mr. Chairman.

I would like to yield my time to my colleague, Dr. Roe.

Mr. ROE. I thank the gentleman for yielding.

Madam Secretary, I think we could have approached—and I read the bill as you did. It is a hard read. And I think we could have approached getting where you wanted to be by doing exactly one of the things you just said. Which if we go sign up the young—the children, 5 million of them I think was what you said who are currently eligible for SCHIP, the people who are currently eligible for Medicaid—and the part about the bill I like a lot is to allow your adult age children pick your number—25, 26, or 27, you could have covered almost as many people doing those two things as you are talking about doing right now with a 2,500 page bill and is so complex that nobody understands it. I just want to make that point.

I want to get into something near and dear to my heart, which is my fear of rationing of health care.

The Independent Payment Advisory Board, as you know, was not in the House version of the Affordable Care Act. It did get in the Senate version. And many of my colleagues on the other side of the aisle opposed this. How do I go answer to my constituents and to patients at home that I have been seeing that, okay, we are going get to a certain spending level, and not based on quality we are going to make a decision about how the money is spent. How is that not going to affect rationing of care in the future, when you have more services chasing fewer dollars, which is exactly the train wreck I see coming.

Secretary SEBELIUS. Well, Congressman, the way the Independent Payment Advisory Board is set up is it is 15 individuals who have to have expertise as either health care providers or health economists, experts in health who actually are forbidden by law to ration care. That is part of the statutory framework.

Mr. ROE. Let me stop you right there. Who ends up rationing it is me when I can't give it in the examining room. We have 15 bureaucrats appointed up here. It is not called rationing, but when

you get up to a certain dollar limit and you can't spend any more money, you can't provide the service. So I am in my examining—

Secretary SEBELIUS. Well, I would share your dismay about a fixed-income level, and that is exactly what the House budget proposed for Medicare. We will give you a fixed amount of money, and you figure out what services you get. That is not what the Independent Payment Advisory Board is about. It is about making recommendations for strategies, for new services, for new—

Mr. ROE. I beg to differ.

Secretary SEBELIUS [continuing]. Research and that comes to Congress. Congress has the intermediary role with—the Independent Payment Advisory Board's recommendations do not go into effect unless Congress chooses to allow them to go into effect.

Mr. ROE. They do go into effect unless we pick some other way to—

Secretary SEBELIUS. Unless you say no.

Mr. ROE. Exactly. No, unless you pick some other way not to spend the money, it is going to end up—I am certainly very familiar with NICE in England. The National Institute of Clinical Excellence is exactly the same type board.

So you would support the IPAB when most of the Congress on the House side did not support the IPAB, including my colleagues on the other side of the aisle. As a matter of fact, several of them have signed onto a bill to repeal that, because—

Secretary SEBELIUS. I do very much support the notion that we would have an independent group making recommendations about cost-effective strategies. We have it now.

Mr. ROE. It is an advisory board now.

Secretary SEBELIUS. It is an advisory board. It would continue to be the Independent Payment Advisory Board. The recommendations would come to Congress—and, again, they are not implementing medical decisions, and there is no global cap that they are working under. And, again, I—

Mr. ROE. I think we have a difference of opinion there.

A question I have on the Mini-Med plans. Why were 1,100 exemptions given? And what will happen to them after those exemptions expire? When they can't afford the government-decided plan, what happens then?

Secretary SEBELIUS. Well, Dr. Roe, the waivers are a part of keeping your plan in at least the time between now and the new marketplace in 2014. Unfortunately, lots of people have some form of coverage that often is not very comprehensive, and they are in a situation where currently in 2011 and 2012 and 2013 something is better than nothing.

So the Congress directed us to take a look at the one provision of the plan that talks about getting to an annual limit that would cover comprehensive medical expenses, but suggesting that if indeed a plan can't meet that annual limit without major disruption in the marketplace between now and 2014 when there is a new exchange, a new opportunity to buy a comprehensive policy at lower cost, that we should indeed look at waivers.

And basically 97 percent of the folks who came in the door who gave us the documentation saying we can't get to this point because we have such, frankly, low coverage and modest applicability

we decided that some coverage was better than no coverage. And those plans will not exist after 2014.

Mr. ROE. I yield back. I recommend you read this.

Chairman KLINE. The gentleman's time has expired.

Mrs. DAVIS, you are recognized.

Mrs. DAVIS. Thank you, Mr. Chairman; and thank you, Madam Secretary, for being here today and for your service as well.

As you are aware, this week the majority singled out and cut funding to create insurance exchanges where Americans could go to buy affordable coverage without discrimination. And we know in California—and thanks to Governor Schwarzenegger in this—California has been one of the first States really to get out of the gate essentially to establish the exchanges. So when it comes to States like California that are already in the middle of this process, what kind of difficulties do you see as a result of cutting off the funding that this action would actually cause?

I am also wondering how the effort would block funding for health exchanges across the country. Would there be some delays and what impact is it likely to have on reducing the number of uninsured Americans?

Secretary SEBELIUS. Congresswoman, if the provision passed by the House would be passed by the Senate and signed into law by the President, I don't think there is any question that there would be serious inability of States to move forward with creating a new marketplace, particularly for small business owners and individuals who currently are not only paying more but many of them are uninsured.

We are actually working with governors around the country to set up State-based exchanges and the resources are being used to do everything from planning to put together IT systems so that you would have a seamless way to come into a market as an uninsured American, with the goal being that every American should have available, affordable health insurance. Whether you end up as a Medicaid beneficiary in a private market, an employer market, that that is the goal to have a fairly seamless system.

Defunding the exchanges would mean that we freeze the status quo where more and more Americans every year are uninsured, where insurance rates continue to rise at an alarming rate and families and small business owners would face either increasing costs or bankruptcy for health conditions which they have no insurance to pay for.

Mrs. DAVIS. Is it anticipated that there would be a delay in this, perhaps a few years, or that they would actually be frozen in place?

Secretary SEBELIUS. Well, if the funding goes away, I really don't know—take the case of California—how indeed California would put together an exchange system that would be operational by 2014. So I think it stops the process unless they find some of that money that we are looking for to fund the school-based health clinics that we haven't found yet. If that appears, we could do this. But, absent that funding stream, I think most States would just stop working on the exchange program.

Mrs. DAVIS. Thank you very much. I appreciate that.

I think that we want—at least in California I know they are continuing to have these intense discussions, as you noted earlier, in



terms of the accountable care organizations and others. It certainly is impacting those discussions, but we are hoping that they at least will continue to have them.

I wanted to also just mention briefly the disease prevention issues that we are all I think very concerned about. Certainly singling out the national diabetes prevention program as well, building on evidence-based methods, give individuals at risk guidance on how to prevent type II diabetes. That is eligible for funding from the Prevention and Public Health Fund at HHS. And so are you saying that this issue is really going to be established as a national priority in many ways? And how does that dovetail with the work that you are doing with this?

Secretary SEBELIUS. Well, I don't think there is any question that the historic investment in the prevention fund is one that we see yielding significant dividends as you go forward.

Again, the snapshot right now is \$0.70 out of every health dollar is spent on dealing with chronic disease. If we indeed can lower the smoking rate, if we can have a healthier population heading into their 50s and 60s by significantly making a dent in everything from diabetes to heart disease, we will have dramatic impact on not only the health costs of this country but on the health of this country.

So lower costs, better health is the goal of the prevention fund. And we have some very exciting programs under way across this country in tribes, in farm communities, in cities that are really looking at measurable ways to change behavior, to change practices, knowing that that is an enormously important step. If we can have a healthier population, invest in primary care and prevention, we wouldn't be spending the dollars that—

Mrs. DAVIS. As a member of Armed Services, it is also a national security issue.

Chairman KLINE. The gentlelady's time has expired.

Mr. Ross.

Mr. ROSS. Thank you, Mr. Chairman.

Madam secretary, thank you for being here.

I want to address health care and jobs, because we note that with the mandates that are in the Patient Protection and Affordable Health Care Act there is going to be some burdens put on employers here. Specifically in the area of service industries in the last 10 years they have been the most predominant and most productive types of jobs we have seen in Florida—agriculture, retail, restaurants, hotels—intensely labor but low profit per employee.

My concern is that that when we understand there is going to be a per employee cost of about \$2,000 for health care that is going to be have to be provided by these employers, these employers may not be able to continue to either keep the employment that they have, won't be able to expand. While I appreciate that in the Act there are exemptions for employers with 50 or fewer employees, my specific question is, would you consider exemptions based on a low profit per employee?

Secretary SEBELIUS. Well, Congressman, we are working within the framework of the law, but my experience is that, currently, most employers who talk to me and particularly most employers

who are struggling in the marketplace find health insurance to be the best way to keep talented employees—

Mr. ROSS. I agree. But when it becomes a cost that exceeds what the market will bear, they are either going to have to release employees or scale back their time.

Secretary SEBELIUS. But right now they are competing against folks who often are playing on an unlevel playing field. Often, the big employers can find health benefits, and they are losing their best workers going down the street or around the corner. I would suggest this creates a framework, and the lowest income employees actually gets help with subsidies in the exchange program that they currently don't have. So it is kind of a win/win.

Mr. ROSS. You think then that the lower employees—the lower-income-earning employees? But if it is mandated that the employer provide the coverage and their coverage is \$2,000 per employee and they only have a margin of \$2,400 per employee, that margin is going to be reduced to \$400. So these are the businesses that will be most concerned about the impact of this care, this Act.

Secretary SEBELIUS. Again, I am not sure we are talking about a large employer who—

Mr. ROSS. It would have to be more than 50.

Secretary SEBELIUS. If a large employer is not providing coverage and has an employee who then takes access of the coverage in the exchange, there will be an employer contribution to help pay the taxpayer burden that is being picked up. A small employer will be able to participate in the exchange and have an opportunity to get lower cost coverage for employees that they are not covering right now.

Mr. ROSS. Let's talk about the exchange for a second. Because I appreciate the fact that, as a former insurance commissioner, you understand the dynamics of insurance and the markets of insurance. And of course the private companies sell insurance for a reason, to make a profit, but they do so with private capital. That is what is going to back the risk that they insure. And that capital is global. They get it from certain areas. They don't consolidate their risk, and it is actuarially assessed in terms of their risk.

But when the government gets in the business of insurance, they don't have that capital. What they have is assessments and taxes with which to go after to satisfy any claims. Unfortunately, in the assessment of that risk, it is more politically assessed, as opposed to actuarially assessed.

So that being said, would you not agree then that when the government gets in the business of insurance that what they are putting at risk are taxpayer dollars and assessments as opposed private capital that is spread globally?

Secretary SEBELIUS. I would say there is certainly more taxpayer dollars involved in the government-based plans, but I would also suggest that private insurers right now participate actively in Medicare Advantage programs. Most States run their CHIP programs through the private market. They are Medicaid beneficiaries. So there is not a line drawn between government plans and the private market.

Mr. ROSS. There is, though; and I think that is something we have to talk about. If we are going to talk about health insurance,

because our President said at the outset of his lobbying on this bill that we had a health insurance crisis. And, as you know, each State under the McCarran-Ferguson Act regulates their insurance market. We have got fewer insurance companies in the State of Florida because of mandates in Florida, fewer in Alabama, but yet we have over 1,200 insurance companies who want to sell throughout this country. Would you not agree then that for consumers, for a market that wants to be based on capital and not taxpayer dollars supporting it, we should open up the barriers and allow for the interstate sale of health insurance?

Secretary SEBELIUS. Congressman, as you know, companies can now sell in any State that they want. They have to be licensed by the State and have to follow the State laws, but—

Mr. ROSS. But they have a different mandates. In other words, you have got 51 mandates in Florida. You may have three in Alabama. You may have so many more in Pennsylvania.

Secretary SEBELIUS. The elected legislators in Florida pass laws that the governor signed. That is the Florida—

Chairman KLINE. The gentleman's time has expired.

Mr. SCOTT. Thank you, Mr. Chairman.

Madam Secretary, just a quick civil rights question. Is it possible for any sponsors of programs run in your Department of private organizations to get grants to run programs to discriminate based on religion? That is to say, you would have been a good applicant for this job, but we don't hire people of your religion. Is that possible?

Secretary SEBELIUS. To my knowledge, that would violate the civil rights umbrella that we operate under, Congressman.

Mr. SCOTT. So that if a faith-based organization were running a program and said we don't hire Catholics, Jews, or Muslims, you wouldn't think they could get funded under your administration, do you?

Secretary SEBELIUS. To my knowledge, no.

Mr. SCOTT. Thank you. Under the essential benefit definition of—under the ACA, it is my understanding that the Institute of Medicine is currently working on recommendations.

In terms of children, the EPSDT program under Medicaid is considered a good standard for care for children. Would it be your recommendation that that be the essential benefit package for children under policies under ACA?

Secretary SEBELIUS. Well, Congressman, the way that actually the essential benefit portion of the discussion is framed in the ACA, there are multiple steps. The Department of Labor has just given us the results of a survey that they did on private-market plans, the typical benefits in a private-market plan, looking at large employers and small employers. So that is a step mandated by the law.

What the Institute of Medicine is doing is sort of step two, which is looking at the process for putting together an essential benefit package and how often that criteria would be updated.

Step three is really for HHS then to do extensive listening and outreach to everybody from provider groups to disease groups to patient advocates in terms of getting input on what an essential benefit package should look like, and then a rule will be promul-

gated. So IOM is actually really more on the process side. They are not doing the health benefits side.

Mr. SCOTT. The EPSDT package of benefits, do you consider that something worth recommending?

Secretary SEBELIUS. Well, I think it certainly sets a standard for an effective package for children; and, currently, the Affordable Care Act would say that the preventive care that is offered needs to be part of all insurance policies going forward if it is recommended as part of the prevention protocol.

Mr. SCOTT. The GOP budget makes certain spending cuts—Pell Grants, education, transportation like high-speed rail, law enforcement, Food and Drug Administration—a list of cuts that total about \$800 billion, which they totally offset with extending tax cuts for that portion of your income over \$250,000. So that is a complete wash.

All of their net savings come from Medicare and Medicaid, cuts in those program. Are you familiar with their little voucher program, with the voucher program in the Medicare?

Secretary SEBELIUS. In the Medicare proposal, yes, sir.

Mr. SCOTT. Does it provide any limit on what the private industry can charge?

Secretary SEBELIUS. Not to my knowledge. I haven't seen the underlying details. Maybe they exist, but I haven't at least seen them. I have seen the outlines.

Mr. SCOTT. Do you know if there is any guaranteed issue if you get one of these vouchers that you can actually buy some insurance somewhere?

Secretary SEBELIUS. There is, I think, a limitation—a ban on eliminating people because of pre-existing conditions, but whether or not the dollar amount itself would allow you to buy a plan, I don't know.

Mr. SCOTT. If you can't afford it, are there any subsidies to help you buy the insurance?

Secretary SEBELIUS. There are, if I understand it correctly, additional resources available to the lowest income. So there is some sliding scale that would increase the buying power of the voucher depending on income.

Mr. SCOTT. As I understand it, when it starts off, the senior citizens will be paying about \$6,000 more of their income towards this policy, and after about 10 more years it gets up to about \$12,000, which would be about half the average Social Security check; is that right?

Secretary SEBELIUS. Yes, I think there is a dramatic shift of costs onto seniors.

Mr. SCOTT. Thank you, Mr. Chairman.

Chairman KLINE. I thank the gentleman.

Mr. Gowdy.

Mr. GOWDY. Thank you, Mr. Chairman.

Madam Secretary, do you believe the commerce clause has sufficient elasticity to allow Congress to mandate individuals purchase health insurance?

Secretary SEBELIUS. I try not to practice law without a license, but I have listened closely to our legal team, and I think they believe strongly that the bill stands on solid constitutional grounds.

Mr. GOWDY. You would have to believe that or you wouldn't be able to support the President's health care reform, right?

Secretary SEBELIUS. That is correct.

Mr. GOWDY. And because you believe that, you also would necessarily have to believe that Congress can also pass medical malpractice reform because we would use that same commerce clause. And I found it instructive that this administration has not proposed any medical malpractice reform, so perhaps we can take this opportunity and identify what medical malpractice reform initiatives you would support.

Secretary SEBELIUS. Actually, Congressman, that last statement is not accurate. The President asked me during the course of the health care debate to actually use the powers that have been with HHS for a period of time to put in place some targeted programs around the country.

Mr. GOWDY. I am not talking about targeted programs, Madam Secretary.

Secretary SEBELIUS. Sir, they are looking at what kind of medical malpractice actually has the following criteria: It increases patient safety, lowers liability costs.

Mr. GOWDY. Has this administration proposed specific medical malpractice reform initiatives?

Secretary SEBELIUS. I have just explained to you what is under way right now. They are actually in place.

Mr. GOWDY. Give me one. Give me a specific. Joint and several liability. Have you proposed reforming that?

Secretary SEBELIUS. Are you saying have we proposed the law to change and preempt State law?

Mr. GOWDY. Have you championed the cause of medical malpractice reform?

Secretary SEBELIUS. Actually, right now, we have across the country health care systems and court systems putting in place malpractice reforms that meet criteria to see and measure what exactly works. Because the data is pretty inclusive whether or not you can increase patient safety and lower liability rates by a variety of strategies.

So those are in place right now. They were put in place by our budget with our authority that had actually never been used before by anybody but President Obama.

Mr. GOWDY. Do you support reforming joint and several liability?

Secretary SEBELIUS. Do I support preempting State law by Congress? No, sir.

Mr. GOWDY. Well, ma'am, and therein lies the issue, right. Because why would that be a preemption of State law in any greater degree than any other Federal initiative? You think if we were to reform joint and several liability that that would preempt State law?

Secretary SEBELIUS. I think State, at a time, they have taken on that issue and dealt with it, yes, sir.

Mr. GOWDY. What about a different standard of care for emergency medicine. Would you support—

Secretary SEBELIUS. I have no idea what is the different standard of care. What does—

Mr. GOWDY. There is not. So if a physician is treating someone at a ball game or at a church, doesn't know the patient history, there is no different standard by which their practice will be judged than if they had a 20-year-long history with that particular patient.

So my question is, would you support a different—

Secretary SEBELIUS. Sir, I would be delighted to look at any proposal. I think it is impossible to answer a question when I haven't seen the specifics of what is being talked about and how it would impact, but I would be happy to take a look at it.

Mr. GOWDY. I have read your comments about the debt, and I have read the President's comments about the debt, and I assume you would agree that, because you have said, that our debt is stifling. So my question is, given the fact that we agree on that, why was there no proposal for an entitlement reform in this administration's initial budget?

Secretary SEBELIUS. Well, Congressman, I would suggest that the Affordable Care Act had a significant step toward entitlement reform with a \$500 billion reduction in growth rate of Medicare. That was a big step forward. That was not supported by many in this Congress, but it was the President's first step.

I would also suggest that the IPAP proposal, which is part of the Affordable Care Act, is also another big step in terms of entitlement reform that actually doesn't potentially cause harm to our seniors but makes us make more strategic decisions about cost-effectiveness of proposals.

We are currently working on proposals around dual-eligibles, which is the most significant cost driver in Medicaid, and have a proposal under way in our innovation center where 15 States are going to be participating to see if we can really find health strategies that look at that highest-cost population. So there are significant steps under way.

Mr. GOWDY. Well, let me ask you this, because the light just went off.

If the President's initial health care reform bill was sufficient, why did he then come out with a second budget after Paul Ryan took on entitlement reform? Why did you come out with a second budget that dealt with it?

Chairman KLINE. The gentleman's time has expired.

Ms. HIRONO.

Ms. HIRONO. Thank you, Mr. Chairman and Madam Secretary.

I just would like to make a comment regarding medical malpractice reform. I would like to see the evidence that connects malpractice reform with lowering of medical malpractice insurance. There has never been—that, I don't think, has been shown; and, therefore, you know, I would like to see that evidence. Because States all across the country have enacted medical malpractice reform, and the doctors are still paying huge premiums for medical malpractice.

I think in both education and health care, early intervention and prevention are the keys. Because we save money in the long run. And that is why we should be supporting programs such as school-based health centers and Head Start and quality early education. I have been a major proponent of quality early education.

Madam Secretary, I understand that you had responded to a question regarding the third round of Race to the Top where your Department and the Department of Education will be working together to, I hope, come up with an early learning competition that is kind of like the Early Learning Challenge Fund, and so I am glad to hear that. I did send a letter to both you and our Education Secretary, Arne Duncan, to that point, and I await your response.

I want to go on to the Medicare changes that the Republicans would like to propose. During the 2 weeks that I was in Hawaii, I met with hundreds of seniors, and they are very concerned about what the Republicans have in mind for Medicare.

For one thing, they are totally astounded that they would have to wait until age 67 before they qualify for Medicare. And I know that they are thinking about when they were 65 and finally got on Medicare, health insurance, and I know that they were thinking what if we had to go 2 years to 67 without any insurance.

So then the next area that they are really concerned about is, even if they are currently on Medicare, they care about those who are under 55 who are going to be in this new plan, as the Republicans would like to enact.

So this voucher system—you responded to some questions about the voucher system, and I am not clear exactly how that is supposed to work. You are a 67-year-old senior, you get a voucher and what? What is supposed to happen? What are you supposed to do to get health insurance?

Secretary SEBELIUS. Congresswoman, I don't pretend to have all the details, but my understanding is it would essentially operate as a subsidy to purchase private insurance coverage. There would be some rules around, as I said, the limitation on pre-existing conditions, so you couldn't be locked out of the marketplace.

I don't know that there is any framework of what you could purchase with that coverage. So I assume that companies would put together packages. Somebody would make a choice about whether that package would be sufficient. I really don't know how it works.

Ms. HIRONO. Madam Secretary, thank you. Because I am wondering what kinds of packages a private insurance company will put together for 67-year-olds and older with all these pre-existing conditions, even if they cannot deny insurance because of pre-existing conditions. I am wondering whether all these private insurance companies will stand in line to put together these kinds of programs for 67-year-olds. And, in fact, when I asked that question of the hundreds of seniors that I talked to, they couldn't even—they were just—I know that they were very scared as to how this was supposed to happen.

So would you share that kind of concern that I have as to whether the private insurance industry can be counted on to come up with all these different plans that our seniors could avail themselves of?

Secretary SEBELIUS. Well, we currently have some model of the private market in Medicare space with Medicare Advantage programs that have been in operation for over a decade. On average, they are more costly than fee-for-service Medicare, with no perceptible health improvements whatsoever after 10 years.

We know that the companies have done somewhat effective jobs of doing a bit of cherry-picking in the marketplace, and I think that that is really how you make a profit in health insurance, is that you hopefully get a population that is less sick than more sick. And what I think is of great concern is that the amount of money identified as the fixed benefit nowhere nearly matches the potential cost of the services to the average Medicare beneficiary right now, much less down the road, and that buying power diminishes over time.

Ms. HIRONO. And I think that seniors across our country are understanding that with regard to the Ryan budget.

Thank you.

Chairman KLINE. The gentlelady's time has expired.

Mr. Barletta.

Mr. BARLETTA. Thank you, Mr. Chairman.

Madam Secretary, as you know, the PPACA has made significant changes to the laws governing insurance markets and employer-sponsored health care, many of which have the effect of increasing costs for employers, workers, and their families.

In an effort to pay for the new subsidy entitlement program, PPACA reduces Medicare expenditures by more than \$500 billion and imposes hundreds of billions of dollars in new taxes and penalties, which will likely raise the cost of coverage and increase the financial pressures on employers struggling to grow their businesses and create jobs.

For small business, home health care providers, this is a huge burden. I have specifically heard from my constituents about the 2.3 percent excise tax on manufacturers and importers of certain medical devices. How can you justify this tax, especially for small businesses, home care providers who work in rural areas?

Secretary SEBELIUS. Well, Congressman, I think that one of the features of the Affordable Care Act, which is different, frankly, from the Prescription Drug Act that was passed in a prior administration, is that it is paid for and it does not add to the deficit. In fact, the Congressional Budget Office has estimated that about \$230 billion in the first decade and over a trillion dollars in the second decade will be decreased from the deficit. So there are pay-fors in the bill.

I think the trade-off that you are talking about with a tax on home health manufacturers is that they are also anticipating additional customers along the way, so there is some additional revenue that will be generated and the return is that they will have access to a far more significant market, who will have, actually, the ability to pay for home health services where they don't right now.

Mr. BARLETTA. Moving on to another question, in response to questions I have received from small business pharmacists in northeastern Pennsylvania, would you be able to address the rapid refill of prescription medicine? More specifically, many in my community are concerned that prescriptions are being offered in 90-day increments by certain large-scale stores, even though their primary care physician may modify the prescription prior to its expiration. Is this a new process allowed by the Department of Health and Human Services as a result of PPACA?



Secretary SEBELIUS. I can tell that you there is no new process about prescription refills that is part of the Affordable Care Act. I don't know what is causing what you are talking about, but I would be happy to go talk to our folks and see if they have heard about it or know about it.

But there is absolutely no—nothing that has been put into effect in the year that has any impact on prescription drug refills.

Mr. BARLETTA. As a former mayor of a city in northeastern Pennsylvania, Hazleton, I have witnessed firsthand the benefits of the human services programs operated by HHS. I am specifically familiar with and interested in the Community Services Block Grant Program. The President's 2012 budget request includes a \$388 million cut to the Community Services Block Grant Program which, as you know, is geared toward anti-poverty activities.

Over the last 10 years, a number of independent studies, including those conducted by GAO, have questioned the program's effectiveness in combating poverty in local communities. In my community, the Commission on Economic Opportunity, an organization committed to combating local poverty, they use the Community Services Block Grant funding to help promote self sufficiency among low-income populations in Luzerne County.

In February, I had the privilege of meeting with the officials of this organization; and I toured their after-school program that ensures children get healthy meals throughout the year. In fact, this organization's food bank, which also assists the elderly population in Luzerne County, has provided over 4 million pounds of foods to 160 agencies over the past year.

And while I have seen the good of this program and others like it, I am supportive in finding ways to make the CSBG program even stronger. What changes do you think the committee should make to the Community Services Block Grant Program to make it more effective, and when was the last time this program was evaluated?

Secretary SEBELIUS. Congressman, first of all, let me say I would look forward to working with you to do just that. I think that there is no question at all that the reduction in funding that is being proposed is not one that would have been proposed if the budget times were better. Let me start there.

I also think that it has been our experience that the funds administered through the State and to a variety of community action agencies, some are very competent and effective, others have been less effective. And we are currently in the process of reviewing, knowing that we are likely to have diminished resources, what are the kinds of criteria to put in place that would actually drive the best practices around the country. Because I would say that the program impact has been really mixed. But we would look forward to working with you around what that strategy looks like.

Mr. BARLETTA. Thank you.

Chairman KLINE. The gentleman's time has expired.

Mr. Tierney.

Mr. TIERNEY. Thank you, Mr. Chairman.

Madam Secretary, thank you for being here today.

Let me just start with a couple of very brief questions about low-income home fuel assistance. On that, can you give me an idea of

when that money is going to be released to the States? Because we have reports of people fearing the loss of their utilities if that money doesn't get released to the States so that they can distribute it.

Secretary SEBELIUS. I am trying to get my experts back here to give me—

Mr. TIERNEY. Well, if you could give me that answer, if you can't give it to me right now, if you could get that to us when you can.

Secretary SEBELIUS. We will get it to you.

Mr. TIERNEY. Thank you.

Secretary SEBELIUS. And what we tried to do up until this moment, I can tell you, is put the money out the door as soon as we had the authorization. So I can get you the precise date that we will try to push the rest of the fiscal year 2011 money out.

Mr. TIERNEY. I appreciate that.

In the President's proposal for 2012, he proposed a 40 percent cut in those funds, premised on the idea that the costs are going to be somewhere around—somewhat lower in the future. Now the costs are back up to what they were in 2008 for oil, and they are increasing for gas. Are you going to revisit that decision?

Secretary SEBELIUS. Well, Congressman, as you know, the budget has been proposed. We would look forward to working with you.

I know it is a vital program. It was a snapshot that looked like we were in times that could return to the historic level, but I think we need to look at the challenges and that impact on particularly the low-income families who rely on it.

Mr. TIERNEY. We would appreciate that. Thank you. We will work with you on that as well.

Just a quick comment on the medical malpractice, as we do quite a bit of looking at that. Are you aware of any study at all that indicates that even if all the medical malpractice reforms proposed went into effect it would do anything more than save a minuscule fraction of the national health care costs?

Secretary SEBELIUS. Well, I think, right now, malpractice premiums are far less than 1 percent of any health care costs; and, unfortunately, the data is very erratic. States that have put in place every kind of tort reform possible and States that have no tort reform possible seem to have about the same malpractice rates. So there doesn't seem to be a corollary impact between the legal framework and what docs are paying.

It is difficult to assess and measure what defensive medicine costs. It is also, I think, very difficult to measure what a lack of patient safety costs. And those—you know, we talked about errors that occur in the medical system right now which kill about 100,000 people a year, so I think that balance is very critical.

Mr. TIERNEY. And it is a State-regulated insurance industry; is that correct?

Secretary SEBELIUS. That is correct, sir.

Mr. TIERNEY. Lastly, I do see reports, however, that draw a correlation between the return on investment from reserve funds by insurance companies and the increase in premiums. I think that would be a more appropriate place to look for some correlation; is that correct?

Mr. TIERNEY. Well, I think the malpractice market has been very lucrative.

Mr. TIERNEY. It has indeed.

The community health centers, in H.R. 1, the original proposal for the continuing resolution, there was a proposal to substantially cut the funding for those centers. It would have closed about 127 centers if it had been passed. It would have cut off about 11 million participants. It would have caused thousands of people to lose their jobs. In the end, there was a much less severe reduction in that.

But can you talk to us just for a second about the value of community health centers, what used to be a bipartisan priority? I can remember working with President Bush on this as well, how important it is or isn't to our system, and what attention we should be giving to those centers?

Secretary SEBELIUS. Well, I don't think there is any question that the current community health center footprint is an enormously important infrastructure for low-cost, high-quality delivery of health care in the most underserved rural and urban areas. The training of docs in community health centers is a terrific training ground, and over and over again they are proven to be enormously effective.

The trajectory that this administration proposed was, actually, moving from the opportunity from 20 million Americans served by community health centers to 40 million Americans, starting with the investment in the Recovery Act and moving on through the Affordable Care Act. That has taken a little bit of a bump in the road, but we still feel that having an expansion of community health centers and matching them to the most underserved area is the most effective, most efficient, most cost-effective way of getting high-quality health services to people who now have limited access to doctors.

Mr. TIERNEY. Thank you.

Let me just close with the notion that the Medicare and the Affordable Care Act reduced monies. I think we have made the point. We want to reiterate it. It would slow the growth of costs, and I note that in the Republican proposal they don't change that fact. They like the savings of those costs, and they understand that that was, in fact, addressing an entitlement by slowing the growth in costs without reducing the number of defined benefits, is that correct?

Secretary SEBELIUS. Well, that is absolutely correct. In fact, the language in the bill, as you know, re-emphasizes the fact that no defined benefit can be tampered with. So, in fact, the Affordable Care Act increased the benefits so seniors now will have the donut hole closed over time and not fall into the gap in drug coverage, will have an annual wellness benefit, will have preventive care without co-pays. So there are some significant enhancements as part of the guaranteed Medicare benefits, along with the reduction in the costs over time.

Mr. TIERNEY. Thank you.

Chairman KLINE. The gentleman's time has expired.

Madam Secretary, we have two final questioners, and we would like to allow both of them to have an opportunity. So, Mr. Rokita, you are recognized.

Mr. ROKITA. Thank you, Mr. Speaker, and thank you, Madam Secretary. I am one of the last questioners, so hopefully we will be able to respect your time. We appreciate your being here.

With regard to this medical malpractice that has popped up fairly late, of course you understand that, at least for many Americans, many of us that I represent, it is not the premium that the doctors pay that is the concern, it is the defensive medicine costs. And you have indicated that it might be a hard cost to determine.

I don't know if I agree with that. I think we have been able to determine in this country a lot of other things. And my doctor colleagues, including the two that sit on either side of me on this committee, when I asked them before they left, they say it could be anywhere between 100 and 500 billion a year in defensive medicine costs. And they do this every day, as specialists at least. So I wanted to let you know about that.

And then as a member of the Budget Committee, in case you are asked these things again, I need you to know that the plan—because you said you saw some outline of the budget but not necessarily the details—it is not a voucher. It doesn't go to the person. It goes to the insurance companies who would want to participate.

And on our Federal plan, as Dr. Bucshon was explaining, there are at least nine or so different kinds of plans depending on what part of life we are in that we can choose from. And to the extent the Congress is a microcosm of the people, generally, I really don't understand why that couldn't work.

Secretary SEBELIUS. Well, part of it is the Federal Government is paying 70 percent of the cost of your health care right now and—assuming that you are in the Federal employee benefit package. This plan is significantly less generous for a more, I would say, likely to be sick population, more difficult conditions, and the growing—it doesn't rise with the cost of—

Mr. ROKITA. No, I think that wasn't in your outline. Because if you look at our plan, we are looking for a needs test and we are calling for a risk test. Those of us who are sicker would get more of it. Those of us who need less of it, because of our stage in life or state in life, would get less of a subsidy.

Secretary SEBELIUS. But, again, according to the Congressional Budget Office, it is significantly less buying power than Medicare provides right now for seniors. And, actually, the buying power decreases over time, again, according to the Congressional Budget Office. And they are saying 10 to 15 years out 70 percent of the costs of health care would be borne by the seniors themselves, not the—

Mr. ROKITA. Right, but you come from State government like I do. I was part of the executive branch of the Indiana government. And so, you know, I come to this place not believing everything CBO says, especially how they are chartered. They are only allowed to look at exactly what is put in front of them. And so we both know—

Secretary SEBELIUS. This was, if I understand it, the specs given to them by the House Republicans, by Congressman Ryan. Those were the only specs.

Mr. ROKITA. As set forth in a previous act that they are chartered by, and we can argue around all of that. But we both know that we have a program that works for the Congress and we both know people clamor and talk about how much or how good we have it here in the Congress. And to see us argue now against that for the rest of the American people, you know, I don't understand—

But let me get on with some of my time.

Secretary SEBELIUS. Well, again, there is no evidence at all that Medicare Advantage, which operates through private market strategy, gives seniors choices, is either more cost effective or more health effective. For seniors, in fact, the cost is significantly higher and the health benefits are lower.

Mr. ROKITA. Well, let me get on to an issue that you didn't—as Dr. Bucshon was explaining you didn't seem to understand the details. Here are some of the details.

Joe Main is the Assistant Secretary for Mine Safety, not under your jurisdiction, of course, but he apparently used something from a set of data from NIOSH to go after the coal dust rule and to propose some things. Now he, on March 28, wrote your office and said, please release this data. It is not mine to release, but please get this to this committee and the stakeholders involved so that we can participate better in this rulemaking.

And so what I want to ask for you on the record, I think you said it with Dr. Bucshon, you would be helpful in trying to get that, right?

Secretary SEBELIUS. Absolutely. I don't know about that issue.

Mr. ROKITA. Understood. But, again, sharing your executive experience, I can tell you have people behind you that you can easily turn around to and say, what date can we get Congressman Rokita some answers on this? Can you tell me how long—

Secretary SEBELIUS. I can't give you a date certain until I know what it is that we are looking for, but I can guarantee you all of us heard the question four or five times. We understand there is a letter, and I will try to get it—

Mr. ROKITA. You can get me a date as to when you will get me the answer.

Secretary SEBELIUS. Sir, I really don't know what it is that we are being asked to produce. I will get you an answer very quickly.

Mr. ROKITA. Yes, this is an answer about when it would come. That is simple. So if it was me in your seat I would say, you know, 24 hours or so. But give me whatever answer—just tell me when you will give me that answer on when this stuff might come.

Secretary SEBELIUS. I don't know what it is that you are looking for, so I can't possibly give you—I will give you an answer about when it will come, you know, within a couple of days once I can talk to Dr. Howard.

Mr. ROKITA. That is all I am looking for. I appreciate it.

Chairman KLINE. The gentleman's time has expired.

Mr. Hinojosa, you are recognized.

Mr. HINOJOSA. Thank you, Mr. Chairman.

Secretary Sebelius, thank you for joining us today to discuss your priorities and to respond to the Ryan budget proposal put forward by the Republican Party.

I am troubled by the Republican plan to end Medicare as we know it. For my constituents in South Texas, the Republican plan would be disastrous. It would force seniors into the private sector for insurance, and it would force them to spend more and more of their limited income on health care.

In regards to our Nation's youngest, just yesterday I sat down in my office with a pediatric anesthesiologist struggling to treat some of my district's most impoverished and vulnerable youth, many of which are Medicaid beneficiaries. The Republican plan slashing Medicaid is not the answer that providers or children are looking for because it would unjustifiably hurt access to quality care.

I wish to ask two questions. As the former insurance commissioner and Governor of Kansas, you understand the heavy burden of health care costs on seniors and families with children in poverty. What is the Obama administration doing to help bear that burden and what new strategies are being pursued to help our most vulnerable populations?

Secretary SEBELIUS. Well, Congressman, I think the President shares your concern about the access to care for the most vulnerable Americans, and that is why I think he has stated an opposition to the block grant idea with a fixed amount of money available, knowing that you can't predict recessions, you can't predict disasters, and you certainly can't predict how many people are needing to access programs at a difficult time, as we have just seen in this country.

The same would be true for Medicare, to change from what is a guaranteed benefit program to a fixed-income situation, I think, could provide an enormous cost shift onto seniors at a time where they could least afford it and make it very, very difficult to access life-saving care.

Mr. HINOJOSA. With respect to Head Start, HHS is in the process of implementing the new performance standards. Seeing more parent and family engagement in our early education services is very important to me. Will you please tell us how these performance standards will strengthen the Head Start program?

Secretary SEBELIUS. Well, Congressman, we are taking the report on program integrity very seriously, and we think it is important that the Head Start grantees follow the law, follow the guidelines.

In addition, we are working closely with our education partners to look at the range of skills that children need to be school ready and making sure that, in addition to social development, that there is a curriculum development as part of the Head Start program. And certainly the parental involvement piece, which has always been a hallmark of Head Start, is something that is going to be strengthened and very critical moving forward.

Mr. HINOJOSA. Mr. Chairman, thank you for letting me ask those questions. I yield back.

Chairman KLINE. I thank the gentleman.

The timing is near perfect. I would like to thank the Secretary for being with us and spending the time with us today and putting up with the interruptions from the votes.

I would like to recognize Mr. Miller for any closing comments he might have.

Mr. MILLER. Thank you very much.

I want to thank the Secretary very much for being here.

I just want to say, after listening to your explanations and your defense of the Affordable Care Act and when I see the excitement and the response across the medical community and the employer community to this legislation and to the initiatives that you have started to roll out, it is really very, very encouraging.

After the Affordable Care Act passed the Congress, President Obama called me and said that I should be very proud, as being one of the chairs of the committees for the major jurisdiction on this legislation. I obviously told him I was very proud.

But listening to your defense and your explanations here and your initiatives on behalf of the law and the government, I am even more proud than at that moment when we passed this legislation. Because this is the kind of implementation that we were hoping to see now. Hundreds of thousands of employees being offered insurance by small businesses because of the tax credit for the first time being reported all over the country is really very exciting for those individuals and their families. So thank you very much for your appearance here before the committee.

Chairman KLINE. I thank the gentleman.

It is always interesting. He and I must always talk to different businessmen and women and different care providers. I am not yet seeing that excitement on their part, and I don't share that excitement with him, but I again very much appreciate your time and your testimony here today.

There being no further business, the committee is adjourned.

[Response to questions submitted for the record follow:]

#### **Secretary Sebelius' Response to Questions Submitted for the Record**

THE HONORABLE JOHN KLINE

1. *Head Start Fraud and Abuse*. Last year, the U.S. Government Accountability Office (GAO) conducted an undercover investigation of 15 Head Start programs, acting in response to tips from former and current employees at two separate Head Start centers. Undercover GAO applicants tried to enroll children in these programs and presented the centers with pay stub data that demonstrated they were above income eligibility requirements. Nine of the 15 sites enrolled the students by encouraging applicants not to submit the pay stubs that would put them over the income threshold. Some of the programs continued to count the students as enrolled, even though the students never actually participated in the program. At a May 2010 hearing before this Committee, the Assistant Secretary for Children and Families stated that the Department was taking immediate corrective action and was undertaking a "top-to-bottom" review of its program oversight responsibilities. Can you give us an update on the Department's effort to combat waste, fraud, and abuse in the Head Start program? How many unannounced monitoring visits has the Department conducted since the release of the GAO report?<sup>1</sup>

*Answer:* We have enhanced current monitoring procedures by partnering with the HHS Office of the Inspector General and conducting 115 unannounced monitoring visits to Head Start and Early Head Start programs, setting up a fraud hotline, and proposing new regulations to strengthen the eligibility verification processes. These actions include the following activities:

- Completed a top-to-bottom review of our program monitoring which includes ongoing oversight by Regional Program Managers and staff, triennial reviews by monitoring teams, Erroneous Payment Study and risk management process to make improvements in program oversight.

<sup>1</sup><http://www.gao.gov/new.items/d10733t.pdf>

- Established a complaint hotline to help identify problems. The Office of Head Start has implemented a process to ensure complaints are handled in a timely manner and appropriate actions are taken.

- Proposed a regulation to strengthen the requirements on eligibility verification for Head Start programs. Under the proposed rule, grantees would be required to maintain the source documentation used to verify income and obtain signatures from the person seeking services and a grantee staff member attesting to the accuracy of the information to the best of the person's knowledge. We expect to issue the final rule this fall.

2. *Recompetition of Head Start Grantees.* In 2007, Congress passed the Improving Head Start for School Readiness Act, which requires the Secretary of Health and Human Services to establish a new, comprehensive system to re-compete Head Start and Early Start grants. The Department is currently in the process of finalizing regulations on recompetition to ensure that Head Start grantees are meeting the requirements of the law and preparing pre-school-aged children for entry into kindergarten. Please provide us with an update on this process. When will the first grantees be re-evaluated?

*Answer:* In September 2010 we issued the Notice of Proposed Rulemaking on the recompetition or Designation Renewal System and have received over 16,000 comments. We are working expeditiously to review those comments and finalize the regulation. We expect to issue the final regulation this fall. The first grantees will be evaluated to determine whether or not they need to compete for renewed funding immediately following the effective date of the rule. We expect to conduct the first re-competitions in early 2012.

3. *Effectiveness of the Community Services Block Grant Program.* The President's FY2012 budget request includes a \$388 million cut to the Community Services Block Grant program, which is geared toward anti-poverty activities. Over the last 10 years, a number of independent studies and research activities, including those conducted by the U.S. Government Accountability Office (GAO), have questioned the program's effectiveness in combating poverty in local communities. What changes do you think the Committee should make to the program to make it more effective? When was the last time the program was evaluated and what were the results?

*Answer:* The Community Services Block Grant (CSBG) program provides a key component in addressing the causes and effects of poverty. For grantees with a strong performance history, CSBG provides a valuable source of ongoing support that allows local planning and service delivery based on a place-based model. The Administration supports the important goals of the CSBG and wants to work with Congress to inject competition into the block grant in order to strengthen it and target resources more effectively to high-performing, innovative organizations.

We would be interested in working with the Congress on CSBG reform based on the following principles for overall program direction:

- Maintaining current emphasis on place-based services, by a community-based entity to effectively address the causes and impact of poverty;
- Holding grantees more accountable for a high standard of service delivery and performance;
- Maintaining current CSBG distribution formula to States, Territories, and Tribes;
- Supporting State flexibility in designing competition based on local need, agency performance records, and quality of service, in consultation with the Federal administering agency;
- Directing resources to agencies that can effectively serve high need communities;
- Promoting evidence-based practice to achieve results; and
- Strengthening program integrity and accountability.

There are barriers in the current CSBG statute to this approach. Section 676(b)(8) and section 678C require States to provide CSBG eligible entities with funds proportional to what they received in a prior year. Funds cannot be terminated or reduced unless, after providing notice and an opportunity for a hearing on the record, the State determines that cause exists. The current process for termination is difficult and time consuming. Current law does not provide a mechanism to rapidly respond to cases of alleged fraud. States usually pursue termination only when there is a determination that the CSBG eligible entity is grossly financially negligent. Outside of basic financial and organizational management standards, States do not have clear criteria for determining the adequacy of agencies' performance, and the current process makes it difficult for states to hold grantees accountable and target available resources based on need and service delivery.



We continue to help States hold agencies accountable within the current confines of the statute. We have issued guidance to States to clarify the termination process to the extent possible under current statute, and provide extensive technical assistance to States when they choose to pursue termination. In addition, we have begun assessing the current performance measurement system. However, statutory changes are needed to improve both processes. We would like to work with you and relevant stakeholders to develop a more efficient and effective system to do more to hold grantees accountable and promote high performance.

We would also like to work with you to expand States' authority to award CSBG grant funds through a competitive process and to give states the flexibility to target resources based on need. Competition for grants is currently allowable under the CSBG Act in certain limited circumstances, including replacing agencies that are terminated due to performance deficiencies. We believe that we can build on this existing process as a method to ensure that high-performing entities receive funding, and look forward to working with you and external stakeholders to determine the best method for doing so.

#### *Evaluation of CSBG*

The Office of Community Services (OCS) has a study underway to document the services provided, challenges addressed and accomplishments achieved as a result of the \$1 billion in ARRA funds provided to the CSBG program. This process evaluation will identify promising practices that could inform future Federal, State and local program activities. OCS has contracted with the Urban Institute located in Washington, D.C. to conduct this study, which will be completed by February, 2012.

The Administration for Children and Families (ACF) has also made program changes in response to reviews conducted by the Government Accountability Office (GAO). A 2006 GAO report, titled "Community Services Block Grant Program: HHS Should Improve Oversight by Focusing Monitoring and Assistance Efforts on Areas of High Risk" (GAO 06-627) called upon ACF to conduct a risk-based assessment of State CSBG programs by systematically collecting and using information and to establish policies and procedures to help ensure that on-site monitoring is focused on States with the highest risk. In addition, the GAO recommended that ACF issue additional guidance on State responsibilities for monitoring and improve a strategic planning and reporting on training and technical assistance efforts. It is important to note that the GAO study focused primarily on program administration issues, and did not include findings regarding the program's effectiveness in combating poverty in local communities.

Based on GAO's report, OCS has restructured its monitoring in a way that heeds congressional intent, and improves management, accountability and outcomes of State and local agencies in the provision of CSBG services. The Health and Human Services (HHS) Office of Inspector General (OIG), in studying the program in preparation for administering the American Recovery and Reinvestment Act of 2009 (ARRA) funding, looked at the adjustments made by OCS since 2006. In August 2009, the HHS OIG issued a report indicating that in all items included in the IG review, the weaknesses cited by GAO had been addressed (Source: A-01-09-02502: Status of the Office of Community Services' Corrective Actions Resulting from the Government Accountability Office Review of the Community Services Block Grant Program).

Since 1987, OCS has worked in partnership with the National Association for State Community Services Programs (NASCSPP) to support a performance reporting system that aggregates reporting information from State CSBG agencies an annual CSBG Information Survey (CSBG-IS). Highlights of the 2009 annual survey result are available on the NASCSPP website at:

[http://www.nascsp.org/data/files/csbg\\_publications/annual\\_reports/highlights/2009/nascsp%2009%20csbg%20highlights\\_final.pdf](http://www.nascsp.org/data/files/csbg_publications/annual_reports/highlights/2009/nascsp%2009%20csbg%20highlights_final.pdf)

According to NASCSPP results for 2009, CSBG agencies provided services to 20.7 million low-income individuals, including nearly 5 million children, nearly 2.3 million seniors, and more than 1.7 million people with disabilities. Based on an aggregate reporting measure used to capture and describe services across 16 outcome areas, NASCSPP reports that the CSBG Network helped to reduce or eliminate 34.3 million "conditions of poverty," as measured by outcomes such as: gaining employment; building assets; and improving child development. A detailed report based on the NASCSPP Information Survey is available at: [http://www.nascsp.org/data/files/csbg\\_publications/annual\\_reports/annual%20report%2009%20final.pdf](http://www.nascsp.org/data/files/csbg_publications/annual_reports/annual%20report%2009%20final.pdf).

OCS continues to work with NASCSPP, its contract agencies, and other partners to refine current performance measurement systems and develop improved methodologies for performance measurement and accountability in this important program.

4. *Health Insurance Exchanges*: You claim in your testimony that in 2014, state health insurance exchanges will provide new options for consumers. However, it has been reported that several governors have vetoed bills intended to implement the new law's requirement for state-based Health Insurance Exchanges, and many states are not working toward establishing such exchanges. Also, one governor rejected a \$54 million "early innovator" grant for an exchange partly on the basis that states do not want to be subjected to federal regulation. Assuming some states will not create health insurance exchanges by 2014, at what point will HHS develop the federal insurance exchange option that would be available to consumers in those states? Can you elaborate on the structure of this option?

*Answer*: The law requires that Exchanges, whether State-based or Federally-facilitated, be operational by January 1, 2014. To date, 49 States have received exchange planning grants to develop plans for Exchange operations. Some States are further along than others, and HHS is actively assisting States as they work through implementation. Additionally, some States have applied for more assistance through the Establishment Grant process.

THE HONORABLE TIM WALBERG

For nearly 20 years, the National Institute for Occupational Safety and Health (NIOSH) along with the National Cancer Institute (NCI) conducted a study on the potential effects of diesel exhaust in underground mines. The Mining Awareness Resources Group (MARG) voluntarily participated in the study by providing access and information for NIOSH to conduct the study; however this was done with the understanding that NIOSH would be providing the study data to the group in order to review the studies. Two federal court orders have ordered NIOSH to provide the data to MARG and the Committee on Education and the Workforce, yet the institute has not fully complied.

1. Why has NIOSH not complied with the court orders of two federal judges?

*Answer*: The Department has complied with the court orders in connection with the litigation commenced by the Mining Awareness Resource Group. We also understand that only one Federal court order, issued by the U.S. District Court for the Western District of Louisiana on June 5, 2001, ordered NIOSH to provide study data.

2. When will the data be made available to all parties involved?

*Answer*: Research data has been provided to the Committee as requested and as it has become available. The mine operators that are litigants have received research data consistent with their attorney's execution of confidentiality agreements.

THE HONORABLE LOU BARLETTA

1. A number of smaller pharmacies in my district in Northeastern Pennsylvania have raised concerns regarding the impact of "rapid refills" on patient care. As you know, an increasing number of doctors are issuing prescriptions for 90 day supplies of medication. However, the patient's condition may change, forcing a doctor to modify the prescription prior to the patient exhausting the huge supply. Additionally, the patient loses out on valuable and more frequent in-person counseling offered by local brick and mortar pharmacies. Can you give the Agency's perspective on the challenges to patient care associated with so-called "rapid refills"? How has the Patient Protection and Affordable Care Act interfered with this process?

*Answer*: The Affordable Care Act did not include provisions that address rapid refills or physicians who provide patients with prescriptions for 90-day supplies of medication. Physicians are able to determine the appropriate treatment for each patient, including how much medication or how many refills a patient should receive before a follow up consultation.

THE HONORABLE PHIL ROE

1. During our dialogue at the May 5, 2011, hearing of the Education and the Workforce Committee, you stated that of the 30 million to 35 million Americans who will receive coverage as a result of PPACA, " \* \* \* about 15 million are likely to be Medicaid-eligible." However Medicare's chief actuary has indicated that the number of new Medicaid enrollees could rise as high as 25 million given that Social Security benefits will not be counted as income for the purpose of determining Medicaid eligibility.<sup>2</sup> How then, is PPACA not just a massive expansion of Medicaid?

<sup>2</sup> See <http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Foster.pdf>

*Answer:* We understand the Committee is interested in the interaction between Social Security benefits and Medicaid for purposes of eligibility determination for certain populations under the Affordable Care Act, and we will provide more information to the Committee under separate cover.

THE HONORABLE LYNN WOOLSEY

The HHS FY 12 budget proposes to zero out two programs in the National Institute for Occupational Safety and Health (NIOSH): the Education & Research Center (ERC) program and the Agriculture, Fishing and Forestry (AFF) program. Combined, these two programs total less than \$50 million. The ERCs were established to implement Section 21 of the Occupational Safety and Health Act's (OSHAct) requirement to train "an adequate supply" of occupational safety and health professionals to implement the law.

With regard to the AFF program, fatality rates in agriculture, fishing and forestry are more than seven times the average and cost our economy \$4 billion per year. NIOSH has developed technology to save lives and property in these industries. The National Academy of Sciences (NAS) found this program conducts high priority, sound research, but indicated that there were opportunities for improvement. The HHS FY 12 budget request zeroes out the program, claiming the program was ineffective, and asserts that the Agriculture Department and the Labor Department can pick up the slack when this program is zeroed out. The NAS panel members have written to Congress contending that the HHS budget justification misrepresents their 2007 report.

1. What specific authorization and funding is available in the Labor Department or Agriculture Department in the President's FY 12 budget to replace the NIOSH AFF research program?

*Answer:* HHS cannot comment on what specific authorization or funding is available to other Federal agencies.

2. Will you be willing to review the budget justification for the AFF program to determine if it is valid and factually supported?

*Answer:* The budget justification for the AFF program in the FY 2012 Budget was developed through a collaborative process within the Administration and reflects the Administration's perspective.

3. Would you be willing to work with the Committee to identify funds within HHS's operating divisions that could be reallocated to allow this priority NIOSH work to continue?

*Answer:* The FY 2012 President's Budget represents the policy priorities of the President and was developed in the context of competing priorities. There are currently no plans within the Administration to reallocate funds among HHS operating divisions.

4. With regards to the ERC program, the HHS FY 12 budget request justifies termination on the grounds that NIOSH had planned to sunset funding after 5 years; however, neither the Centers for Disease Control nor OMB can find any documents to back this up. Congress never intended to sunset this program after 5 years, and the Institute of Medicine recommended continuing this program.

Has HHS conducted a recent assessment of whether the ERC program has fulfilled its mission pursuant to Section 21 of the OSHAct? If so, has such assessment determined that there is an adequate supply of occupational safety and health professionals?

*Answer:* NIOSH commissioned a national workforce needs assessment that was designed and implemented by an independent research firm and guided by a multi-disciplinary advisory task force of occupational safety and health (OSH) professionals and practitioners, and included public comment and input from major stakeholder groups. We expect to release this assessment soon.

5. If such study had not been done, why would HHS terminate this program before such assessment has been completed?

*Answer:* As noted in the response to Question #4, NIOSH commissioned a national workforce needs assessment to assess the current supply and future demand for OSH professionals in the United States and to determine the professional competencies needed in these professions over the next five years. The Administration recognizes the vital role of occupational safety and health professional training. Within the context of a budget that requires tough choices, the Administration put forth a proposal to discontinue Federal funding for the ERCs.

6. Will you be willing to undertake a review to determine if the budget justification for the ERC program is valid and fully supported?

*Answer:* The budget justification for the ERC program in the FY 2012 Budget was developed through a collaborative process within the Administration and reflects the Administration's perspective.

7. Would you be willing to work with the Committee to identify funds within HHS's operating divisions that could be reallocated to allow this priority NIOSH work to continue?

*Answer:* The budget justification for the AFF program in the FY 2012 Budget was developed through a collaborative process within the Administration and reflects the Administration's perspective.

THE HONORABLE CAROLYN MCCARTHY

1. Congress included a provision in the Patient Protection and Affordable Care Act requiring that patients receiving Medicare home health services have a face-to-face encounter with a referring physician prior to certification for home health services.

Having heard from both home health care providers and physician groups alike, I am concerned that in implementing the provision, CMS has gone beyond Congressional intent. In doing so, the agency has created significant additional administrative paperwork and documentation burdens on physicians for which they are not reimbursed. The requirement also creates obstacles to care for patients, who are by definition homebound, and may not have convenient access to physician offices.

I am very concerned that the outcome of this will be that patients are denied access to the care they need, and that is provided in both the lowest cost and most desired setting—one's own home.

We will continue to work with the agency, but would appreciate your attention and thoughts on this matter as well. Would you support efforts to streamline and simplify the process for documenting the face to face encounter so that we address concerns of referring physicians, home health providers, and the patients they serve?

*Answer:* We constantly strive to strike the delicate balance between ensuring the integrity of the program and minimizing the administrative burdens that are imposed. In the case of the home health face-to-face encounter requirement, CMS made every effort to set up the necessary administrative requirements and bounds within which they must be completed, while allowing providers the flexibility to fulfill these requirements in a manner that is right for them.

As a condition for payment, the Affordable Care Act mandates that prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) has had a face-to-face encounter with the patient beginning January 1, 2011.

CMS recognized that some providers needed additional time to establish operational protocols necessary to comply with these requirements and provided a measure of leeway for them. In addition, CMS developed educational and outreach materials, reached out to state and local associations, and held meetings with the industry, as well as open door forums, to educate those affected by these requirements during the first quarter of CY 2011. Long-standing regulations have described the distinct content requirements for the plan of care (POC) and certification for a beneficiary requiring home health. Providers have the flexibility to implement the content requirements for both the POC and certification in a manner that best makes sense for them.

As part of the certification form itself, or as an addendum to it, the physician must document when the physician or allowed NPP saw the patient, and document how the patient's clinical condition as seen during that encounter supports the patient's homebound status and need for skilled services.

Aside from allowing providers the flexibility to implement the content requirements of the both the POC and certification in a manner that makes sense for them, in order to reduce any obstacles to care, there is an ample timeframe within which the face-to-face encounter requirement must be met. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care. Additionally, there is additional flexibility to accommodate providers and beneficiaries in rural areas. The face-to-face encounter can occur via telehealth, in rural areas, in an approved originating site.

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[Whereupon, at 12:45 p.m., the committee was adjourned.]

