THE PRESIDENT'S FISCAL YEAR 2013 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

SECOND SESSION

FEBRUARY 28, 2012

Serial No. 112–21

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

77–382 WASHINGTON : 2012

For sale by the Superintendent of Documents, U.S. Government Printing Office
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THE PRESIDENT'S FISCAL YEAR 2013 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

TUESDAY, FEBRUARY 28, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to notice, at 1:05 p.m., in Room 1100, Longworth House Office Building, Hon. Dave Camp [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
Tuesday, February 28, 2012

CONTACT: (202) 225–1721

Chairman Camp Announces Hearing on the President's Fiscal Year 2013 Budget Proposal with U.S. Department of Health and Human Services Secretary Kathleen Sebelius

House Ways and Means Committee Chairman Dave Camp (R–MI) today announced that the Committee on Ways and Means will hold a hearing on President Obama's budget proposals for fiscal year 2013. **The hearing will take place on Tuesday, February 28, 2012, in 1100 Longworth House Office Building, beginning at 1:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On February 13, 2012, President Obama submitted his fiscal year 2013 budget proposal to Congress. The President's proposed budget contained his tax, spending, and policy proposals for the coming fiscal year, including his proposed budget for the Department of Health and Human Services and the programs it operates and oversees. Many of the Department's programs such as Medicare, efforts to assist those who lack health insurance, and Temporary Assistance for Needy Families are within the Committee's jurisdiction.

In announcing this hearing, Chairman Camp said, **"Given that the President's plan does nothing to protect and save the Medicare program for future generations, it will be interesting to learn why the Administration is content to end Medicare as we know it. While the Administration turns a blind eye to Medicare and the seniors it serves, they are aggressively pushing forward with implementation of their health care law, despite the Supreme Court reviewing its constitutionality, resistance from many States, and opposition from the American people. Finally, Members will review the Administration's proposals affecting human services programs, including Temporary Assistance for Needy Families, child support, and child welfare."**

FOCUS OF THE HEARING:

U.S. Department of Health and Human Services Secretary Sebelius will discuss the details of the President's HHS FY13 budget proposals that are within the Committee's jurisdiction.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "*Hearings*." Select the hearing for which you would like to submit, and click on the link entitled, "*Click here to provide a submission for the record*." Once you have followed the online instructions, submit all re-

quested information. ***ATTACH*** your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 13, 2012**. **Finally**, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman CAMP. The Committee will come to order. We do have a vote in progress. This is a little bit unusual.

I have visited with Mr. Levin and we will have a looser Gibbons Rule in terms of voting. We will go by seniority once we return, so Members, feel free to come and go, to make sure you are able to make that vote.

Secretary Sebelius, thank you for joining us today for a discussion of the President's 2013 budget.

The Administration's budget is a reflection of his priorities and vision for the country. I am disappointed to say that in reviewing the Health and Human Services' budget for fiscal year 2013, I find myself asking where is the leadership, where is the plan, where is the vision.

Despite repeated promises by the Administration to strengthen Medicare, to make health care more affordable for all Americans and to reduce the country's debt and deficits, the President's budget fails to accomplish any of these goals.

The President's budget lacks guidance about one of the greatest challenges facing the Federal Government, and by extension, American taxpayer, the long term solvency of Medicare.

The Medicare trustees have made it very clear that Medicare is going broke and that without reform, it will not be able to provide the benefits so many seniors rely on.

The Hospital Insurance Trust Fund alone has more than $8 trillion in unfunded liabilities and is slated to go bankrupt in roughly 10 years.

With more than 10,000 baby boomers becoming eligible for benefits each day, it is critical that Republicans and Democrats work together to secure Medicare's future and ensure current and future beneficiaries have continued and uninterrupted access to much needed care.

This budget also lacks any assurance or evidence that the health care law will make health insurance more affordable. Last year, health insurance premiums rose by 9 percent for the average American family purchasing insurance in the workplace.

In part, health care costs are directly impacted by regulations and guidance being issued by your Department, including government mandated health benefit packages and exchanges.

Take, for example, your government mandated benefits in actual value and cost saving bulletins. If implemented, these bulletins will significantly increase the price of health insurance.

Using these bulletins instead of standard regulatory procedures, you have chosen to hide the expected costs of your decisions for the American people.

It is clear that each decision your Department makes impacts the price of a monthly insurance premium, and one more mandate, one more service, and one more Washington requirement only adds to the likelihood that costs will increase, not decrease.

In addition to the costs consumers bear today, this budget ensures they will face even greater costs in the future.

The President's fiscal year 2013 budget contains the highest deficit ever proposed and fails to deliver on his promise to cut the deficit in half by the end of his first term.

For example, in our human resources jurisdiction, instead of consolidating programs and ending those that do not work and making real reforms to others, your budget proposes creating more programs and increasing spending on others by over $10 billion, and how exactly does that help cut the deficit?

I would also note that in addition to the $1 billion already spent on implementing the health care law, the budget requests an additional $1.35 billion in 2013.

Even more troubling is the fact that the President's budget requests funding for an additional 848 full time equivalent IRS employees compared to 136 CMS employees, solely for the purpose of implementing the health care law.

What does this say about health care when you request more than six times the number of IRS employees than CMS employees?

Furthermore, over the next 10 years, spending in Medicare, Medicaid and Social Security will increase as a percentage of GDP from 9.7 to 11.2 percent.

Madam Secretary, all this boils down to is more money for Washington to spend, more government employees to spend it, and not a dime in deficit reduction for the hard-working American taxpayer.

I would like to close with a couple of additional points, Madam Secretary. On previous occasions, Members of the House and Senate have written to you and your agency seeking information about how the health care overhaul is being implemented.

Too often, these inquiries are either ignored or Members are receiving incomplete and insufficient explanations.

Congress and in particular this Committee has a responsibility to conduct oversight of your Department. We expect full cooperation from you and your Department so we can ensure that taxpayer dollars are used effectively, efficiently, and in compliance with the law.

Many Americans opposed the new health care law because they believed it to be an unconstitutional power grab by Washington, forcing Americans to buy government approved insurance and then taxing them if they do not was not bad enough, it is something I hope the Supreme Court throws out pretty soon.

Recent actions by your Department prove that Americans have even more reason to worry, that decisions made behind closed doors, in secret, by a small cadre of insiders, will impact our most fundamental constitutional rights.

Madam Secretary, I hope you can provide some additional information today on how we address these problems for the American people. I look forward to your testimony.

I will now recognize Ranking Member Levin for his opening statement.

Mr. LEVIN. I will shorten my statement and enter a larger statement into the record, Mr. Chairman.

Actually, I think we can say it quite briefly, health care reform is working. The prophets of doom and gloom are being proven wrong. Already—and you will testify to this and welcome—there are successes.

For the first time in years, according to the Chief Actuary for the Centers for Medicare and Medicaid Services, growth in national health expenditures was slow, thanks to health care reform. It is reducing overpayments and will reform the way we deliver services.

We have strengthened through health care reform Medicare and improved the benefits. For example, four million Medicare beneficiaries saved more than $2 billion last year because health care reform closed the prescription drug doughnut hole.

Health reform is not just helping those on Medicare, it is helping all Americans save money. My statement, for example, shows what has happened for 86 million Americans in terms of preventive care, 2.5 million young adults have been covered through their parents' policies, nearly 50,000 Americans are now receiving health care who were denied because of preexisting conditions, and 3,800 employers have received much needed help to retain benefits and lower costs for countless retirees and their spouses.

Let me just repeat once again, we welcome you, and we think this system, this reform, is working.

It was just a few days ago, Mr. Chairman, that you said "I will not rest until Congress, the Supreme Court or the Attorney General dismantles ObamaCare."

Health care reform is working. I think the trouble with its opponents, the real trouble is they are facing successes for millions and millions of American people.

Chairman CAMP. Mr. Price.

Dr. PRICE. Thank you. Madam Secretary, I want to welcome you and appreciate you joining us again today, and I look forward to your statement.

STATEMENT OF THE HONORABLE KATHLEEN SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Secretary SEBELIUS. Thank you, Congressman. It is nice to be here with the Ways and Means Committee.

I wanted to thank the Chairman, Ranking Member and Members of the Committee for the opportunity to discuss the President's 2013 budget for the Department of Health and Human Services.

Our budget helps create an American economy that is built to last, by strengthening the Nation's health care, supporting research that will lead to tomorrow's treatments and cures, promoting opportunity for America's children and families, so everyone has a fair shot to reach his or her full potential.

It makes investments that we need right now to keep our economy growing in the right direction, while reducing the deficit in the long term, to make sure that the programs that millions of Americans rely on will be there for generations to come.

I look forward to answering your questions, but first, I want to share some of the budget highlights.

Over the last 2 years, we have been working diligently to deliver the benefits of the Affordable Care Act to the American people.

Thanks to the law now in place, we have 2.5 million young Americans who have health coverage today, thanks to getting coverage through their parents' plans.

More than 25 million of our senior citizens have taken advantage of free recommended preventive services under Medicare.

Small businessowners are taking advantage of the tax breaks on their health care bills that allow them to keep their health insurance and hire more employees.

This year, we want to build on the important efforts by continuing to support States as they work to establish affordable insurance exchanges by 2014.

Once these competitive marketplaces are in place, they will ensure that all Americans finally have access to quality affordable health coverage.

Because we know that the lack of insurance is not the only obstacle to care, our budget also invests in the health care workforce.

The budget supports training more than 7,100 primary care providers and placing them in parts of the country where they are needed the most.

We are investing in expanding America's network of community health centers.

Together with our 2012 resources, our budget creates more than 240 new access points for access care along with thousands of new jobs.

Altogether, the health centers will provide access to quality care for 21 million people, 300,000 more than last year.

This budget also continues our Administration's commitment to improving the quality and safety of care by spending health care dollars more wisely. It means increasing our investments in health information technology, and improving care for those who rely on both Medicare and Medicaid.

It also means funding the first of its kind CMS Innovation Center, our own R&D Support Center, which is supporting and partnering with physicians, nurses, hospitals, private payers and others, who have accepted the challenge to develop a new sustainable health care system.

In addition, our budget ensures that 21st century America will continue to lead the world in biomedical research by maintaining funding for the world's leading researchers at the National Institutes of Health, and will support their work with an emphasis on outcomes research that compares the risks, benefits and effectiveness of medical breakthroughs, so we can get the biggest pay off possible for our research dollars.

The Administration recognizes that in order for the country to succeed, we need to invest in tomorrow's scientists, as well as tomorrow's teachers, engineers, doctors, and architects.

Today, too many young children have their futures short-changed because they start school behind and never catch up.

We know that high quality early education programs put kids on a path to school success and to lifetimes of opportunity.

High quality early education does not just lead to higher test scores and graduation rates. We know it leads to more productive adults, stronger families, and more secure communities.

That is why our budget increases funding to support the 962,000 children in Head Start, and the 1.5 million American children in federally funded child care assistance programs.

Our investments also support critical reforms in both Head Start and child care programs to raise the bar on quality. This year for the first time, we will require Head Start programs that do not meet important quality benchmarks to compete for funding.

Our budget supports a new child care quality initiative that allows States to invest directly in programs and teachers, so that individual child care programs do a better job of meeting the needs of children and of their families.

Investing in health care cutting-edge medical research, early childhood education and other priorities that help us create an American economy built to last requires resources.

That means we have to set priorities, make difficult tradeoffs, and ensure we use every dollar wisely.

Our budget does this, helping reduce the deficit even while we invest in areas critical to our Nation's future. That starts with continuing support for President Obama's historic push to stamp out waste, fraud and abuse in our health care system.

Over the last 3 years, every dollar we have put into health care fraud and abuse control has returned more than $7. Last year alone, these efforts recovered more than $4 billion.

Our budget builds on those efforts by giving law enforcement the technology and data to stop perpetrators early and prevent payments based on fraud from going out in the first place.

The budget reflects the careful review we gave every program, looking for opportunities to make them leaner and more effective.

It includes some difficult cuts we would not have made if our Nation's fiscal health in tight budget times did not require them.

Our budget also contains more than $360 billion in health care savings over 10 years, most of which comes from reforms to Medicare and Medicaid.

These are significant, but they are carefully crafted to protect beneficiaries. For example, we proposed significant savings in Medicare by reducing drug costs, a plan that both lowers the overall cost of Medicare and puts money back in the pockets of Medicare beneficiaries.

Our budget makes smart investments where they will have the greatest impact, and ensures millions of Americans will have access to the health care they need, funds cutting-edge biomedical research, and invests in our youngest children, so they can achieve their fullest potential, and it puts us all on a path to build a stronger, healthier and more prosperous America for the future.

Thank you again for the opportunity to be here today, and I look forward to our conversation.

[The prepared statement of Hon. Kathleen Sebelius follows:]

** This Testimony is Embargoed Until 10:00 AM, Tuesday February 28, 2012**

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

THE PRESIDENT'S FISCAL YEAR 2013 BUDGET

BEFORE THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 28, 2012

Testimony of
Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
before the
United States House of Representatives
Committee on Ways and Means
February 28, 2012

Chairman Camp, Ranking Member Levin, and Members of the Committee, thank you for the invitation to discuss the President's FY 2013 Budget for the Department of Health and Human Services (HHS).

The Budget for the Department of Health and Human Services (HHS) invests in health care, disease prevention, social services, and scientific research. HHS makes investments where they will have the greatest impact, build on the efforts of our partners, and lead to meaningful gains in health and opportunity for the American people.

The President's fiscal year (FY) 2013 Budget for HHS includes a reduction in discretionary funding for ongoing activities, and legislative proposals that would save an estimated $350.2 billion over ten years. The Budget totals $940.9 billion in outlays and proposes $76.7 billion in discretionary budget authority. This funding will enable HHS to: Strengthen Health Care; Support American Families; Advance Scientific Knowledge and Innovation; Strengthen the Nation's Health and Human Service Infrastructure and Workforce; Increase Efficiency, Transparency, and Accountability of HHS Programs; and Complete the Implementation of the Recovery Act.

STRENGTHEN HEALTH CARE

Delivering Benefits of the Affordable Care Act to the American People: The Affordable Care Act expands access to affordable health coverage to millions of Americans, increases consumer protections to ensure individuals have coverage when they need it most, and slows increases in health costs. Effective implementation of the Affordable Care Act is central to the improved fiscal outlook and well-being of the Nation. The Centers for Medicare & Medicaid Services (CMS) is requesting an additional $1 billion in discretionary funding and 136 full-time equivalents to continue implementing the Affordable Care Act, including Affordable Insurance Exchanges, and to help keep up with the growth in the Medicare population.

Expand and Improve Health Insurance Coverage: Beginning in 2014, Affordable Insurance Exchanges will provide improved access to insurance coverage for millions of Americans. Exchanges will make purchasing private health insurance easier by providing eligible individuals and small businesses with one-stop shopping where they can compare benefit plans. New premium tax credits and reductions in cost-sharing will help ensure that eligible individuals can afford to pay for the cost of private coverage through Exchanges. FY 2013 will be a critical year for building the infrastructure and initiating the many business operations critical to enabling Exchanges to begin operation on January 1, 2014. The expansion of health insurance coverage for millions of low-income individuals who were previously not eligible for coverage also begins in 2014. CMS has worked closely with states to ensure they are prepared to meet the 2014 deadline and will continue this outreach in FY 2013.

Many important private market reforms have already gone into effect, providing new rights and benefits to consumers that are designed to put them in charge of their own health care. The Affordable Care Act's Patient's Bill of Rights allows young adults to stay on their parents' plans until age 26 and ensures that consumers receive the care they need when they get sick and need it most by prohibiting rescissions and

lifetime dollar limits on coverage for care, and beginning to phase out annual dollar limits. The new market reforms also guarantee independent reviews of coverage disputes. Temporary programs like the Early Retiree Reinsurance Plan (ERRP) and the Pre-Existing Condition Insurance Plan (PCIP) are supporting affordable coverage for individuals who often face difficulties obtaining private insurance in the current marketplace. Additionally, rate review and medical loss ratio (MLR) provisions helps ensure that health care premiums are kept reasonable and affordable year after year. The already operational rate review provision gives states additional resources to determine if a proposed health care premium increase is unreasonable and, in many cases, help enable state authorities to deny an unreasonable rate increase. HHS reviews large proposed increases in states that do not have effective rate review programs. The MLR provisions guarantee that, starting in 2011, insurance companies use at least 80 percent or 85 percent of premium revenue, depending on the market, to provide or improve health care for their customers or give them a rebate.

Strengthen the Delivery System: The Affordable Care Act established a Center for Medicare and Medicaid Innovation (Innovation Center). The Innovation Center is tasked with developing, testing, and—for those that prove successful—expanding innovative payment and delivery system models to improve quality of care and reduce costs in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Since the Innovation Center began operations it has undertaken an ambitious agenda encompassing patient safety, coordination of care among multiple providers, and enhanced primary care. These projects can serve as crucial stepping stones towards a higher-quality, more efficient health care system.

HHS is also working to ensure that the most vulnerable in our Nation have full access to seamless, high-quality health care. The Affordable Care Act established a new office to more effectively integrate benefits and improve coordination between states and the Federal Government for those who are eligible for both Medicare and Medicaid. While Medicare-Medicaid beneficiaries make up a relatively small portion of enrollment in the two programs, they represent a significant portion of expenditures. HHS is currently supporting 15 states as they design models of care that better integrate Medicare and Medicaid services and is designing additional demonstrations to continue to improve care.

CMS is currently offering three initiatives that will help spur the development of Accountable Care Organizations (ACOs) for Medicare beneficiaries. ACOs are groups of health providers who join together to give high-quality, coordinated care to the patients they serve. If an ACO meets quality standards, it will be eligible to share in savings it achieves for the Medicare program, and may be subject to losses, offering a powerful incentive to restructure care to better serve patients.

Ensuring Access to Quality Care for Vulnerable Populations: Health Centers are a key component of the Nation's health care safety net. The President's Budget includes a total of $3 billion, including an increase of $300 million from mandatory funds under the Affordable Care Act, to the Health Centers program. This investment will provide Americans in underserved areas, both rural and urban, with access to comprehensive primary and preventive health care services. This funding will create 25 new health center sites in areas of the country where they do not currently exist and provide access to quality care for 21 million people, an increase of 300,000 additional patients over FY 2012. The Budget also promotes a policy of steady and sustainable health center growth by distributing Affordable Care Act resources over the long-term. This policy safeguards resources for new and existing health centers to continue services and ensures a smooth transition as health centers increase their capacity to provide care as access to insurance coverage expands.

Improving Healthcare Quality and Patient Safety: The Affordable Care Act directed HHS to develop a national strategy to improve health care services delivery, patient health outcomes, and population health. In FY 2011, HHS released the National Strategy for Quality Improvement in Health Care, which

highlights three broad aims: Better Care, Healthy People and Communities, and Affordable Care. Since publishing the Strategy, HHS has focused on gathering additional input from private partners and aligning new and existing HHS activities with the Strategy. HHS will enhance the Strategy by incorporating input from stakeholders and developing metrics to measure progress toward achieving the Strategy's aims and priorities. Already, the Strategy is serving as a blueprint for quality improvement activities across the country.

CMS will continue funding for the Partnership for Patients, an initiative launched in April 2011 that sets aggressive targets for improving the quality of healthcare: reducing preventable hospital-acquired conditions by 40 percent and preventable readmissions by 20 percent by the end of 2013, as compared to 2010.

Investing in Innovation: HHS is committed to advancing the use of health information technology (health IT). The Budget includes $66 million, an increase of $5 million, for the Office of the National Coordinator for Health Information Technology (ONC) to accelerate the adoption of health IT and promote electronic health records (EHRs) as tools to improve both the health of individuals and the health care system as a whole. The increase will allow ONC to provide more assistance to health care providers as they become meaningful users of health IT. Furthermore, through the Health Information Technology for Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act, CMS is providing hospitals and medical professionals who participate in Medicare and Medicaid with substantial incentive payments for the adoption and meaningful use of EHRs. As of the end of 2011, CMS had made incentive payments to 15,859 providers who have met the objectives for meaningful use in the Medicare EHR Incentive Program and 15,132 providers who have adopted, implemented, or upgraded EHRs in the Medicaid EHR Incentive Program. By encouraging providers to modernize their systems, this investment will improve the quality of care and protect patient safety.

SUPPORT AMERICAN FAMILIES

Healthy Development of Children and Families: HHS oversees many programs that support children and families, including Head Start, Child Care, Child Support, and Temporary Assistance for Needy Families (TANF). The FY 2013 Budget request invests in early education, recognizing the role high-quality early education programs can play in preparing children for school success. The request also supports TANF and proposes to restore funding for the Supplemental Grants without increasing overall TANF funding.

Investing in Education by Supporting an Early Learning Reform Agenda: The FY 2013 Budget supports critical reforms in Head Start and a Child Care quality initiative that, when taken together with the Race to the Top Early Learning Challenge, are key elements of the Administration's broader education reform agenda designed to improve our Nation's competitiveness by helping every child enter school ready for success.

On November 8, 2011 the President announced important new steps to improve the quality of services and accountability at Head Start centers across the country. The Budget requests over $8 billion for Head Start programs, an increase of $85 million over FY 2012, to maintain services for the 962,000 children currently participating in the program. This investment will also provide resources to effectively implement new regulations that require grantees that do not meet high quality benchmarks to compete for continued funding, introducing an unprecedented level of accountability into the Head Start program. By directing taxpayer dollars to programs that offer high-quality Head Start services, this robust, open competition for Head Start funding will help to ensure that Head Start programs provide the best available early education services to our most vulnerable children.

The Budget provides $6 billion for child care, an increase of $825 million over FY 2012. This funding level will provide child care assistance to 70,000 more children than could otherwise receive services without this increased investment; 1.5 million children in total. In addition to providing funding for direct assistance to more children, the Budget includes $300 million for a new child care quality initiative that states would use to invest directly in programs and teachers so that individual child care programs can do a better job of meeting the early learning and care needs of children and families. The funds would also support efforts to measure the quality of individual child care programs through a rating system or another system of quality indicators, and to clearly communicate program-specific information to parents so they can make informed choices for their families. These investments are consistent with the broader reauthorization principles outlined in the Budget, which encompass a reform agenda that would help transform the Nation's child care system to one that is focused on continuous quality improvement and provides more low-income children access to high-quality early education settings that support children's learning, development, and success in school.

Improve the Foster Care System: The Budget includes an additional $2.8 billion over ten years to support improvements in child welfare. Additional resources will support incentives to states to improve outcomes for children in foster care and those who are receiving in-home services from the child welfare system, and also to require that child support payments made on behalf of children in foster care be used in the best interest of those children. The Budget also creates a new teen pregnancy prevention program specifically targeted to youth in foster care.

Child Support: The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to TANF families. Recognizing that healthy families need more than financial support alone, the proposal would also require states to include parenting time provisions in initial child support orders and increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and implement domestic violence safeguards. The Budget request also includes new enforcement mechanisms that will enhance child support collection efforts.

Strengthen TANF and Create Jobs: The Budget would provide continued funding for the TANF program and would fund the Supplemental Grants for Population Increases. When Congress takes up reauthorization, we want to work with lawmakers to strengthen the program's effectiveness in accomplishing its goals. This should include using performance indicators to drive program improvement and ensuring that states have the flexibility to engage recipients—including families with serious barriers to employment—in the most effective activities to promote success in the workforce. We also want to work with Congress to revise the Contingency Fund to make it more effective during economic downturns.

Million Hearts Initiative: The Million Hearts Initiative is a national public-private initiative aimed at preventing 1 million heart attacks and strokes over 5 years, from 2012 to 2017. It seeks to reduce the number of people who need treatment and improve the quality of treatment that is available. It focuses on increasing the number of Americans who have their high blood pressure and high cholesterol under control, reducing the number of people who smoke, and reducing the average intake of sodium and trans fats. To achieve this overall goal, the Initiative will promote medication management and support a network of electronic health record registries to track blood pressure and cholesterol control, along with many other public-private collaborations. In FY 2013, the Budget requests $5 million for CDC to achieve measurable outcomes in these areas.

ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

Enhancing Health Care Decision-Making: The HHS Budget includes $599 million for research that compares the risk, benefits, and effectiveness of different medical treatments and strategies, including health care delivery, medical devices, and drugs, including $78 million from the Patient-Centered Outcomes Research Trust Fund established by the Affordable Care Act. Evidence generated through this research is intended to help patients make informed health care decisions that best meet their needs. This level of funding will primarily support research conducted by NIH, core research activities within the Agency for Healthcare Research and Quality (AHRQ), and data capacity activities within the Office of the Secretary. Resources from the Trust Fund will support comparative clinical effectiveness research dissemination, improved research infrastructure, and training of patient-centered outcomes researchers. HHS core research will be coordinated to complement projects supported through the Trust Fund and through the independent Patient-Centered Outcomes Research Institute.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORK FORCE

Investing in Infrastructure: A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes $677 million, an increase of $49 million over FY 2012, within HRSA to expand the capacity and improve the training and distribution of primary care, dental, and pediatric health providers. The Budget will support the placement of more than 7,100 primary care providers in underserved areas and begin investments that expand the capacity of institutions to train 2,800 additional primary care providers over 5 years.

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILIY OF HHS PROGRAMS

Living Within our Means: HHS is committed to improving the Nation's health and well-being while simultaneously contributing to deficit reduction. The FY 2013 discretionary request demonstrates this commitment by maintaining ongoing investments in areas most central to advancing the HHS mission while making reductions to lower priority areas, reducing duplication, and increasing administrative efficiencies. Overall, the FY 2013 request includes over $2.1 billion in terminations and reductions to fund initiatives while achieving savings in a constrained fiscal environment. Many of these reductions, such as the $452 million cut to the Low Income Home Energy Assistance Program (LIHEAP), the $177 million cut to the Children's Hospital Graduate Medical Education Payment Program, and the $327 million cut to Community Services Block Grants, were very difficult to make, but are necessitated by the current fiscal environment.

In September 2011, the Administration detailed a plan for economic growth and deficit reduction. The FY 2013 Budget follows this blueprint in its legislative proposals, presenting a package of health savings proposals that would save more than $360 billion over 10 years, with almost all of these savings coming from Medicare and Medicaid. Medicare proposals would encourage high-quality, efficient care, increase the availability of generic drugs and biologics, and implement structural reforms to encourage beneficiaries to seek value in their health care choices. The Budget also seeks to make Medicaid more flexible, efficient, and accountable while strengthening Medicaid program integrity. Together, the FY 2013 discretionary budget request and these legislative proposals allow HHS to support the Administration's challenging yet complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Program Integrity and Oversight: The FY 2013 Budget continues to make program integrity a top priority. The Budget includes $610 million in discretionary funding for Health Care Fraud and Abuse Control (HCFAC), the full amount authorized under the Budget Control Act of 2011 (BCA). The Budget

also proposes to fully fund discretionary program integrity initiatives at $581 million in FY 2012, consistent with the BCA. The discretionary investment supports the continued reduction of the Medicare fee-for-service improper payment rate; investments in prevention-focused, data-driven initiatives like predictive modeling; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives, including Medicare Strike Force teams and fighting pharmaceutical fraud.

From 1997 to 2011, HCFAC programs have returned over $20.6 billion to the Medicare Trust Funds, and the current three-year return-on-investment of 7.2 to 1 is the highest in the history of the HCFAC program. The Budget proposes a 10-year discretionary investment yielding a conservative estimate of $11.3 billion in Medicare and Medicaid savings and 16 program integrity proposals to build on the Affordable Care Act's comprehensive fraud fighting authorities for savings of an additional $3.6 billion over 10 years.

Additionally, the Budget includes funding increases for significant oversight activities. The request includes $84 million for the Office of Medicare Hearings and Appeals, an increase of $12 million, to continue to process the increasing number of administrative law judge appeals within the statutory 90-day timeframe while maintaining the quality and accuracy of its decisions. The Budget also includes $370 million in discretionary and mandatory funding for the Office of Inspector General (OIG), a 4 percent increase from FY 2012. This increase will enable OIG to expand CMS Program Integrity efforts in areas such as HEAT, improper payments, and focus on investigative efforts on civil fraud, oversight of grants, and the operation of new Affordable Care Act programs.

Additionally, Durable Medical Equipment (DME) Competitive Bidding is providing competitive pricing, while continuing to ensure access to quality medical equipment from accredited suppliers, which will save Medicare $25.7 billion over 10 years and help millions of Medicare beneficiaries save $17.1 billion in out-of-pocket costs over 10 years. The Budget proposes to extend some of the efficiencies of DME Competitive Bidding to Medicaid by limiting Federal reimbursement on certain DME services to what Medicare would have paid in the same state for the same services. This proposal is expected to save Medicaid $3.0 billion over 10 years.

COMPLETING IMPLEMENTATION OF THE RECOVERY ACT

The American Recovery and Reinvestment Act provided $140 billion to HHS programs, of which $110 billion had been spent by grant and contract recipients by the end of FY 2011. The vast majority of these funds helped state and local communities cope with the effects of the economic recession.

Thousands of jobs were also created or saved, including subsidized employment and training for over 260,000 people through the Temporary Assistance for Needy Families (TANF) program Emergency Contingency Fund.

The Recovery Act provided states fiscal relief through a temporary increase in Federal matching payments of $84 billion for Medicaid and foster care and adoption assistance.

HHS Recovery Act funds are also making long-term investments in the health of the American people and the health care system itself. Beginning in FY 2011 and continuing for the next few years, HHS will be investing more than $20 billion to support implementation of health information technology in the health care industry on a mass scale. This effort is expected to significantly improve the quality and efficiency of the U.S. health care system. In addition, $10 billion in Recovery Act funds were invested in biomedical research programs around the country, including a major effort to document genomic changes in 20 of the most common cancers and to build research laboratory capacity. Of more immediate impact,

$1 billion has been supporting prevention and wellness programs, including projects in 44 communities with a total combined population of over 50 million aimed at reducing tobacco use and the chronic diseases associated with obesity.

HHS has also met the challenges of transparency and accountability in the management of its Recovery Act funds. More than 23,000 grantees and contractors with Recovery Act funding from HHS discretionary programs have submitted reports on the status of their projects over the last 10 quarters. More than 99 percent of the required recipient reports have been submitted on time and are available to the public on Recovery.gov; non-filers have been sanctioned. Finally, HHS Recovery Act program managers are working hand-in-hand with the Secretary's Council on Program Integrity to ensure that risks for fraud, abuse, and waste are identified and steps are taken to mitigate those risks.

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

Mr. HERGER [Presiding]. Thank you, Secretary Sebelius. I was surprised that you failed to even mention the need to reform the Medicare physician payment formula in your eight page written statement. Even more troubling is that President Obama continues to recommend that the SGR be dealt with by expanding the deficit and debt.

The President's budget proposes to spend $429 billion to fix the SGR, without suggesting any offsets, a deficit financed SGR package failed the Democrat controlled Senate a couple of years ago, and it certainly would not pass this House.

Instead of doing something to protect seniors' access to their doctors, the Administration chose to cut Medicare by more than one-half trillion dollars to fund a new entitlement that our country cannot afford.

As a result, reforming the SGR has become exponentially more difficult, and doctors in my Northern California District and across the country are wondering if they will ever get more certainty about their payments.

The Administration has yet to offer a single serious suggestion as to how to reform Medicare for physician payments. Is this truly a priority for the Administration?

Secretary SEBELIUS. Mr. Herger, I think the President from the outset of this Administration has recommended a long term fix for the SGR proposal. In each of the last several HHS budgets, we recommended specific offsets for those proposals, some 2, some 4 years.

The President's 10 year budget includes a 10 year fix to the SGR proposal, unlike the month to month, week to week, day to day operations that we have been seeing.

I could not agree more that a long term fix is required. As you know, the President's budget taken as a whole indeed does propose not only to fix the SGR, but to lower the deficit.

We feel that we are eager to work with Congress on a long term fix. We are eager to look at the situation. I would suggest it is not an HHS fix, it is a budget fix that is required for the 48 million Americans who currently rely on Medicare and more coming in every day.

Nothing could be more important than ensuring that they will have their health care providers, and we are eager to work with you to make sure that happens.

Our budget does contain an SGR fix, not only now but into the next 10 years.

Mr. HERGER. The Medicare savings in the budget, the President's budget, totals $302.8 billion, but the estimated cost for the SGR fix is $429 billion. Taken together, that means the President is proposing to increase Medicare spending by nearly $130 billion over the next 10 years.

Is that not just making the entitlement crisis even worse?

Secretary SEBELIUS. Again, Mr. Herger, I think the President's budget anticipates a long term Medicare fix, not entirely made up from within the Department of Health and Human Services.

He feels that making sure that Medicare beneficiaries have access to doctors is something that has failed to be dealt with by Congress for years, the gap keeps growing year in and year out.

We have proposed a variety of strategies, but his budget as a whole does have a 10 year fix built into the budget as well as deficit reduction overall recommended.

We do have some of those proposals within our budget, but the President's budget as a whole does recommend a long term fix and no deficit, additional spending for this matter.

Mr. HERGER. I might say that the Republicans look forward to working with you and the Administration.

Secretary SEBELIUS. That would be great.

Mr. HERGER. Thank you. The Ranking Member, Mr. Levin, is recognized for 5 minutes.

Mr. LEVIN. Welcome again. Fortunately, your testimony was given to us in advance. Those of us who went to vote and missed your testimony had a chance to read it.

Let me just ask you, I tried to touch on it in my opening remarks, about how it is going. How would you sum up how health reform is going, what it has meant so far? You live with it every day if not every minute.

Just give us your very personal view as to what is happening.

Secretary SEBELIUS. Congressman, I have the opportunity to visit around the country, not only health care providers and some of the best medical systems in the world who are eagerly implementing strategies around care improvements and quality improvements, but also to talk to individuals who have already benefited from some of the early aspects of the health care law.

I was with a group of women the other day in Baltimore. There was a mother of a child born with a preexisting health condition who now knows that her child has insurance coverage, not only now but into the future.

We had a young recent college graduate who is trying to decide whether to go to law school or work in a social service project who has insurance on her parents' health plan, one of 2.5 million Americans who has already taken advantage of that.

We had two new National Health Service Corps' providers with us in that room, two young doctors who wanted to practice in their community but were afraid that the debts they were acquiring as a result of medical school would be too significant to look at community service.

The National Health Service Corps is helping them pay those scholarship loans so they can indeed turn around and serve their communities.

We know efforts are underway in the Medicare system that millions of seniors have already taken advantage of, accessing at least one of the new preventive services that no longer have co-pays, like mammograms and colon cancer check-ups, and have taken advantage of the new wellness visit, which is now a yearly annual visit.

We have millions of Americans that have now instead of trying to make their prescription payments out of pocket because they reached the doughnut hole, had almost $4 billion worth of relief because of closing of the doughnut hole in the health care plans.

I talk to people each and every day who are already seeing the benefits. There are a lot of people who are eager for the new insurance markets to exist, who are paying higher and higher rates, who

see their policies not covering the needs for their families, who are locked out or priced out of the market.

We are seeing new benefits take hold and folks eager for 2014 to arrive and have a reset of the insurance marketplace.

Mr. LEVIN. As to the exchanges, do you want to just briefly give us a report on that?

Secretary SEBELIUS. We are working actively with States around the country to implement State-based health insurance exchanges. I would say we have virtually every State in the country who have taken a plan and grant.

We have about 28 who are in the process of working on implementation grants. We have States who have strengthened their insurance oversight, which is critical right now, to make sure that they actually are reviewing year to year rate increases.

I know as a former insurance commissioner, some States have the resources to do that, and a lot did not.

We are working on IT programs and outreach programs. We see Governors doing everything from issuing executive orders to helping to pass legislation, Republicans and Democrats, who feel a State-based exchange is the preferable way to go.

For those States who do not choose to build an exchange on their own in their own area, we are putting together the framework to make sure that every American has access to the benefits of an exchange marketplace beginning in 2014.

Mr. LEVIN. Thank you.

Chairman CAMP [Presiding]. Thank you, Madam Secretary. In order to put the President's budget into context, I compared it to what he had proposed spending last year.

With regard to the health insurance exchange subsidy, using the same time period, 2011 through 2016, this year's proposal predicts a $33 billion increase, almost a third more will be spent on subsidies than what was anticipated and predicted last year over the exact same budget period. This is just in the exchanges.

To me, it means either one of two things. Either health insurance premiums in the exchange are going to be more expensive than first predicted, or more employers will drop health care coverage, forcing more people into the government run exchanges, or a combination of those two.

I would just ask your opinion, which of those do you think that is?

Secretary SEBELIUS. I have to confess, Chairman Camp, I do not know all the underlying assumptions that those numbers are based on.

We are clearly watching very closely what is happening in the marketplace. I do not think there is any question that as rates continue to go up, employers are making a moment by moment decision.

We are also informed by what has happened in the one fully fledged operational exchange in the State of Massachusetts, which preceded the Affordable Care Act, where employers not only did not drop coverage, did not drop coverage, but additional employers came into the marketplace.

I think that gives us a real live example of what happens when you have affordable available coverage with some competition in the market.

Chairman CAMP. More than a 30-percent increase in the budgeted spending on health insurance exchanges is a significant departure from last year's prediction.

I would just wonder what would cause a $33 billion increase? It either has to be the exchanges are going to be more expensive or more employers are going to drop coverage, and therefore, more people will be in the exchanges, and therefore, they are more expensive.

Secretary SEBELIUS. Chairman Camp, what is the $33 billion you are referring to?

Chairman CAMP. When looking at last year's budget over the same time period, 2011 to 2016, this year's budget, using the same time period, just in the exchanges, is saying there will be $33 billion more spent over that period in the exchanges, in that 5 year period, than last year.

My question to you is why is it going up by a third? Why is there a $33 billion increase? My estimate is it is either the subsidies, the exchange subsidies, are much more expensive, and/or employers are dropping coverage and more people are going in. I just wanted your opinion on that.

Secretary SEBELIUS. Nothing has changed in terms of the exchange subsidy rates that was built into the law when this bill was passed almost 2 years ago.

I would be delighted to go back and get you a very specific answer, but I am still a little baffled. It could be the budget window has moved. I really do not know——

Chairman CAMP. The budget window did not move.

Secretary SEBELIUS. I mean we are in a different year, so the budget window for 5 years is out a year further. I do not know the $33 billion that you are referring to, and I would be glad to try to get you——

Chairman CAMP. Last year's budget window was also 2011 through 2016. If maybe you could respond in writing.

Secretary SEBELIUS. I will do that very quickly. I just cannot answer that question at the moment.

Chairman CAMP. Also in your statement, which I did have a chance to read—thank you for getting it to us early, and I apologize for the vote and not being able to hear your oral testimony.

With regard to entitlement reform, under the section of your statement headed "Living Within Our Means," the budget proposes to spend $126 billion more on Medicare over the next decade than would otherwise occur under current law.

The President has said that Medicare reforms are needed to put our Nation on stable financial footing, but your statement really does not address Medicare reform or any direction or specifics on how we can protect and preserve Medicare.

Can you tell me what is the plan to make sure that Medicare is here for today's and tomorrow's seniors? As we all know, it is going to go broke in the next 10 to 15 years. That does not really change under this budget.

What is being done to help seniors, to make sure Medicare is there for them?

Secretary SEBELIUS. Actually, Chairman Camp, passage of the Affordable Care Act according to CBO and various other analyses, added about 12 years to the life of the Medicare Trust Fund.

The President's budget adds an additional 2 years with some additional proposed savings, and we would be the first to acknowledge that is not the next generation and beyond.

We are eager to engage in a comprehensive conversation about the future of not only Medicare but a variety of entitlement programs while we protect beneficiaries.

I think what we can tell you pretty definitively is the proposal put forward and passed by the House Republicans that actually shifted costs to the backs of Medicare beneficiaries, whether they be seniors or disabled folks, with no real underlying health care costs transformation, is not something that is able to be supported by this Administration.

The voucher program, that would essentially end Medicare as we know it. Shift costs onto seniors, and yet no underlying health reform——

Chairman CAMP. I do not see any plan in this budget for the long term sustainability of Medicare. I will give you it extends Medicare's life by 2 years.

I do not think that gives much comfort to seniors who are looking for a long term—those who are at or near retirement who are looking for the solvency of Medicare over the next 30 or 40 years.

I will say that sustainability for 2 years comes largely at the cost of provider cuts in part A, which how sustainable those will be over the long term, we cannot tell.

I do not see any real reform to Medicare here. I appreciate the talking points with regard to our budget, but at least we had a plan that really addressed the long term solvency of the program.

Medicare is still going broke in the next 10 to 15 years, and I do not see anything in this budget that specifically addresses that. I see money spent on a doc fix and provider cuts.

Secretary SEBELIUS. Mr. Chairman, I would suggest that in the Affordable Care Act, for the first time, are the real tools, not only to have an opportunity to look at a sustainable Medicare Program long term and a sustainable Medicaid program long term, but really more importantly or as importantly, to address underlying health care costs which affect the private sector.

What we do not want to do is just keep shifting dollars onto either payments on the backs of beneficiaries or private payers.

We have to actually get a handle on the overall health care costs. I think some of the strategies in the Affordable Care Act to use for the first time the public payment system as an innovative strategy, moving us to a value based payment system, moving away from a volume based system, is not only going to be enormously cost effective and patient effective in Medicare and Medicaid, but can be enormously helpful for the private sector, which is why they have enthusiastically embraced a lot of the new innovative strategies that are beginning to be realized.

Chairman CAMP. All right. Thank you. Mr. Stark may inquire.

Mr. STARK. Thank you, Mr. Chairman. Madam Secretary, thank you, as always, for your work in these fields.

If we were to replace traditional Medicare with a voucher or some kind of fixed payment plan as my colleagues on the other side voted for in the Ryan budget, in your position, what would you suggest? What would be the effect of that on Medicare beneficiaries?

It is probably a selfish question, but for my kids. If you throw them into the private insurance market with a voucher that arguably would not pay today's rates, what happens?

Secretary SEBELIUS. Well, I do not think there is much question, at least the analyses done on the original proposals is there is a very substantial cost shift onto beneficiaries, and no real indication that overall costs would go down.

It is not that we are saving money. The government is saving money, but health care costs continue to rise, and one could speculate given the fact that Medicare Advantage has been in place for years and was allegedly going to lower costs through competition with the fee-for-service plan, and that really has not proven to be an effective strategy, that costs would rise even more significantly than they are now.

The government would shift the cost of providing health care from a government beneficiary ratio where it is today much more heavily onto beneficiaries.

Seniors would pay more and disabled people would pay more overall on their health care costs.

Mr. STARK. Could we speculate for a minute on the doomsday, worse case scenario, whatever you want to call it.

Whenever people want to project that Medicare is going to go broke, I cannot speak to Medicaid, we have to leave that to our sister Committee, but in the case of Medicare, it would be my understanding that the maximum that we would have to increase the payments from employers and employees to keep Medicare solvent for the indefinable future would be about half a percent, a quarter on employees and a quarter on the employers. Not an insignificant amount.

If that were the maximum as I am led to believe, it hardly sounds like doomsday to me. Am I about in the right ballpark of that half a percent?

Secretary SEBELIUS. I think, Mr. Stark, it is my understanding that if you just froze things in place, what is really incumbent upon all of us, and I would eagerly work with Members of Congress to look at this scenario—looking at our overall health spending, not Medicare in isolation or Medicaid in isolation. Those are frankly two of the largest insurance programs in the world.

What we are doing in terms of just overall health costs, where we are spending significantly more than any nation on Earth, and yet we have fairly mediocre health results.

That to me is the underlying challenge that we have, and within solving that challenge, how we eliminate duplication, go after waste and fraud, figure out strategies that actually intervene at a much earlier stage with preventive care and wellness care, go to the underlying causes of 75 percent of our deaths here in America, which are smoking and obesity.

If we could actually address that, it will lower costs overall and produce a healthier country.

Mr. STARK. Thank you very much. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Johnson is recognized for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman. Thank you, Madam Secretary. The Democratic health care law provided $1 billion to implement the health care overhaul. Now, the President is requesting another $1 billion for implementation of the same law.

I do not understand how HHS can blow through this kind of money when many of the provisions it is supposed to implement do not even take effect until 2014.

Your testimony has a section you refer to as "Living Within Our Means." How can you say that HHS is committed to deficit reduction and living within your means when you are continuing to make requests like this?

It is just another example of how the Administration drastically underreported the cost of the health care law.

Can you tell us exactly where the money is going and how much more do you think you are going to need before we get to the point where it really takes effect?

Clearly, those first numbers were off.

Secretary SEBELIUS. Well, actually, Mr. Johnson, they were off. The good news is we are underspending what was estimated. The original estimations for implementation of the health care act, and this was part of the public testimony, and actually would have been in some reconciliation legislation but was not able to be considered, was about $1 billion a year.

We have to date, as of December of this year, obligated about $475 million of the original $1 billion. We are spending after 2 years significantly below what the estimate was.

Mr. JOHNSON. But you are asking for another billion.

Secretary SEBELIUS. I would love to finish this. What we have coming up in the remainder of 2012 and again out of that $475 million, about $260 million is HHS spending. The rest is with our companion agencies.

We anticipate that during the remainder of fiscal year 2012, the first $1 billion will be spent. That will be about 2½ years into implementation, significantly again below the $1 billion a year that was estimated.

In 2013, we are requesting about $800 million to come into the overall implementation of health reform, to build one time build out for the framework of a federally operated exchange, which is part of the law.

That will go into everything from education and outreach to building the IT system to setting up the technology, and the remainder of that $1 billion request to the Centers for Medicare and Medicaid Services, Mr. Johnson, is directed toward Medicare and Medicaid activities, not to the exchanges.

Mr. JOHNSON. You had $1 billion to start with for setting all that up and you are asking for another billion this year.

I do not think you really adequately answered that, but let me ask you another question.

Medicare actuaries at CBO have warned it is unclear if current Medicare cuts can be sustained or if they will instead reduce access to care or lower the quality of care for Medicare beneficiaries.

I hear from back home in all areas of health care, doctors, hospitals, rehabilitation centers, who say they are seriously considering not accepting Medicare or will have to close because of reimbursement issues and burdensome regulations.

Are you going to put steps in place so you can identify access problems before they become a crisis? How are you going to keep seniors from being denied access?

Secretary SEBELIUS. Congressman, I think there is no higher priority within not only this Administration but certainly within CMS to make sure that beneficiaries are getting the health care they need and deserve.

We have a very active monitoring process. I would say the most significant blooming challenge, and the Chairman and I discussed this a bit, is the not long term addressing of the doctor payments in Medicare.

The reason that providers are getting very frustrated is that we have not indeed found a long term solution, making sure that providers know if they engage in the Medicare system, they will be paid, month to month, year to year.

We are watching that very closely. As I say, the President's budget includes a 10 year fix to the SGR program. We would love to engage with you and Congress and have a multi-year fix. That has not happened.

As you know, we have come right up to the precipice, and last year had to actually suspend payments for a period of time to get a fix done.

We are eager to look at reimbursement to providers being the most essential, I think, component of making sure there is some certainty to deliver benefits.

Mr. JOHNSON. Doctors are an important part of our society. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Brady is recognized for 5 minutes.

Mr. BRADY. Thank you, Mr. Chairman. There is no question, I think, and now a year later, we can tell the President's health care plans costs are exploding.

Prices are up for families and businesses. Many businesses are preparing to drop their private coverage and move their workers into the exchanges at cost to taxpayers. Many other businesses are working hard to stay under the 50-employee limit.

One thing that worries me is how we will treat the seniors who today rely upon Medicare Advantage, a hugely popular program in my State and others.

I saw in a recent White House blog that one of the staff, Nancy-Ann DeParle, stated the $200 billion in cuts to Medicare Advantage programs that was predicted to disrupt seniors' access to health care "turned out to be wrong."

Can you tell me what percentage of the cuts to Medicare Advantage called for under the President's health care law—how many have been implemented so far?

Secretary SEBELIUS. Well, Mr. Brady, what is not going to happen is a cut to Medicare Advantage. What is going to happen is a gradual reduction in the overpayments to Medicare Advantage, which were being paid at about 12 to 14 percent more than traditional fee to service——

Mr. BRADY. According to CBO, those reimbursements will be cut from Medicare Advantage. Your actuary said the impact would be over seven million American seniors would lose coverage and almost 50 percent of seniors would no longer be enrolling in Medicare Advantage. Is your actuary correct?

Secretary SEBELIUS. We have seen just the opposite. Enrollment has increased 10 percent.

Mr. BRADY. When you say it is just the opposite, is it not true only 4 percent of the cuts contained in the law have been implemented and you backfilled it recently with $6 billion of grants to the same Medicare Advantage providers?

How can you truthfully say that there has not been an impact when in fact these cuts have been delayed, I think, probably for election year gain.

How can you say there has been no impact when the cuts have not occurred?

Secretary SEBELIUS. As you just said yourself, cuts have been—the reduction in overpayment has begun.

Mr. BRADY. But they have been delayed. Correct?

Secretary SEBELIUS. No, that is not true, sir. The average plan premiums are down.

Mr. BRADY. I am sorry. I am asking you about the cuts within the law.

Secretary SEBELIUS. We are reducing the payments to companies, not to providers. We are by law reducing the payments, and that actually has begun to be a very successful strategy.

At the same time, for the first time ever——

Mr. BRADY. I am just trying to get to the truth here. Are you saying—will you agree that according to your actuaries, only 4 percent of the cuts have taken place?

Secretary SEBELIUS. I assume that is accurate.

Mr. BRADY. You backfilled that with over $6 billion of grants.

Secretary SEBELIUS. We have put in place for the first time ever a quality program so that higher performing Medicare Advantage plans for the first time are actually receiving a quality bonus, the lower performing plans are not.

The beneficiaries finally have a place to make——

Mr. BRADY. There are no real cuts, you have backfilled it——

Secretary SEBELIUS. No, that is not true. Sir, that just is not true.

Mr. BRADY. You started your answer to me saying there has been no cuts in Medicare Advantage.

Secretary SEBELIUS. Four percent is what the actuary quoted. I am agreeing with your numbers. We are now in year two of the strategy. What we are seeing is more plans, lower prices for beneficiaries, better quality.

I think that is kind of a win-win situation.

Mr. BRADY. You will say that and you are saying that will continue because the $206 million in cuts will occur in the future?

Secretary SEBELIUS. Yes, sir. We are seeing more companies—the companies are well aware of what the framework of the law is. We are not saying——

Mr. BRADY. Your own people are saying those cuts will push seven million American seniors off Medicare Advantage, cutting nearly half of them out of enrollment.

Secretary SEBELIUS. Sir, with all due indifference to actuaries, they are not running the companies.

Mr. BRADY. Those are your actuaries.

Secretary SEBELIUS. We are seeing the companies, the insurance companies running Medicare Advantage programs, coming into the market. More plans are available——

Mr. BRADY. Because the cuts have not occurred, would you not agree?

Secretary SEBELIUS. They know exactly what the framework is. I do not agree.

Mr. BRADY. You are giving them grants to stay in the marketplace.

Chairman CAMP. The time has expired. Mr. McDermott is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman. Secretary Sebelius, I do not think the President could have picked a better person to be the Health and Human Services' Secretary, given your insurance background and your Governor's background. I know that you have managed these programs out at the State level.

As I listen to this debate about whether there are cuts or not, let me clarify something. Does Medicare guarantee the doctors can submit their usual and customary fees?

Secretary SEBELIUS. Yes.

Mr. MCDERMOTT. They get to set the price, and then you pay how much of that? Seventy percent? Sixty percent?

How do you decide that? Doctors sound like farmers to me. I am a doctor, so I can say that. They sound like farmers. There is never a good year. This is the year we had too much rain or too much sun or too much something.

Doctors always say they are underpaid, but they are submitting amounts that you do not pay. That is your stewardship of the Federal purse, is that not correct?

Secretary SEBELIUS. The payment schedule, as you know, Mr. McDermott, is determined a year at a time with a global look to provider fees, and it is well known to providers, which is why I think we have 99 or 99.6 percent of all medical providers participating in the Medicare Program.

Mr. MCDERMOTT. We are actually listening to .4 percent bellyache about the fact that they did not get every dime they billed?

Secretary SEBELIUS. I think what is true, and I am very sympathetic to this and also eager to work on a long term strategy, is having looming a 30 percent budget cut with the sustainable growth rate not fixed, and having that come up year in and year out, month in and month out provides a level of serious instability to the program long term.

I think that is something that we must fix, that the President is eager to work on, his budget includes it, but that is the instability of Medicare, not, I do not think, the other payment issues.

Mr. MCDERMOTT. That was built into the Medicare system by Chairman Thomas of this Committee in 1997 in the Balanced Budget Act.

Secretary SEBELIUS. It worked for a number of years because it was supposed to rise and fall. I would suggest over the last decade, it has been not so terrific.

Mr. MCDERMOTT. Built into the Affordable Care Act was an attempt to develop a new payment system for doctors, not based on volume.

I see this press release that just came out on the largest Medicare fraud in Dallas, Texas, $375 million to one doctor.

I ask myself, how did he get away with that for 5 years. Was it revealed because somebody blew the whistle on him or was it because your format of looking at the bills found this guy down there, and he was doing it on the basis of volume.

He collected the largest number of Medicare beneficiaries in history, in the entire country. This guy was building up his money by putting through volume. That is what it looks like to me.

That is why the efforts in the Affordable Care Act to get to a new payment system really makes sense to me.

Secretary SEBELIUS. I think all of the above is true. What the Congressman is referring to is that today in Texas, a single health care provider was arrested, and has been billing 78 Texas home health agencies fraudulently.

We think the amount is somewhere around $375 million. It could be well more.

I think it is part of the effort that is really underway with the HEAT Task Force, which includes not only the Department of Health and Human Services' personnel, but Justice Department, U.S. Attorneys and investigators on the ground, to really target where we think the fraud hot spots are, and building the predictive modeling which looks at billing errors.

In the past, you really could not do that very easily because there were six different billing systems, so you could not even look at data real time.

I think this is an indication that we are beginning to at least turn some of the corner, and we intend to be very serious about it.

You are absolutely right, in the long run, paying doctors differently is part of an overall reform strategy, and again, not only affects Medicare Programs, but will affect private payers.

Paying on volume, the number of tests you do, the number of days someone spends in a hospital, the number of things done, as opposed to quality outcomes, preventive interventions, more timely access, and a patient center care system, I think, is where we need to go in this country as rapidly as possible.

In the short term, we need a strategy that assures doctors that if they are taking 48 million Medicare beneficiaries and treating them, we need to make sure the government is a good payment partner and they do not have to worry month to month, week to week, about whether they are going to get paid.

Mr. MCDERMOTT. Thank you.

Chairman CAMP. Time has expired. Chairman Ryan is recognized for 5 minutes.

Mr. RYAN. Thank you. Madam Secretary, we had Rick Foster, your chief actuary at CMS, in the Budget Committee this morning to testify, along with Steve Goss from Social Security.

He went into great length and discussed sort of the virtue of a premium support like model, and how having bid based pricing, competitive bidding, can help to actually reduce cost growth, to help stretch that health care dollar further, and to get the best benefit at the lowest possible price.

I would just encourage you to listen to some of the testimony he has offered and some of the wisdom he has given, and some of the lessons we have learned through various things like Part D and DME, other issues, where we have been able to, through bid based pricing and competitive bidding, stretch our health care dollars further.

I want to ask you about your latest budget proposal, page 55 of your budget, where you talk about strengthening IPAB to reduce long term care drivers of Medicare cost growth.

You take the cap from GDP plus one to GDP .5, and obviously, that achieves savings. Some of the tools available, it talks about offering new tools to IPAB, including consideration of value based benefit design.

What does that mean?

Secretary SEBELIUS. What does "value based benefit design" mean?

Mr. RYAN. Yes.

Secretary SEBELIUS. I think it means you look at outcome strategies which is part of our direction in the Affordable Care Act, so we are implementing, for instance, through the innovation center everything from bundled payment strategies, to see if that actually lowers hospital re-admissions, to make sure doctors and follow up placements are coordinating.

We are looking at medical home models to look at chronically ill and where our care delivery could be more effective, and prevent re-admissions in the first place.

We are looking at patient partnerships, to look at hospital acquired infections.

All of those are value based payment strategies.

Mr. RYAN. Does it mean changing the benefit design to get better value?

Secretary SEBELIUS. It is not changing necessarily the benefit design. It is changing the way that the delivery system works.

Mr. RYAN. Does that mean IPAB is given this tool for them to decide how that is to be interpreted?

The point I am trying to make is in one sentence, the budget and the Affordable Care Act says IPAB cannot change beneficiaries' benefit designs.

Secretary SEBELIUS. That is correct.

Mr. RYAN. In another sentence, it says IPAB should be given this tool to implement value based benefit designs. It seems to me there is a contradiction here. I am trying to understand how that occurs and how IPAB will come down on that.

It strikes me that IPAB is given this discretion to interpret what that means and that could clearly collide with beneficiary design.

That is question one. How is that not a contradiction? That is the question.

Question two is what is the status of IPAB? I understand you are supposed to select the Board this year and it is supposed to be up and running next year. I think implementing recommendations by 2014, if I am not mistaken. Can you give me a status update on that?

Secretary SEBELIUS. Sure. Let me take the first question. As you know, Chairman Ryan, the IPAB statutory framework is they are prohibited as an entity from doing certain things, from shifting costs under beneficiaries, from changing the benefit package, so there are a series of prohibitions that control what IPAB's recommendations need to be as they look at a more efficient and effective way to deliver health care.

Also, IPAB does not do anything, implement anything. They make recommendations to Congress. If the targeted spending is above what the IPAB target is, they are charged with making recommendations to Congress about how to make up that difference.

Mr. RYAN. If Congress does not act, do their recommendations go into place?

Secretary SEBELIUS. If Congress does not act, if Congress fails to act on the recommendations or substitute those recommendations, I am directed to implement the IPAB recommendations.

Congress is the intervening body receiving the recommendations.

Mr. RYAN. Is the required threshold more than a majority vote for Congress' action?

Secretary SEBELIUS. Congress clearly can act. Although the recommendations come to Congress, IPAB does not have the authority to implement anything on its own.

In terms of the status of IPAB, at this point, as you know, the statute entails having Members who would be nominated by a series of both legislative leaders and the President, confirmed by the U.S. Senate.

There are active discussions underway about those possible candidates, vetting those folks. It is not an easy task because this must be a full time job. They cannot have any conflicts with any of the possible payment sources. That discussion is underway.

Mr. RYAN. What is your general time line?

Secretary SEBELIUS. I really do not know, Chairman, because IPAB is not likely to even be operational into 2018 or 2019, given the cost trends.

Mr. RYAN. The recommendation is 2014, correct?

Chairman CAMP. The time has expired. Mr. Tiberi is recognized for 5 minutes.

Mr. TIBERI. Thank you, Madam Secretary. Welcome to our Committee. Thank you for being here.

Three points and then a question. First point is I had a constituent who met with CMS late last year over a program that he believes would save, and he has documentation on this, $200 million a year to CMS, and also save beneficiaries.

He was kind of laughed out of the building, he said, because that was not very much money.

We sent a follow up letter to CMS, and have been given kind of the brush off. I would like to send you a letter.

Secretary SEBELIUS. I would appreciate that.

Mr. TIBERI. And have you look into it, thank you very, very much.

Secretary SEBELIUS. $200 million is real money.

Mr. TIBERI. I agree. The second issue is you and I had a discussion last year when you were here about my godmother, who just lost her physician because he began not accepting not only new Medicare patients, but got rid of former Medicare patients.

Just a week ago, I received a letter, a copy of a letter, that was actually sent to your boss, the President of the United States, and I spoke to this doctor who I have never met before or talked to before. Her name is Deborah Morris. I would like to read you part of it.

It says "Dear Mr. President: I can no longer afford to take new Medicare patients. I have seen a lot of inadequate management of Medicare patients, including my own parents. We can no longer afford to spend the time it takes to address multiple problems Medicare patients face.

Rather than trying to accept inadequate time or costs, I have decided to decline seeing new patients. I just cannot afford to treat them. A free market even if for only 3 to 5 years would eventually level out the costs so that the true costs could be assessed.

I am not even going to address the burn out all these issues create. All my colleagues have expressed concern that we as doctors will not even be able to get medical care when we retire because all the good doctors are burning out and quitting."

Mr. Chairman, I would like to submit this letter for the record, along with an attachment that she included from a Medical Journal entitled "Government Medicine is Hazardous to Your Health."

Again, I think it is a problem. You do not need to comment on it.

Chairman CAMP. Without objection.

Mr. TIBERI. Thank you, Mr. Chairman.

[The insert of Hon. Patrick Tiberi follows:]

Dear Mr. President,

This article was in one of my medical publications. I don't know if the author sent you a copy, but his thoughts are very accurate.

I can no longer afford to take new Medicare patients. My staff does not want a salary cut. My supplies have never gone down in price. My computer support never goes down in price. My malpractice insurance never goes down. My utilities never go down. My equipment and repairs of current equipment do not go down in price. Every reimbursement cut comes right out of my pocket.

I have seen a lot of inadequate management of Medicare patients including my own parents. We can no longer afford to spend the time it takes to address multiple problems Medicare patients face and therefore integrate care. Rather than trying to accept that inadequate time and/or care is "better than nothing", I have decided to decline seeing new patients. I just can't afford to treat them. When you look at the reimbursements, I don't know how you can say, "yes, that's a fair price for medical care."

The problem with your calculations regarding Medicare reimbursement is that the "price of medical care" has been shifted so much that no one knows the true value anymore. A free market, even if for only 3-5 years would eventually level out the costs so that the true costs could be assessed. I know this would be painful for some at first, but I don't see any other way.

Many physicians, including myself, used to give away a lot of care. I still "no charge" patients who express to me their hardships. But when it gets to where you can barely pay your own bills, charity declines and costs go up.

Coding software/computerization is the other reason the costs keep going up. With coding software, many physicians/billing specialists are heading to seminars learning to maximize every single thing. In other words, no more charity.

And, I'm not even going to address the burn-out all of these issues create. All my colleagues express concern that we, as doctors, won't even be able to get medical care when we need it because all the good doctors are burning out and quitting.

I regret I don't have any other suggestions for the problems.

Thank you for your time and all you do for my country.

Very sincerely,

Deborah L Moritz, MD

CC: Patrick Tiberi, Sherrod Brown, Rob Portman

From the President:

Government Medicine Is Hazardous to Your Health

Lee D. Hieb, M.D.

The Association of American Physicians and Surgeons was founded in 1943 specifically to fight against the government takeover of the practice of medicine. Since that time, the organization has had triumphs and losses, but has tirelessly supported free markets and patient-centered ethical medicine

Today we continue the battle, and to paraphrase Winston Churchill, we have fought them on the beaches, and now the enemy is in our own backyard. Why do we persevere? Because government medicine fails, and it fails spectacularly. Government healthcare wonks around the world and in America promise better quality, lower cost, and better access, but government medicine produces just the opposite The same government that brought us the $600 toilet seat is now bringing us the $3 aspirin, and the $250 bone screw Let us review the talking points and the facts

Myths and Facts about the Quality of American Medicine

The World Health Organization (WHO) loves to devalue American medicine, ranking it 37th in the world, somewhere behind Sudan. But in spite of this report card, the powerful and wealthy, when sick, flock to America for care Boris Yeltsin underwent heart surgery in a special hospital, by American-trained surgeons, and imported Dr. Michael Debakey from Texas to supervise. His free universal Soviet healthcare system was satisfactory for the gray masses, but not for him Two Canadian premiers and at least one member of parliament have crossed the border clandestinely to get their medical care in the U S. If universal government medicine is so great, why didn't they stay home?

When the former sultan of Brunei needed care, did he go to Sweden or France or any other socialized, "equitable," more highly WHO-ranked country? No, he came here. People who know, and can afford to, vote on quality with their feet. And for good reason They know that "fairness of distribution," one of the major determinants of the WHO ranking, doesn't really count when you are sick

What really counts is outcomes In 2007, the British journal of cancer *Lancet Oncology* looked at survival from cancer around the world by country [1] On every chart, for every cancer examined, the best outcome, the best survival, was in America And the differences were not trivial For example, if one considers cancers that affect men, and lumps all cancers into a pool of outcomes, the chance of surviving five years after diagnosis in America was 66%, but in Europe it was 47%, and in Britain, nicknamed the "sick man of Europe," 45% Canada fared a little better at 53%, which may reflect the ability of some Canadians to jump the border to America for treatment For breast cancer, five-year survival was 90.5% in America, and 78 5% in Britain Similarly, survival after heart attack or stroke is better in the U.S. than in Britain or Canada, with their universal healthcare care. So, in answer to "Who you gonna call?" when you get sick, the answer is "us."

Why is there a 20% better cancer survival in America? A major reason for this discrepancy is the lack of access to specialty care in government-run systems In addition to the million-plus patients waiting for surgery under the National Health Service (NHS) in Britain, many more wait for evaluation for cancer or heart disease The average time from diagnosis of breast cancer to seeing a cancer specialist in Canada is 45 days In fact, only 50% of women biopsied for abnormal screening mammography get their diagnosis within 7 weeks [2] In America, we worry if we can't get a patient in to see the oncologist over a long weekend. In America for every million people 1,000 are receiving dialysis, in Europe it is 537 per million, and in England 328 per million Those who are untreated suffer and die As reported in a study by the National Kidney Research Fund and Sheffield University, "If the doctors responsible for those patients cannot find a unit to take them, then the only option is for the doctors to keep them comfortable in hospital until they die" [3] And while American cardiologists debate the best noninvasive ways to stratify cardiac risk in asymptomatic patients, Canadian medical journals publish articles concerning the best way to keep people from dropping over dead while waiting in line for care [4]

Another recurrent chant of the pro-government medicine forces is, "We spend more than any other country, yet have shorter lives and a higher newborn death rate!" The first truth is, longevity is very much determined by genetics and lifestyle and has less to do with medical care. Secondly, America, being a very large and industrialized country, kills many more people on the highway and in farm accidents than does tiny Luxembourg. And, unfortunately, we have an epidemic of obesity, which is a major cause of disease and mortality. But it turns out that this talking point may use untrue "facts."

In a recent comparison of life expectancy in Britain and the U.S by the RAND Corporation, [5] the British have longer life expectancy at birth, possibly skewed by the newborn tally differences noted below, but for every year of age after that, America begins to narrow the gap, and by age 60 catches up. By age 75 there is a clearly better life expectancy in America than in Britain: an additional 0.6 years for men, and 0.7 years for women—in spite of our obesity, trauma, and racial disparity, and higher incidences of cancer and diabetes. This suggests that over one's lifetime, medical care in America may be playing an even more significant role than the sound-bites suggest

As James P Smith stated, "It appears that at least in terms of survival at older ages [of people] with chronic disease, the medical system in the United States may be better than the system in England" [6] Coauthor James Banks concluded "The United States'

health problem is not fundamentally a healthcare or insurance problem, at least at older ages It is a problem of excess illness—and the solution to that problem may lie outside the healthcare delivery system The solution may be to alter lifestyles or other behaviours"[3]

As for infant mortality in America, an infant who takes a single breath and has a single heartbeat is counted as a live birth So if it dies in the next minute, it counts towards our perinatal mortality statistic and lowers our apparent life expectancy. Most of the world does not do this In Switzerland an infant must be 30 cm long before being counted as a "live birth," thereby dismissing the many premature infants that count toward the statistics Cuba doesn't bother to waste its precious bureaucracy on a baby until it is 2 to 3 months old If a baby is still alive at that point, a birth certificate will be issued. Michael Moore, where are you?

Myths and Facts about Cost

It is asserted that the U S spends much more than nations with universal healthcare In fact, we do not. The British pay 112 billion pounds per year for the NHS. Given exchange rates and a population of 61 1 million, this is about $3,232 per year per person, and this does not include the money paid by private citizens for insurance used to escape the NHS Although a Kaiser Family Foundation study says the average American family pays $13,375 for healthcare, this was through employer-purchased insurance Buying an individual policy with a $2,500 deductible, I pay $7,500 a year in health insurance for a family of four aged 19-62, or $2,500 per person. And for that fee I get access to top-quality care. The British, for half again as much outlay, get waiting lines, lack of access to primary care, and antiquated hospitals with inadequate staffing and a shortage of equipment As reported in a recent *Guardian*, referring to intended budget cuts, the chairman of the Royal College of General Practitioners warned, "The NHS shake-up risks wrecking GPs' relationship with their patients by turning them into rationers of care who deny the sick the treatment they need."

What is usually left out of the cost discussion is the great difference in incentive for care depending on who is paying When individuals pay themselves or through their purchase of insurance, they are motivated to get the most for their money, and those who profit from providing care are motivated to provide it. It is often—mostly falsely—claimed that doctors recommend and provide care solely to make money But how often do we hear the opposite and truer point that government avoids giving care because care-giving is a money loser?

In America there is profit in performing computed tomography (CT), so we invest in CT scanners, and to pay off the investment we keep the machines well maintained and run them efficiently There is no place in America where I cannot get a CT scan for a patient within hours. In Canada and other socialized government systems, there is no profit, and in fact, the more a CT scanner is run, the more drain on the government budget So, there is no incentive to maintain and run the CT machines In fact, for the government bureaucrat who pays the cost of the CT scanner, it is better if the scanner sits idle and does no studies. Anything else costs more money As a result, in Thunder Bay, Ontario—a major regional medical center—it takes on average 3 months for a patient to get a CT scan (Lee Kurisko, personal communication, 2010) Nor can this be blamed on some woeful Canadian technology lag, or the cold climate, or any other variable one could conjure up, because a dog or cat can obtain a CT scan within hours in Canada They are cash-paying patients

Improved technology often gets blamed for rising medical costs, but note that in areas of life not touched by any government agency, technologic advance drives costs down and quality up With cell phones and computers, the free market has brought us thousands of improvements in service and capability at a fraction of the cost In medicine too, Lasik is better today than 10 years ago at less than half the cost because no insurance or government payer drives up the administrative cost, and there is free-market competition.

The real cost problem in medicine is directly related to the 150,000-plus pages of Medicare regulation with monthly updates that carry the force of law, the ponderously slow bureaucracy of the FDA, and the codification of medicine via the AMA's Current Procedural Terminology (CPT) and WHO's International Classification of Diseases (ICD) book. We are being buried in mounds of bureaucratic paperwork that costs a fortune in compliance. My orthopedic office employed seven people. They were needed for billing and Medicare compliance If patients had paid cash for outpatient visits and my office had not been subject to Medicare audits, I could have managed quite well with two employees. In 1970, after 20 years of practice, my father's files barely filled a small three-drawer filing cabinet. After 16 years of private practice, my records filled a medium storage unit, and I destroyed charts of adults after seven years Costs, costs, costs

The FDA, under the guise of making us safer, makes everything vastly more expensive The price of the obstacles of getting drugs to market has been well described,[4] but the FDA has many other ways of inflating costs. A few years ago, the FDA decided that if hospitals or offices were going to re-use equipment designated for "one-time use," they must re-do the testing procedure, which initially took an average 15 years by the manufacturers, to insure multiple-use safety This is simply no possible for hospitals to do. Predictably, manufacturers began marking obviously re-usable items, such as carbon fiber externa fixators costing $6,000, as "one-time use," and the hospitals were forced into throwing away and re-buying costly items Does make sense that Hibiclens antibacterial soap become "outdated"? We just threw cases of it away at my hospital, but have never seen an expiration date on my household dis detergent And when the FDA demanded that pharmaceutic manufacturers bring factories making long-establishe preparations up to new standards, they simply closed th factories, rather than lose money. This resulted in a shortage tetanus toxoid, and increased cost from the one remaining sour now a government-created monopoly Currently we are short Fentanyl, a mainstay of anesthesia care, and the antibio Levoquin, and have been critically short of Propofol for gene anesthesia—what will be next? And are we safer?

Just when you thought the government could not get a more intrusive, or sillier, the Center for Medicare and Medic

Services (CMS) is demanding that doctors start using ICD-10 Dr. Tamzin Rosenwasser, a past AAPS president, notes in her recent article "Call a Code This Doctor's Heart Stopped Beating"[7] that we have gone from 13,000 to 70,000 diagnostic entries, including codes for such things as a "burn due to water-skis on fire, initial encounter." And there is one for drowning while jumping from said burning skis Codes such as "pecked by a chicken, initial encounter," and "pecked by a chicken, subsequent encounter" would be funny if the implementation of such minutiae did not create such a drain on the capacity to actually practice medicine

The hours and manpower wasted on regulatory compliance far exceed other costs in the system Call Stephen Hawking: we may be nearing a previously unrecognized physical barrier—the black hole of regulatory inertia where so much negative government force is applied that no actual medical care can escape the bureaucratic gravitational field.

Coverage versus Access

Most importantly, government does not increase access to care Having "coverage" and having a doctor are very different, as Canadians know At first, Canadians were simply in long lines for specialists, but now they stand in long lines—sometimes years—in hopes of signing on to a primary care doctor. Currently two million Quebecers are without a family physician[8] Yves Boldac, the province's health minister, and a physician himself, says, "Improving access is a key concern for the government."[8] Has he forgotten that the reason for implementing government medicine was to provide improved access?

Despite frequent praise for Canada's "universal healthcare," there are uninsured persons in Canada Canadians, to be part of the system must be legal residents who file taxes and pay the "premium" or fee for health care The homeless, self-employed, and illegals do not qualify unless they pay the "premium" to be enrolled At least 5% of working, non-homeless British Columbians are without health insurance because they have not paid the premium Recently, in an Ontario Emergency Room, a sign read "Uninsured Canadians (Canadian Resident with no valid health card) must pay $169 before being seen in the Emergency Room Life-threatening emergencies are, of course, cared for But the definition of life-threatening may be disputed. A British Columbian psychiatric nurse reported that her emergency department turned away a homeless man who was brought in by the police after trying to jump off a bridge to commit suicide His problem was not deemed life-threatening, and he was referred to the next day walk-in clinic

A recent Medicare decision epitomizes how government regulation decreases care, quality, and access Recently, CMS imposed new credentialing requirements on the technicians who perform Doppler ultrasound testing This testing is to check for life-threatening blood clots in a person's legs, and has been around for more than 20 years Prior to the new regulation, patients at my hospital could have the test done in about 10 minutes at a cost of $235 to Medicare. But now, because our technician, who has been doing the test for 20 years, is no longer "qualified" according to the new Medicare statutes, patients must be transported to another facility 45 minutes or more away The time for the doctor to get results has gone from 30 minutes to well over six hours, and the cost has risen from $235 to more than $3,500 because of the ambulance ride. As for access to care, it is clearly less for Medicare patients, but sadly, even if you are a non-Medicare patient who has bought insurance (i.e. paid money for the privilege of this testing), even you cannot receive the testing at our facility because that would be "discriminatory" against Medicare patients Presumably, someone at CMS wrote this requirement in the name of quality enhancement or patient safety But the results are so horrific that some hospitals are practicing civil disobedience and continuing to do the test without further certification of technicians. The rest of us are just praying no one dies as a result of this regulatory nightmare.

Finally, government can never deliver care without choosing who gets what and therefore valuing some citizens above others The NHS would never allow discrimination against "Peter" in favor of "Paul," but will decide not to treat "Peter's disease" in order to care for "Paul's disease" Government divides the population into disease groups, and allots funds to each group. By any name you want to give it, government rations care.

There is a real cost to the goods and services of medical care, and the reality is that there will always be more medical care available than any one person or any government can afford The question is, do you and your family decide how to spend your money, or do you give those decisions to a faceless government agency? Under "ObamaCare," 15 non-elected officials decide what treatments will be paid for, and are therefore available Neither physicians nor patients can appeal their decisions, and only a two-thirds U.S. Senate vote can overturn their ruling.

Government may be inefficient and ineffective in healthcare management, but it is very effective in usurping liberty, while claiming all the while to be making us safer and healthier. Columnist Charley Reese said it best when he opined, "There's no dishonor in being forced by a superior power into slavery, but it is an eternal disgrace to voluntarily surrender one's liberty for a filthy bowl of oatmeal and the promise of security by liars."

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Mr. TIBERI. I think it is a problem that continues to occur throughout our Nation.

The final issue I would like to see if you would answer a question on, the Bishop of Columbus, Bishop Frederick Campbell, put out a letter a couple of weeks ago after the ruling you put out, and I would like to read part of it.

This was sent out to his constituency within the Columbus Diocese, which also includes, according to Bishop Campbell, a number of schools and a number of charities.

I quote from his letter regarding the HHS' recent ruling, "In so ruling, the Administration has cast aside the First amendment to the Constitution of the United States, denying to Catholics our Nation's first and most fundamental freedom, that of religious liberty, and as a result, unless the rule is overturned, we Catholics will be compelled either to violate our consciences or to drop health care coverage for our employees, and suffer the penalties for doing so.

The Administration's sole concession was to give our institutions 1 year to comply. We cannot, we will not comply with this unjust law."

In talking to Bishop Campbell, he believes the so-called "accommodation" recently issued by the President does nothing to remedy the problem, and that the regulation encroaches on the religious freedoms and the First amendment.

CRS just put out a report saying if employers, for instance, had 100 employees, Madam Secretary, and refused to comply with the mandate, there would be a $100 a day fine for each individual employee.

You could add that up to $3.65 million for the year. The Diocese of Columbus has many more than just 100 employees, all of whom when they got hired knew what health care they were getting, and the Bishop and I talked about the President so clearly saying if you like what you have, you can keep it. He said that over and over many times.

My question to you is if they refuse the mandate, refuse to violate their First amendment, refuse to violate their religious beliefs, and refuse to pay the fine, what consequences as an employer will Bishop Campbell face?

Secretary SEBELIUS. Congressman, I think what you are referring to is a portion of the Affordable Care Act where we were directed to develop a set of preventive health measures specifically for women's health, which has been a missing piece of a lot of insurance puzzles for a long time.

We turned to the independent doctors and researchers at the Institute of Medicine who came back with eight recommendations, well women screening and domestic violence screening, contraceptive coverage, mental health services, which are often missing from parts of the plan.

We then looked around the country at the 28 States which have mandatory contraception laws already in place, many of which existed from the mid-nineties, and looked at the way those laws are enacted, particularly with regard to religious freedom and religious facilities, and proposed in the rule the exemption that was the most commonly used among States who had any kind of exemption.

That rule was finalized at the end of January, and it fully exempts churches and church affiliates. We think it also applies to likely most parochial schools, many religious high schools.

Those employers who are not fully exempt in the declaration in January would be given a year to comply, and we pledged to work with religious leaders around their religious objections.

In February, I joined the President in announcing that we will be promulgating a rule which will, I think, both not only ensure religious liberty but also women's health benefits.

It mandates that insurance companies, not the providers, but insurance companies will be making available to women at their choice—we will have a provision dealing with self-insured plans who work through third party administrators, to make sure anyone with a religious exemption will not provide or pay for or refer people to contraception services, and maintain their religious freedom.

On the other hand, we will make sure that women across this country do not by the virtue of where she works or where her spouse works or where her parents work have health benefits that are limited.

I think the accommodation made to religious providers, which does not come into effect for 18 months, is one that protects religious liberty but makes sure that women's health services will be full and complete for the first time ever in the history of this country.

Chairman CAMP. The time has expired. I did not hear what would be the penalty if they did not comply, to Mr. Tiberi's question. We are way over time here, but if you could.

Secretary SEBELIUS. I have no idea. It is a hypothetical. If you want to submit that in writing, I will get you an answer in writing.

Mr. TIBERI. Thank you.

Chairman CAMP. Thank you. Mr. Lewis is recognized for 5 minutes.

Mr. LEWIS. Thank you very much, Mr. Chairman. Madam Secretary, thank you for being here today. Thank you for your vision. Thank you for your leadership.

You know, Madam Secretary, I believe that health care is a right and not a privilege. As we implement the Affordable Care Act, I know we are moving closer and closer to that promise of health care for all Americans.

I am so proud of the success you are having with the Affordable Care Act. Already, millions of young people have access to their parents' health insurance. Millions of seniors with free preventive care and low costs on prescription drugs. That is just the beginning.

I want to take just a moment to thank you for your commitment to women's health. That is important.

No man, no State, no Federal Government, should be able to tell a woman what she can or cannot do with her body.

Madam Secretary, Republicans in Congress have made it a first priority to repeal the Affordable Care Act and put insurance companies back in charge. After all the success we have had, I think this is just a bad idea.

Can you tell us, tell Members of this Committee, what would happen to American families, consumers and seniors, if Republicans repeal health reform?

Secretary SEBELIUS. Congressman, I think the benefits that you just recited with 2.5 million young Americans who now have coverage who were uninsured 2 years ago would go away.

Clearly, seniors would lose the preventive care measures that now they can access without co-pays or co-insurance through Medicare. We know that millions of seniors are doing just that.

The 3.5 million almost 4 million seniors who are watching their doughnut hole payments for prescription drugs be cut in half this year would again be in a situation where they would have to choose between buying groceries or buying their medicine.

We know that parents who have children with preexisting health conditions would once again have the insurance companies lock them out of the marketplace. Cancer victims who now know their benefits cannot run out in the middle of treatment would be back in the soup.

I think back to the discussion that I know is of great concern to this Committee overall, there would be no opportunity to really look at the overall trajectory of health care costs.

Insurance companies would pick and choose who gets covered. The health insurance market would continue to shrink, which it has been doing year in and year out, as young and healthier people drop out because of the lack of competition and the lack of affordable coverage.

I think short term, it is bad news for millions of people who already have engaged with the benefits. Long term, it is even worse news. There would be no health care spending control, and there would be very little opportunity for small businessowners and individuals to ever have affordable health coverage.

Mr. LEWIS. Madam Secretary, some people suggest that the Affordable Care Act will be bad for small business. Can you describe how this Act helps small businesses?

Secretary SEBELIUS. Well, I do not think there is any question, and some of this is based on days in the insurance department in Kansas, small businessowners, family farmers and others are often at the shortest end of the stick in the insurance market.

They do not have any market leverage because they do not have enough employees to negotiate for their own policy.

If there is a health incident of any family member or any employee, they actually pay significantly higher rates. I think on average they are paying about 20 percent more than their large competitors are paying for exactly the same coverage.

Year in and year out, those rates are sky rocketing, again, because often they do not have market power.

In the days where there will be a State-based insurance exchange, small businessowners will not have to join an association or provide any membership fee or so anything else, they will have a new shopping marketplace where they will be part of a much larger virtual pool.

Preexisting conditions may not be considered. Companies will have to compete on the basis of price and product for the first time ever, and small businessowners, I think, not only get tax credits

now and into the future, but are potentially the biggest winners in the new marketplace.

Mr. LEWIS. Thank you very much, Madam Secretary.

Chairman CAMP. Thank you.

Mr. LEWIS. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Davis is recognized for 5 minutes.

Mr. DAVIS. Thank you, Mr. Chairman. I would like to move away from health issues for a moment and talk about human services, from temporary assistance to needy families, to child care and child support enforcement.

I know we both share the view that the programs are important to families as they move to self sufficiency.

While they all have a similar goal of helping low income families, for the most part, they operate independently. I notice there is a tremendous amount of program redundancy and also a lack of ability of systems to communicate.

Before I came to Congress, I ran a consulting firm focused on system integration, in effect, helping companies maximize effectiveness by minimizing complexity.

In the private sector, a well run business will coordinate information and resources between its operating divisions, saving a lot of money in the process in reducing overhead, being much more agile in being able to respond to customers.

Unfortunately, many of your human services programs do not operate this way.

I chair the Human Resources Subcommittee and deal with this on a weekly basis here in Congress.

Inside HHS, there are many legacy systems and processes that are siloed, many of which were actually put in place when you and I were children.

As you know, the House has moved several bipartisan efforts to standardize the exchange of data and reporting in human service programs.

The most recent example was in the recent Middle Class Tax Relief and Job Creation Act. We had referred to a provision inside that as "data standardization," and the Chairman worked very hard to make sure that got all the way through the Conference Committee.

My view is that you cannot fix what you cannot measure. Data standardization will make reported and collected data more interactive and useful to better measure our outcomes and proactively identify problems and improve the effective use of taxpayer dollars.

Our over arching long term goal was to improve the efficiency and coordination of these programs and to help more families become self-sufficient.

I think there is some common ground here.

What I am interested in is hearing your thoughts on data standardization in general, but several questions or a question with several parts.

First, do you agree the human service programs are siloed and could operate in a more efficient manner?

Second, do you think the data standardization provision will be helpful in better coordinating programs and services, and in fact, should be expanded into other parts of your jurisdiction?

Third, what more can Congress do to help your Department bring these programs into the 21st century?

I am focused very much on the processes. There will always be ideological or policy issues where we may disagree. From a fundamental business perspective, I would like to hear your views on this.

Secretary SEBELIUS. Mr. Davis, my understanding from our staff is this effort on data standardization was not only enormously productive and found a lot of common ground, but we are eager to continue to work with you and others on identifying other areas.

I do not think there is any question that government programs are often siloed. We have done an effort across the Department of Health and Human Services to look at redundancies, try to eliminate areas where we are repeating mechanisms.

We have gone to a data sharing platform in many systems where people are not any longer building new data systems to support some unique program by looking at ways to share that.

We would be eager to find additional strategies. Sometimes new eyes and looks at budgets reveal things that people have not seen from the outside.

I am a huge believer in the more efficiently we can operate any of our programs, the more strategies we can implement, not only that have been in place in the private sector 10 years ago, but some of them 50 years ago are all good news.

I would look forward to that. Again, I think the project that you mentioned, my understanding is it is off to a good start. We would love to find additional ways to continue that.

Mr. DAVIS. I appreciate that. One thing that I would note, I know the gentleman from Washington State mentioned earlier about the recent fraud case in Dallas, Texas—when we look at improper payments, the wider aspect of this, about 10.5 percent of all payments coming out of the Center for Medicare and Medicaid Services fall into the category of improper.

Frankly, as an engineer by background, I am not looking at this in terms of that, but most of the challenges that I think we are facing are driven by broken processes in this area with payments.

We do look forward to working with you on this. Would you like to see this standardization effort extended into the health care jurisdiction, for us to move that legislation, and would you help us move that data standardization legislation into the space with the Center for Medicare Services to address this issue?

Secretary SEBELIUS. I would certainly love to continue a conversation. I am not quite sure what the global question implies. I can tell you in the improper payment space, I just want to make it very clear to Members of Congress that improper payment and fraud are two very things.

There are health care providers who do not fill out a form accurately and it is sent back and they fill it out accurately. That is an improper payment.

It is important to reduce those numbers, and we have had a program in place of lots of training and outreach.

Some is fraud. We are also building, I think, for the first time ever a central data system, a predictive modeling system, using some of the strategies that have been very effective in the private sector for decades, finally bringing them to this program.

Again, I would just look forward to continuing the conversation and finding ways to make this more applicable across the board.

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

Chairman CAMP. Thank you. Mr. Reichert is recognized for 5 minutes.

Mr. REICHERT. Thank you, Mr. Chairman. Welcome, Madam Secretary. Thank you for being here today.

I think that all of us on this panel agree with you on a number of things that you have testified to today. Some of those, I would like to quickly repeat.

Quality versus quantity. I think we can all agree that is a goal. Efficient service. Cost effective service. Accessible service. All of those things that I think all of us who are trying to resolve this issue would agree would be a great thing to accomplish, but we know it is going to take a while.

I want to focus on the cost increase. The Chairman touched on this question as did some others, and a promise that was made by the President.

This was a promise that everyone could keep their health insurance if they liked it, if you like your health insurance, you can keep it. I think Mr. Tiberi mentioned that earlier.

You and I had a conversation the last time you appeared here, I think, regarding this issue.

Since that time, your own organization has said on regulation on grandfathered health plans, "Seven out of ten employers will not be able to maintain their grandfathered status.

According to a survey completed last Fall by Towers Watson, one out of every ten mid-sized or big employers expect to stop offering health care coverage to workers after insurance exchanges begin in 2014.

That seems to run contrary, at least from my perspective, to the President's promise.

Also connected with this issue is the 11.4 million Americans who have their own health savings accounts have great concerns as to whether or not they will be able to keep their health care plans because of the restrictions of the law placed upon health savings accounts.

Can you commit today that the 11.4 million Americans with HSAs will be able to keep their plans in 2014 and beyond?

Secretary SEBELIUS. Congressman, as you know, as part of the implementation strategy, we are looking at what will constitute health insurance, and some of those plans are very much companions to a health insurance plan, and would very much be applicable on into the future.

Others are not insurance plans. They are really kind of savings plans for portions of health care costs that are not covered by insurance, but they do not accompany a health care plan.

It is impossible to say across the board what will happen as part of the goal of the Affordable Care Act, as you know, is to have a

health insurance plan which has a comprehensive set of benefits, but also has affordable characteristics.

Your notion that somehow companies in grandfathered plans will not be able to keep their grandfathered plan is really not accurate.

What that reflects is employers changing the plan on a voluntary basis in a marketplace where they are looking to newer, innovative strategies or other operations, so they have made the choice to change the insurance plan outside the grandfather rule. It is nothing that the Affordable Care Act is imposing on them. It is the employer/issuer's choice.

Mr. REICHERT. Do they not make that decision based upon the language in the law though?

Secretary SEBELIUS. No, sir. The language in the law basically defined what you have in 2010, and it put some framework around that snapshot.

If an employer in a voluntary market chooses to change that plan, he or she is well within their capability of doing that, and they are doing that all the time. That is what the projection is.

Mr. REICHERT. If I may, Madam Secretary. The bottom line is if you like your health care plan, you are not going to be able to keep it. It is going to change.

The last question I have is that thanks to Children's Hospital's Graduate Medical Education Program, Children's Hospitals have not only expanded their residency programs, they have also increased their training experience and services in underserved communities, expanding children's access to care.

Hospitals like Children's train over 5,600 full time equivalent residents annually.

The Administration has proposed cutting this funding by two-thirds. Have you looked into the impact of this cut on children's access to health care, and how it will look in the future?

Secretary SEBELIUS. I have, Congressman. I have actually visited with a lot of the leaders at Children's Hospitals across the country.

There is no question that in a better budget time, I think a robust funding of all graduate medical education would be the preferred path forward.

What this budget reflects is a redirection of some of those dollars to research universities and others who are focused primarily on additional primary care providers.

There are other sources of funding outside of the Children's Graduate Medical Education that funnel into Children's Hospitals.

We are watching very closely the good work they do in the access to care, and will continue to monitor that as we move forward.

Mr. REICHERT. Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Mr. Neal is recognized.

Mr. NEAL. Thank you, Mr. Chairman.

Madam Secretary, I do not think we should understate the progress you have been making in the area of fraud. I think there are many more stories that dominate headlines and evening newscasts.

During the run up to the health care debate, I pushed the Democratic leadership really hard as an act of credibility to continue to weed out fraud wherever it can be found.

It is still estimated, as you know, that there is up to $50 billion of fraud in Medicare. Is that number accurate as you see it?

Secretary SEBELIUS. I think, Mr. Neal, it is almost impossible—if we knew where it was, we would go get it.

Mr. NEAL. Sure. My point is you are making progress.

Secretary SEBELIUS. It is a substantial program and we think there is probably way too much fraud involved in the operations.

Mr. NEAL. I think it should be acknowledged that the effort is now being made on a sustained basis.

Secretary SEBELIUS. There is no question that the tools that were provided as part of the Affordable Care Act are the toughest antifraud legislation ever in the history of this country, doubling criminal penalties, giving us new civil sanctions, setting up resources for the first time on a department to department basis. The Justice Department and HHS are very much at the table focused on hot spots.

The ability to build a predictive modeling system. Recredentialing of providers in some of the most troubled areas, all of which is beginning to pay big dividends.

The Attorney General and I were able to announce a couple of weeks ago that in calendar year 2011, the largest single year for recovering fraudulent efforts, $4 billion was returned to the trust fund. Medicaid funds were returned to Medicaid.

These efforts are really just beginning. We are 2 years in. I do not think there is any question that for the first time, there is a very serious, very focused—driven from the President on down—effort to really target, and not just prosecute after the fact, but prevent before the money goes out the door, and that is going to be a huge change.

Mr. NEAL. I think that needs to be acknowledged. I am pleased with the way you framed it.

I do share Mr. Reichert's concerns about Children's Hospitals. We have an exceptional one, as you know, in Boston. They have petitioned me, obviously, to raise the issue with you. I cannot think of better advocacy than the role they play every day. That is a jewel in the hospitals across Massachusetts.

I think where we might be able to find additional money for them, it would be very helpful.

In addition, the rehabilitation hospitals. They are concerned their funding has been flat now since about 2004. I would urge there. I have a substantial rehab hospital as well. Of course, across Massachusetts, you could find a hospital in many places.

It is very important to all of us, not just in terms of first class health care, but as a great economic engine for research across the New England region.

Thank you, Mr. Chairman.

Chairman CAMP. Thank you. Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Secretary Sebelius, in July of last year, you told the House Energy and Commerce Committee IPAB may not ration care but you admitted this word remains undefined in the 2010 law.

The health law only requires IPAB to protect seniors' access to the extent feasible—when dealing with meeting mandatory spending targets.

As a physician, a heart surgeon, who has dealt with a lot of quality initiatives that gave demonstrable results with regard to quality in the hospital where I practiced, I feel very comfortable in speaking for a number of physicians across this country and Members of Congress in a bipartisan way who have deep concerns about IPAB and how it may affect the doctor/patient relationship.

Mr. Ryan asked some intricate questions over some of the terms that were laid out. I want to take it down to a very basic level that I think everybody in the room could easily understand.

Could you please tell seniors if you plan to define the word "rationing" when you issue rules for setting up and implementing IPAB?

Secretary SEBELIUS. I am certain that definition will be defined, and just to clarify once again, Congressman——

Mr. BOUSTANY. You are saying yes?

Secretary SEBELIUS. IPAB cannot implement any recommendations. They are a recommending body. They do not implement anything. They do not control the Medicare benefit package. They do not control the spending package.

The last thing they can do, according to the law, is ration care.

Mr. BOUSTANY. But the IPAB recommendations go into effect unless a majority——

Secretary SEBELIUS. If Congress fails to act. If it fails to object to an IPAB recommendation——

Mr. BOUSTANY. Why is the bar set so high in the law for Congress? Two-thirds vote in the House, two-thirds in the Senate to change IPAB.

Secretary SEBELIUS. I think there is a sense that Congress would object to issues or cuts that would harm beneficiaries. IPAB is prohibited from that. They cannot ration care. They cannot——

Mr. BOUSTANY. It is a seeming contradiction. You are planning to define "rationing" in the implementation?

Secretary SEBELIUS. I would assume we will make a series of definitions around what IPAB can and cannot do based on the law.

Mr. BOUSTANY. Okay. Thank you. Let me change tracks now. In December 2011, there was an article published in Health Affairs that stated that HHS knew in 2010 that the CLASS Program would not work.

It was noted the Obama Administration quietly negotiated a series of legislative fixes to the law aimed at maintaining the long run stability of CLASS, but these amendments were never discussed with this Committee, yet you waited until February of 2011, nearly a year later, after the law was passed, to announce that CLASS was totally unsustainable as written.

It seems as if your Department knew for some time that the program would not work, and yet you did not bring this information that was requested forward to Congress.

I have to tell you, having sent a number of letters on this, working with Senator Thune and others, I am a bit irate that I first learned about these supposed fixes in a journal article because we had been requesting documents since last March.

However, in the documents we have received from your Department, not one word mentions secret back room deals HHS was making in early 2010.

Why has not the Department released this information?

Secretary SEBELIUS. Congressman, I have no idea who was in the back room with whom and making deals. That was certainly nobody from our Department.

What I can tell you is that during the Fall when there was discussion about the CLASS Act, and subsequently prior to votes, our actuary, the CMS actuary, did present open testimony that was available, casting some real doubt about the long term viability of the program.

As you know, when CLASS was put into law, I was directed to come to Congress before a program could be started——

Mr. BOUSTANY. My time is running short. In follow up to letters we have recently submitted and in the past, I would like for your Department to disclose details of HHS meetings and contacts with CBO regarding CLASS over the past 2 years.

Secretary SEBELIUS. I would be happy to.

Mr. BOUSTANY. Thank you.

Chairman CAMP. Mr. Roskam is recognized for 5 minutes.

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

Madam Secretary, much of the HHS component of the White House budget deals with the President's health care overhaul.

I would like just to have a conversation with you about that. Back in 2008, then candidate Obama promised that his plan would save the average family $2,500 on their premiums, and yet according to Kaiser Health News, workers paid an average of $132 more for family coverage in 2011 alone.

The rhetoric did not match the reality, did it?

Secretary SEBELIUS. As you know, the plan is not implemented yet for families. That will be the case. The Congressional Budget Office has actually estimated that families will save thousands of dollars once the exchanges are up and running, but the vast majority of Americans do not yet have access to affordable available coverage. That is correct.

What you are seeing is a private market continuing to escalate year in and year out as they have for years prior to the Affordable Care Act.

Mr. ROSKAM. How about when the President said you can keep your health care coverage if you like it. If you like it, you get to keep it. Yet, the reality is, according to Bloomberg at least, 9 percent fewer businesses are offering medical coverage than in 2010.

There, the rhetoric did not meet the reality, did it?

Secretary SEBELIUS. Well, again, Congressman, I think what you are seeing is it would not have mattered if we had passed the Affordable Care Act or not.

The private market is in a death spiral and has been in a death spiral I would say for 10 to 15 years, with more and more employers dropping coverage as rates continue to skyrocket.

For the first time, I think we have an opportunity, and we have seen some pretty good news with new rate review going on in States across the country, where double digit rate increases are being withdrawn, where insurance commissioners are stepping up for the first time and making studies on actuarial soundness.

We are going to see some stability, but short term, we will still see a very shaky market until we get to 2014.

Mr. ROSKAM. All right. Back in 2009, President Obama told the American public that he was "Pledging to cut the deficit that we inherited in half by the end of my first term in office."

That rhetoric surely did not meet reality, is that not right?

Secretary SEBELIUS. Unfortunately, as you well know, Congressman, the President inherited probably the worse downturn in the economy since the Great Depression.

Mr. ROSKAM. It is true, the rhetoric and reality do not connect?

Secretary SEBELIUS. We are currently, I think, on a positive trajectory, but that is not likely to happen, which is why he needs a second term.

Mr. ROSKAM. Yes, so we can keep doing trillion dollar deficits.

Turning back to your conversation with Congressman Tiberi a minute ago, under this new health care law, the Secretary of Health and Human Services has required a group of individuals to really violate a fundamental belief that they have.

You walked through and had a little bit of a discussion, but it was not really clear to me what the remedy is for the Department if you have an organization that says look, with all due respect to the Department of Health and Human Services, we are going to follow our conscience. We are going to follow the fundamental belief that we think we have, and we do not agree with the interpretation in the guidance of the Federal Government.

What is the remedy, Madam Secretary, that you have? For example, you have the ability to fine these organizations $100 a day per employee. Let's say you have a hospital. That is $50,000 a day. That is $1.8 million in fines.

What else can you do to make them comply?

Secretary SEBELIUS. Congressman, I think that the issue of religious liberty is one that I and the President take very, very seriously.

The issue of women's health coverage is also one that I take very seriously.

What we have proposed and what we will put into a rule and solicit comments on, and we are already doing outreach to a variety of not only religious employers but labor groups and women's groups and providers, is an accommodation so that the employers who have a religious objection to contraceptive coverage do not offer, do not pay for, do not refer people to contraception.

On the other hand, their employees, whether she be a teacher or a doctor or a janitor, will have a choice about her own health care services, and be provided, according to the recommendations of the Institute of Medicine.

Chairman CAMP. The time has expired.

I do hope that the Secretary will give as much weight to the First amendment to the Constitution as to the other factors you have mentioned.

Mr. Levin and I have consulted. There will be a series of votes about 3:15. We are going to move into 3 minutes. I am going to have to keep very tight on the time here so that everyone has an opportunity.

Mr. Becerra is recognized for 3 minutes.

Mr. BECERRA. Madam Secretary, thank you very much for being here. I am heartened some by the conversation here because while 2 years ago we had a very wrenching debate about trying to move reform in this country forward, now it seems like the concerns are around the edges, about improving health care.

There are some concerns, but I think no one would deny that there have been remarkable improvements made to the system. You mentioned some.

I know there are over 54 million Americans who today are receiving expanded preventive health care services. Some additional 30 million or so seniors who are receiving expanded preventive services.

There are seniors who today have saved some $2 billion from not having to pay for prescription drugs through the doughnut hole, where they would have to pay out of pocket the whole cost.

There are some four million small businesses today that can claim a tax credit for providing health care coverage to employees that before they would not cover.

There are some 72,000 children who have become newly insured because today there are protections against discrimination by health insurers, health insurance companies, against children who have preexisting conditions.

You mentioned the 2.5 million young adults who today have insurance because they are able to stay on their parents' insurance coverage.

There are some 20,000 Americans/consumers who no longer have lifetime limits on their benefits.

Surprise, surprise, what I think is very important as well, we have been hearing about how this reform would be a job killer.

In fact, last year, some 300,000 jobs were created in the health care sector. One in every five jobs created last year was in the health care sector.

I think there are any number of good surprises, and we thank you for all the work you are doing to try to make it even better as we continue forward.

A question to you regarding the Medicare Advantage Program, which you were asked about earlier. It seems to me you made a very important point. We are not making any cuts to the Medicare Advantage Program. We are reducing the amount they have been overpaid for years.

I think you mentioned the amount of overpayment on average. Do you remember what that number was that you said?

Secretary SEBELIUS. It is about 13 percent more than fee-for-service side by side.

Mr. BECERRA. If I recollect, no senior would be deprived of health care through Medicare. They may find their health insurer may decide to change the package of benefits a bit, but not the core benefits that Medicare requires or guarantees to every senior in America. Is that right?

Secretary SEBELIUS. That is correct. If anything, what we are seeing, Congressman, in spite of the accusations 2 years ago that somehow reducing this subsidy, which was built in by Congress years ago to overpay companies to encourage them to come into the market, reducing that subsidy would somehow have a damaging ef-

fect on Medicare Advantage, but what we are seeing is companies do just the opposite.

They are eagerly coming into the space, staying in the space. Medicare beneficiaries have choices in virtually every part of the country between fee-for-service and Medicare Advantage plans, and rates for Medicare Advantage plans are coming down.

Mr. BECERRA. All right. Thank you.

Chairman CAMP. Time has expired. Mr. Gerlach is recognized.

Mr. GERLACH. Thank you, Mr. Chairman.

Madam Secretary, I would like to get back real quickly to the Medicare fraud issue, if I might.

The Department of Justice estimates the fraud problem to be about $60 billion a year. Congressman Neal mentioned the figure of $50 billion a year. You indicated you do not have a clear estimate of what that is.

Let's assume it is $50 billion a year. Take that times ten. That is $500 billion over a 10 year budgeting window.

In your testimony, you indicate here that you have some initiatives going on within HHS that by a conservative estimate would save $11.3 billion in Medicare and Medicaid savings, as well as another $3.6 billion over 10 years through this comprehensive fraud fighting effort.

That is $15 billion over 10 years compared to a $500 billion problem. I think that is about 3 percent, actually.

Why is there not more being done to really root out fraud? You said if we knew where it is, we would go after it. We do know it is phantom billing. We know it is the criminal use of physicians' UPIN numbers. We know it is stealing beneficiary identifications for criminal use.

We know how it is occurring, so why are you only proposing a 3 percentage point reduction in fraud over 10 years?

Secretary SEBELIUS. Congressman, I think there is no question we need an "all of the above" strategy, and that is exactly what we are doing, I would say for the first time.

We have a senior administrator who is for the first time charged with building a fraud and antifraud system throughout the program.

We are as I said re-credentialing providers, using the law enforcement tools, building a predictive modeling system, bringing the billing strategies into one—we are doing exactly that.

Mr. GERLACH. Have you thought about using a smart card system? Germany uses a smart card access system, which has eliminated fraud. The Department of Defense uses a smart card system to prevent fraud.

Are you looking at that specific effort to tie beneficiary with the service provider at the time of the transaction to eliminate fraud?

Secretary SEBELIUS. We are. There are a number of strategies looking at a different kind of Medicare card that would be less easy to access and less easy to steal or share.

There are about 50 different billing systems that currently take the card. We are working actively——

Mr. GERLACH. Could you share that information with us?

Secretary SEBELIUS. Certainly, sir.

Mr. GERLACH. Okay. Thank you, Madam Secretary.

Secretary SEBELIUS. If you have new strategies, I would love to hear them.

Mr. GERLACH. We have a pretty good idea we would love to share. Thank you, Madam Secretary.

Chairman CAMP. Thank you. Dr. Price is recognized for 3 minutes.

Dr. PRICE. Thank you, Mr. Chairman.

Madam Secretary, welcome back.

Secretary SEBELIUS. Thank you.

Dr. PRICE. I wonder if you ever relished the irony of a former State executive director of the Trial Lawyers Association heading the Health and Human Services Department? Does that ever cross your mind at all?

Secretary SEBELIUS. No.

Dr. PRICE. Good. Some of us relish in that. Mr. Lewis asked you what would happen if the President's health care law were repealed. You went through a whole series of scare tactics that you revealed to the American people.

You know better than that, Madam Secretary. There are wonderful, positive proposals and options to be able to get folks covered, to be able to solve the insurance challenges, to address some of the real costs that are driving physicians out of being able to take care of patients, and driving patients away from being able to see doctors, that we ought to have a honest debate about.

The President has mentioned over and over if you like what you have, you can keep it. Grandfathered plans have been talked about. You said yourself if you keep what you had in 2010, then you are eligible for grandfathering.

The fact of the matter is that the law stipulates that if anything changes, if an employee is added, if there is a benefit that is changed at all, then one is not eligible.

Secretary SEBELIUS. That is not accurate, Congressman. I would be glad to provide you the details.

You cannot shift——

Dr. PRICE. I look forward to that.

Secretary SEBELIUS. You cannot shift costs onto beneficiaries and you cannot cancel benefits to the detriment of beneficiaries.

Dr. PRICE. It is huge for seniors, and they are being denied right now. You mentioned that 99.4 percent of physicians are seeing Medicare patients. Do you know how many are limiting the Medicare patients that they see?

Secretary SEBELIUS. I do not, sir.

Dr. PRICE. It would be an important number to know. I would suspect——

Secretary SEBELIUS. I can tell you we have an active monitoring system, and we are not getting complaints from people.

Dr. PRICE. This is from one of your third party administrators, this is denial of payment to a physician. This is all that came in the mail.

It says "Dear Provider: In January, your facility filed nine claims to Dr. Smith that were suspended because the diagnosis code was not consistent with patient gender."

What is he supposed to do with that? How is he supposed to figure out whether or not he is able to care for that patient again or not?

This is the kind of hassle that is driving physicians out of the practice of medicine. The costs of health care are huge challenges. The practice of defensive medicine, as you know, is massive.

What does your bill do to address the practice of defensive medicine?

Secretary SEBELIUS. As you know, Congressman, there is about $50 million in various programs that are currently being funded, some of which look like they have great promise for——

Dr. PRICE. Any liability reform, any lawsuit abuse reform in your bill? Is that not how you address defensive medicine?

Chairman CAMP. Time has expired. Mr. Doggett is recognized.

Mr. DOGGETT. Thank you. Madam Secretary, I come, as you know, from a State that officials like some Members of Congress compete to come up with the most critical comments about the Affordable Care Act, and yet only yesterday in our State Capitol in Austin, a State official testified that when this law is implemented, the percentage of Texans who have insurance will go up from 74 percent to 91 percent. I hope he under estimated it and we can get it higher than that.

We have heard just now about all these wonderful proposals that are out there, but the Republicans have had more than a year now to advance the "replace" part of "repeal and replace," and to date, all we have is one page of 12 platitudes that they adopted with enthusiasm last January.

A concern that I have is what happens in nay sayer States like Texas, which has so many uninsured individuals that could and I hope will benefit from the Affordable Care Act.

Texas, of course, when it came to those who are high risk, it took the no, we will not help approach, and you reached out, and a number of States for different reasons, did not provide the high risk pool, and provided a network or national network of high risk pools for those States like Texas that said no.

If Texas, which has sent back about $900,000 of the $1 million grant they got to begin preparing, if Texas is not ready in January, will you be ready to assure people in Texas that they can get access to the exchanges through the Affordable Care Act?

Secretary SEBELIUS. Congressman, as you know, the way the Act is written, States have the authority and the ability to not only set up a State-based exchange, but with resources and technical assistance provided by the Federal Government.

If indeed a State opts not to take advantage of setting up a program at the State level, we are directed to set up a Federal exchange.

The discussion earlier about additional resources at the Department of Health and Human Services are to do just that, to put the framework together for a Federal exchange, to make sure that Americans regardless of where they live will have access to the benefits that an exchange can provide come January 2014.

Mr. DOGGETT. If Texas sets up a program and like our Medicaid program, it is far inferior to that in other States, how much flexibility does the State have, or put another way, how likely is

it that our citizens end up with a State program that provides much less in the way of coverage and benefits than those in other States under the announcement you made recently about these State exchanges?

Chairman CAMP. If you could answer quickly because time has expired.

Secretary SEBELIUS. Well, I think the essential health benefit definition that you are talking about tries to balance a comprehensive insurance policy with affordability, and with the notion that insurance is regulated at the State basis.

I think there are some underlying rules, what categories need to be covered, anti-discrimination, making sure there is competition and no cherry picking.

Hopefully, we will have some State flexibility reflecting the fact that those programs as benchmarked plans have been marketed and priced at the State and can be up and running.

Chairman CAMP. Thank you. I do want to remind my friend from Texas that we did have a health care bill that did not cost $1 trillion. It did cover preexisting conditions, and was the only piece of legislation scored by CBO as reducing health care premiums.

Mr. DOGGETT. Was that something from this year that you all have introduced or are you talking about the alternative——

Chairman CAMP. The alternative, and it has been re-introduced by Congressman Herger. It is currently in the legislative arena.

Mr. Buchanan is recognized.

Mr. DOGGETT. Will we be marking it up any time soon?

Chairman CAMP. Mr. Buchanan has the time.

Mr. BUCHANAN. Thank you, Mr. Chairman. I want to thank Madam Secretary for being here today.

I want to shift gears a little bit. I represent a district in Florida, but being the only Member of Ways and Means in Florida, I want to talk about pill mills.

Prescription drug abuse is a national epidemic. I have an L.A. Times article here. "Deaths from drugs now out number traffic fatalities in the U.S. data shows. In 2009, 37,485 deaths."

You probably know this, but in Florida, seven people a day are dying from prescription drugs. There are more pill mills in Florida than McDonald's.

They are saying the overall cost, one study, has the abuse at $70 billion a year.

I had three mothers come in, all of them lost their son or daughter.

I have a very good friend that was the chief executive officer of the YMCA, which is large in our area. His son was weight training, hurt his back at 18. I think he was a football player or wrestling. He got on OxyContin. All of a sudden, he is dead now, 6 months later.

What are we doing or what are you doing, what is your area doing to address this concern?

It used to be even in the workplace about drugs and alcohol. Now, these kids are getting—I do not say it is just kids—a lot of them are getting hooked up on these pain killers.

Secretary SEBELIUS. It is a very serious problem and you are absolutely right, the data is enormously alarming where prescription drugs have now out paced criminal drugs in terms of over abuse and deaths and injuries.

We are trying to approach this along with the private sector in several areas. We have efforts at the State level through the Medicaid program looking at——

Mr. BUCHANAN. Madam Secretary, just because we are so short on time.

Secretary SEBELIUS. We would love to get you a full answer and tell you what is going on.

Mr. BUCHANAN. I have introduced a bipartisan bill, a lot of Democrats, every Democrat in Florida, and all the Republicans on it.

Secretary SEBELIUS. We would like to work with you on that.

Mr. BUCHANAN. I would like to get you that bill and have you consider it and ideally support it.

Secretary SEBELIUS. Okay. Thank you.

Mr. BUCHANAN. The other thing is I just want to say in terms of Florida, it has been talked about here today, is the whole thing of SGR and doc fix. We have a lot of doctors very concerned.

I came to Washington in 2007. We have addressed the doc fix probably five/six/seven times, last year, three times roughly.

I do not know how you run a practice, how you run a business this way. A lot of them are trying to make long term capital investments in their practices. They said we cannot do it. The banks will not even support them.

We really need to have you guys provide some leadership on this because obviously it is not getting done any other way.

The President and the Administration really needs to step up and address this because in Florida, health care is so critical when we have obviously more seniors than most States, and health care is critical to our seniors. We need good doctors and to be able to keep them and pay them.

Chairman CAMP. All right. Time has expired. Mr. Smith is recognized for 3 minutes.

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

I want to touch on a few budget related health care items. The first being critical access hospitals, and the second being the Medigap plans, and then also this new fee increase at FDA to cover a 17-percent increase in their budget, if time allows.

Regarding the critical access hospitals, as you know, and I think you can appreciate, service in a rural State, how important health care is. These critical access hospitals really are modest gateways to health care and are entry points to health care.

The President's budget has proposed reducing the reimbursement to critical access hospitals. Can you tell us kind of the background to that strategy and what the impact might be?

Secretary SEBELIUS. I cannot do it with any precision in terms of the years it would hit. I share your concern about the importance of critical access hospitals.

I know in the overall payment strategy, we are continuing to pay an increased amount to critical access hospitals as we move for-

ward, recognizing that often they are the only service provider in an area, and it is essential to keep them there.

I can get you a more detailed answer in writing, sir.

Mr. SMITH. I know they are very concerned about the proposed reduction. I do look forward to hearing more on that.

The budget also recommends that seniors with the Medigap plans, which have near first dollar coverage, pay a surcharge equal to roughly 30 percent of their Medicare part B premium.

Can you speak to why the President recommended this policy?

Secretary SEBELIUS. Well, I think there is a market strategy that indicates having some investment among consumers, and the Medigap plans are a positive step forward. He is following some recommendations that have been made over time and looking at some of the market strategies that seem to be effective.

Mr. SMITH. What do you see the impact being? I hear from seniors concerned and obviously providers as well.

Secretary SEBELIUS. Well, I think there are a variety of plans, many of which, as you know, do not provide dollar one coverage from the outset. We have looked carefully at the health outcomes, measuring the plans.

This is seen as a way to not only reduce some revenue in the long run, but also discourage what may be redundant use of services, and have some strategies in place that actually are more cost effective.

There are a variety of plans that currently without any impact on beneficiaries do not have the dollar one payment by the company.

Chairman CAMP. Mr. Thompson is recognized.

Mr. THOMPSON. Thank you, Mr. Chairman. Madam Secretary, thank you very much for being here today and for your willingness to stay as long as necessary to answer all these questions. It is refreshing——

Chairman CAMP. There is a hard stop at 3:15 with our vote, so we do not have all day.

Mr. THOMPSON. Do I have 12 minutes or 3 minutes?

Madam Secretary, you were kind of cut off when you were speaking to the issue of medical liability and what some of the promise has shown. Is there anything else you want to add to that?

Secretary SEBELIUS. Well, I can tell you, and I will make it very brief, we are encouraged under the Agency for Healthcare Research and Quality. We were directed to put some dollars out to look at possibilities with hospital systems and provider groups that actually are working in the market.

I think we will be coming back to Congress very shortly with a robust set of options. We are encouraged by what we are seeing, some programs that really work.

Mr. THOMPSON. Thank you. I am encouraged by what I hear in my district in regard to the Affordable Care Act. People are glad that they cannot be cut off from their insurance if they get sick.

They are glad their kids can stay on until they are 26 years old. Seniors are very, very happy that the doughnut hole is closing.

Just today, I had a major California insurer in my office who was very complimentary about the things we put forward in health care reform.

They have some real good statistics as to how that is benefiting California consumers, as well as consumers in other States where they operate.

It is not all doom and gloom. I think we are seeing some really positive and refreshing success as a result of this bill.

I am particularly encouraged by HIT. Everybody I talk to at home is glad we are moving to health information technology, and they are seeing the improvements, and they are putting it in place.

Can you discuss why health IT is important and what is the expansion looking like?

Secretary SEBELIUS. Well, I think there is some great news there, again, we have now twice as many doctors and hospitals using electronic health records as were using them 2 years ago. That is a huge up tick. We think that trajectory is going to continue.

What we know by looking at the information is that having an electronic record is the best way to coordinate patient care. It enables providers to eliminate duplication, lower medical errors, and provide much more patient centered care, in that patients actually own their own information, can look at their own information, monitor their own information.

What we are also seeing, Congressman, is a huge number of jobs being created, not only in the software companies building these systems, which often are companies under 50, and any one of them could be the next Google or Microsoft, but the number of health IT workers——

Chairman CAMP. I am afraid I am going to have to stop you there.

Mr. THOMPSON. Thank you very much.

Chairman CAMP. We are just running short. Mr. Schock is recognized for 3 minutes.

Mr. SCHOCK. Thank you, Mr. Chairman. Welcome, Secretary Sebelius.

Secretary SEBELIUS. Thank you.

Mr. SCHOCK. Do you agree with the effort to lift the ban on using Federal funds on lobbying campaigns?

Secretary SEBELIUS. To lift the ban?

Mr. SCHOCK. Correct.

Secretary SEBELIUS. We just recently got a proposal in the 2012 budget which we are in the process of implementing. I do not know anything about a proposal lifting the ban.

Mr. SCHOCK. The President's budget lifts a longstanding prohibition on using Federal funds in lobbying campaigns.

Secretary SEBELIUS. I do not know anything about that effort. I do know that language added to our budget in 2012 went well beyond what has been the longstanding policy, and I know there are Members of Congress who have expressed some concern that in looking at the 2013 budget, we would look at that expanded language, which the language that has been in place for a long time affects Federal agencies.

The language in the 2012 resolution that was reached actually reaches down to grantees and stakeholders and implies that their activities can no longer be engaged in any kind of activities to change public policies.

I am not involved in an effort and I am really not aware of an effort to lift the ban. I am sorry if I am not answering your question.

Mr. SCHOCK. No, you are. In fact, I am glad to hear that you are not involved in that. My question really targets the grantees, which you mentioned just a moment ago.

Secretary SEBELIUS. Which is brand new language. This is not a longstanding policy. It is brand new language in 2012.

Mr. SCHOCK. To allow them to use Federal funds?

Secretary SEBELIUS. No. The ban that we are now expected to implement reaches down into grantees and their activities at a State, local, municipal or a school board level.

Mr. SCHOCK. The folks who are receiving dollars from the Federal Government, grantees, who may be currently using them for lobbying campaigns——

Secretary SEBELIUS. To change public policy.

Mr. SCHOCK. Okay, to change public policy. We call that "lobbying." Okay.

The people that are using Federal dollars to change public policy will no longer be able to do that once your rule is fully implemented?

Secretary SEBELIUS. That is my understanding. Yes, sir.

Mr. SCHOCK. Okay. Thank you. Second, I have a question about the Agency's desire to change the time period for biologics. My understanding there is an effort underway to change pharmaceuticals that are biologics based from the current 12 year time period.

I was just wondering if you could speak to why you believe that is important.

Secretary SEBELIUS. I am sorry. I want to make sure I answer the question accurately. Yes, sir. I just wanted to make sure what the span was.

This has been under discussion for a while to lower the strategy from 12 years to 7 years, which I think is seen as an assistance, frankly, to consumers, to get products to the market in an affordable fashion and a much more timely basis.

Chairman CAMP. Ms. Jenkins is recognized.

Ms. JENKINS. Thank you, Mr. Chairman. Thank you for being here, Madam Secretary.

Secretary SEBELIUS. My Congresswoman, nice to see you.

Ms. JENKINS. That is right. The Affordable Health Care Act makes it clear that health insurance subsidies are only available to individuals and families enrolled in an American health benefit exchange, which is defined in the law as a State-based exchange.

Further, the law requires that in order to be eligible for exchange subsidies, the "individual must be enrolled through an exchange established by the State." That is a quote.

In response to Mr. Levin's question, you explained that it is clear that many States will not set up exchanges. As you know, the law does not allow subsidies to flow through Federal exchanges.

However, back in August, the IRS issued a proposed rule allowing premium subsidies to be made available in all exchanges, whether State or federally run.

The IRS Commissioner responded to a congressional letter on this matter stating and I quote "The statute includes language that

indicates that individuals are eligible for tax credits whether they are enrolled through a State-based exchange or a federally facilitated exchange."

I cannot find the term "federally facilitated exchange" in the health care law. I am just wondering exactly where in the law is the term "federally facilitated exchange" or what specific language authorizes the Administration to allocate subsidies via the Federal exchange.

Secretary SEBELIUS. Congresswoman, I would be glad to get you that answer in writing. There are some very detailed legal analysis and also a variety of statutory language. I will be sending that back right away.

Ms. JENKINS. Okay. It appears, and I would just be curious if you would agree, that essentially the IRS is amending the health care law through the regulatory process.

Secretary SEBELIUS. I do not think that is accurate at all. I will send you the statutory references and the legal interpretation.

Ms. JENKINS. Okay. If the law provides it is only Federal, it is only allowed for the State run exchanges——

Secretary SEBELIUS. I will be happy to answer this question in detail. It has been analyzed and looked at. You may disagree with the analysis, but I will be delighted to get you the language in the statute and the legal interpretation of that language.

Ms. JENKINS. Okay. Those of us in Congress—I can get a little defensive when our constitutional authority to write tax policy is taken away from us and imposed through a regulatory agency.

Thank you. I yield back.

Chairman CAMP. Thank you. Mr. Larson is recognized.

Mr. LARSON. Thank you, Mr. Chairman. Thank you, Secretary, for being here.

Let me say that I am very proud of the Affordable Health Care Act. Sometimes called "ObamaCare," but I kind of like that as well because it is pretty clear that the President does care.

At the end of the day, that is what it is all about, even here on this Committee where sometimes we appropriately, and good Members on both sides of the aisle, deal with all of the economic issues and all of the green shade issues, et cetera, but what an honor to have a person of your capability of both a former Governor who knows how to administrate and get to solutions, and also a woman, who understands the incredible balance that needs to take place in this day and age, and finally, because of the Affordable Health Care Act, bringing into parity the women's health issues that you talked about.

I thank you for making and moving responsibly the accommodations that your Agency has to Catholic charities and to our university systems. It is great to see Father Jenkins and the Affordable Health Care people all coming forward and praising your efforts in this area.

At the core of this, when you look at these issues, where 15,000 women still are susceptible to cervical cancer and die every year, you begin to appreciate and understand the importance and significance of this, as well as people and constituents who say to me every single day, I do not care whether you are a Democrat or Re-

publican or independent, I have a 19 year old son that needs a liver implant. Please, keep that Act enforced.

How many more people do you think will benefit by this? People want to see solutions. I commend you and your Agency for being about solutions.

Secretary SEBELIUS. Thank you.

Chairman CAMP. Thank you. Mr. Paulsen is recognized for 3 minutes.

Mr. PAULSEN. Thank you, Mr. Chairman. Thank you, Madam Secretary, for being here as well. We had a chance to talk in the past about some medical device issues.

I want to just follow up and ask a question here. All things being equal, do you believe that encouraging the use of lower cost alternatives like generics, generic drugs, for example, makes sense for both the patient as well as the consumer as a way to help lower health care spending overall? I assume that is a goal you would generally agree with.

Secretary SEBELIUS. I think the more consumer information that people have about effective outcomes and prices is great, absolutely.

Mr. PAULSEN. I think you would probably agree we have a shortage of primary physicians.

Secretary SEBELIUS. We do. We are filling that pipeline thanks to some of the resources in the Affordable Care Act. We do.

Mr. PAULSEN. I should just share that one of my chief concerns with the new health care law is a provision in there that does not allow those that have flexible spending accounts or health care savings accounts to access the purchase of over-the-counter medications unless they have a doctor's prescription.

I have certainly heard from a lot of suburban mom's and constituents in general that have been frustrated about how they get Claritin for their kids or Advil, whatever it might be.

They sort of resort to having to visit the doctor or the primary physician to get a prescription for Advil or some of these generic drugs.

It is not accessing a lower cost alternative to lower health care costs.

Do you think the prohibition that is in the current law should be changed or repealed or would you be willing to work to modify that to the benefit of more consumer driven health care for those over-the-counter/generic drugs?

Secretary SEBELIUS. I think, Congressman, the notion about the provision was not to discourage the purchase of generic drugs. It was to recognize that health savings accounts are often for health needs that are not being met.

The same way that most insurance coverage does not cover over-the-counter medicines, the health savings account was brought in line with what insurance policies currently have in place.

Clearly, people hopefully will continue to buy aspirin and buy a variety of over-the-counter drugs. They just will not use their health insurance policy or their health savings account to do that.

Mr. PAULSEN. I just want to mention the flexible spending account as well. These are their own health care dollars. They set them aside through their employer's plan.

I had one constituent who said this rule is really a burden for consumers as well as physicians since additional office visits are required to get an over-the-counter medication prescription, and these FSAs really are a valuable tool. They are used by a lot of hard working Americans to help manage and hold down these out of pocket costs.

This is a significant issue. I do not know if it was overlooked in the concept of the new law passing, both FSAs and HSAs. This is definitely an issue that I think we should work on.

Secretary SEBELIUS. I would be glad to talk to you further about that.

Mr. PAULSEN. Thank you. I yield back.

Chairman CAMP. Mr. Marchant is recognized.

Mr. MARCHANT. Thank you, Secretary. I am very concerned about the Texas women's health program's current Medicaid and waiver status.

This program was first implemented in 2007 and must receive HHS waiver approval.

It is currently authorized by HHS through the end of next month. The program currently provides services to over 100,000 Texas women on an annual basis.

I would like to ask three or four questions, and if we do not have time for you to answer, I would appreciate you submitting an answer in writing to me.

What is the current status of the HHS' review of the waiver for the Texas women's health program? Number one.

Number two, please tell us about the HHS's main reasoning behind its review for the current Texas waiver request. Is this reasoning consistent with other waiver requests for similar health programs from other States?

In the past, has not HHS allowed States to make the decision about who can be a qualified provider? Has HHS ever tried to overturn a State law about who can be a qualified provider, and the last question is is the waiver being refused because of a current Texas law that prohibits State funding to go to Planned Parenthood?

Secretary SEBELIUS. Congressman, I would be glad to answer those questions in writing, but let me just say at a 30,000 foot view, this ruling is very consistent with what has been Medicaid policy around women with a family planning waiver to be able to choose a provider.

It is consistent with the information we gave to Indiana in June 2011. We made it very clear to Texas we are eager to have this program continue. Their women's health program provides coverage to, as you say, about 183,000 women in Texas.

It is very important, and we want to work with them around the policies that are allowable to move this forward.

I will be glad to answer your specific questions in writing.

Mr. MARCHANT. Okay. Thank you.

Chairman CAMP. Thank you. Mr. Blumenauer is recognized.

Mr. BLUMENAUER. Thank you, Mr. Chairman. Thank you, Secretary.

Let me just say coming from one of those States that are low cost, high quality, our legislature just passed legislation. Governor Kitzhaber, probably the best qualified——

Secretary SEBELIUS. I think he is living in my office.

Mr. BLUMENAUER. We just want to say there is a commitment top to bottom to take advantage of the potential of this legislation. I think we have demonstrated billions of dollars of savings in the past. We hope to have flexibility for people that want to charge ahead on this.

I think you were too kind earlier to Congress when people talked about the fast track provision in the legislation. It seems to me it is Congress that has been spineless and has had to try to have it both ways.

They want to cut costs. They do not want to say no to anybody. The procedures that are here in this legislation do not have any restriction on majority in the House.

In the Senate, where it appeared to take a 60 vote threshold to literally do the most mundane of business, it seems to me that putting that in here so there would not be the goofy procedural thing that has driven Republicans and Democrats alike in the House crazy in the other body, it still makes us responsible.

We have a chance. I thought you were too kind. Anybody who is concerned about it ought to look at what is written. I think it is very, very reasonable.

I identify with some of the comments my friend, Mr. Gerlach, talked about, smart cards and moving forward.

I would think there are techniques here that personally I am very interested in pursuing. Indeed, what can be done under flexible savings accounts, I think, is different than drawing on insurance. Not just for over-the-counter medications but also some types of physician services that are not now eligible, that seem a little goofy to me.

I wanted to go back to the contraception controversy. It seems to me that for years, there were Catholic institutions that had provisions exactly like this in their health care coverage, as well as a number of States that have been doing this for years, without controversy.

Is that correct? Would you care to elaborate on that at all? This mystifies me that some Catholic institutions have been doing this for years and now all of a sudden it is a threat to religious liberty.

Secretary SEBELIUS. I do not think there is any question that there are a variety of religious facilities, Catholic universities, hospitals, systems, others, who have long offered contraceptive benefits to their employees and let the employee pick and choose whether or not to access those benefits based on his or her own faith/belief system, some to comply with State laws in place, some in States where there was not a State law in place.

Chairman CAMP. Mr. Berg is recognized.

Mr. BERG. Thank you, Mr. Chairman. Thank you, Secretary, for being here.

First of all, I would like to echo my colleagues' concerns about the President's health care overhaul, with the un-elected IPAB, and also the regulatory encroachment on religious freedoms.

Having said that, coming from North Dakota, I think a State with high access and affordable health care, one of the things I am most concerned about is critical access hospitals.

North Dakota has 36 of those, and my understanding is this proposal would impact them by about $1.2 million. With almost 20 percent of our population in rural North Dakota—excuse me—in rural America, I am concerned about that access.

Obviously, coming from Kansas, I understand you have many of the same issues.

My question really relates to what process did you go through in terms of consulting and including the rural practitioners with this proposal that is presented?

Secretary SEBELIUS. Well, I think, Congressman, I do share your concern about access in rural areas. It is a critical issue and one that I did see in Kansas.

I can assure you also that the head of one of our key agencies is a fellow North Dakotan, Mary Wakefield, who each and every day reminds us that every policy as we implement this—she informs a lot of our policies—need to be done with rural health care providers in place.

I think we are confident this proposal does not jeopardize long term access because there are other funding streams that increase in this proposal, but we are going to watch this very closely because access in a rural area is critical and a critical care hospital.

Mr. BERG. I will yield back.

Chairman CAMP. Ms. Black is recognized.

Mrs. BLACK. Thank you, Mr. Chairman. Madam Secretary, we all know and it has been said a couple of times here before that the President did say prior to the passage of this legislation that if you like what you have, you can keep it.

We are continuing to find out that is not true. I do want to point to the fact that I have been reading this and I am almost finished with it, but I am astounded with the number of times it says in here "The Secretary shall establish," "The Secretary shall promulgate rules," "shall develop standards," "The Secretary may develop and impose appropriate penalties," over and over again, a lot of authority is given to you as the Secretary.

Where I am concerned is knowing that there was a Senate hearing where you said you did not consult with the Bishops before the Administration announced a change in the conscious protections.

What can we be assured of as we move forward that you are going to have an open rulemaking process and that you are going to involve those entities that are going to be impacted by these rules and regulations that need to be written?

Secretary SEBELIUS. Congresswoman, I did not talk to the Bishops because the President talked to the Bishops. I felt that was sufficient since he is my boss.

We did promulgate a rule in July. We got 200,000 public comments on that rule. We consulted with a whole variety of people in addition to those comments.

This was a very open process. It was a very inclusive process, and I can guarantee you there was a very robust dialog that went on between July when the initial rule was put forward and January when it was finalized.

Mrs. BLACK. In those comments that you got, were there comments from the entities that were going to be directly affected?

Secretary SEBELIUS. Absolutely. There were comments from providers. There were comments from women's groups. There were comments from labor organizations. There were comments from university presidents, religious leaders, charity groups.

We heard from a whole lot of people, 200,000 comments. Yes, ma'am.

Mrs. BLACK. I hear what you are saying, that the President was the one who met with the Bishops.

Secretary SEBELIUS. Yes.

Mrs. BLACK. And had those comments. I guess there was maybe not a communication between what was said to the President and then what eventually came out on this because the Bishops were quite surprised to find that this ruling, which they were told from my understanding, was not going to occur, and there would be no effect on the way in which they were operating.

Again, going back to the President saying if you like what you have, you can keep it.

Secretary SEBELIUS. Churches are totally exempt from this ruling. The Bishops and the churches that they run and their church affiliates are exempt from this rule.

Mrs. BLACK. It seems to me again we are having our freedoms taken away from us, and I hope we are not going to see that continue as we go through this rulemaking process, and there are a lot of rules to still be made.

Chairman CAMP. Mr. Pascrell is recognized for 3 minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Madam Secretary, it is obvious that the President recognizes that we cannot simply make Draconian cuts to solve the deficit problem.

It sounds good. It is an over simplification and it does not work. It only adds to the deficit later on.

New payment models, more efficient delivery of care, and curbing Medicaid fraud are all better options than transitioning to a voucher program that shifts the costs to beneficiaries. Nobody is denying that.

I personally believe we can balance the deficit without cutting Medicare for seniors and breaking our promises to them.

My question is while the Republican budget proposals shift the burden to Medicare beneficiaries by transitioning to a voucher program, how does the President's budget cut costs without changing the fundamental structure of Medicare or cutting benefits?

Secretary SEBELIUS. Well, Congressman, the President both as part of the Affordable Care Act and then again in this budget window, has proposed I would say a gradual slowing down of some of the cost increases.

We have talked about Medicare Advantage. This budget contains some additional proposals dealing with drug costs, that Medicare should take advantage of some of the drug rebates that are currently in place in the Medicaid program, which would save significant dollars. Additional fraud efforts.

The basic package of benefits that is a guarantee to seniors and those with disabilities, the 48 million Americans who rely on Medicare day in and day out, is not harmed by this.

In fact, what we are seeing is care improvements and beneficiaries, every time the dollars go down and premiums go down, beneficiaries actually have more money in their pockets.

Seniors have actually had a great deal of relief, those in the doughnut hole, from the closing of the doughnut hole.

As Medicare Advantage premiums go down, that saves beneficiaries money because they pay less of their co-pay and their share of those costs.

It has been a win-win situation that slows down the growth trend, which was significantly ahead of inflationary costs, and yet protects the guaranteed benefits for the beneficiaries.

Mr. PASCRELL. Thank you.

Chairman CAMP. Thank you. Mr. Reed, last but not least, is recognized.

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

Madam Secretary, I have a very direct question for you. On the individual mandate penalty, is it a tax? Yes or no?

Secretary SEBELIUS. I am not a lawyer so I am not equipped to answer that question.

Mr. REED. When the OMB Director stated before the House Budget Committee that the individual mandate penalty is not a tax, President Obama has publicly stated it is not a tax, yet your legal briefs in the Supreme Court case in writing submitted on your behalf, because you are a named defendant in that proceeding, states the minimum coverage provision is as a tax law.

Do you agree with your attorneys' assertions to the Supreme Court that it is a tax provision?

Secretary SEBELIUS. I think it operates the same way a tax would operate, but it is not per se a tax.

Mr. REED. It is not a tax but it operates as a tax. That is your testimony?

Secretary SEBELIUS. I am not a lawyer. I do not want to try to quote the legal briefs. I would defer to my legal team. I am not really going to try to parse this back and forth.

Mr. REED. With that, I yield back. I know we have to vote, Mr. Chairman.

Chairman CAMP. All right. I want to thank the Secretary for her time today.

We do have votes on the House Floor.

Secretary SEBELIUS. Thank you, Mr. Chairman.

Take good care of Traverse City.

Chairman CAMP. I will. With that, this hearing is now adjourned.

[Whereupon, at 3:34 p.m., the Committee was adjourned.]

[Questions for the Record follow:]

Secretary Sebelius Questions for the Record
House Committee on Ways & Means
February 28, 2012

The Honorable Kenny Marchant

1. What is the current status of HHS's review of the waiver for the Texas Women's Health Program?

Answer: As you know, Texas has elected to move forward with a State rule that will restrict freedom of choice of health care providers for women enrolled in the Women's Health Program effective March 14, 2012. Consistent with longstanding statutory provisions that assure free choice of family planning providers, the Demonstration does not provide the State the authority to impose such a limitation, and we advised the State in letters dated December 12, 2011 and March 15, 2012 that such authority would not be granted. In light of the State's preference to move forward in implementing the State rule, the Centers for Medicare & Medicaid Services (CMS) is not in a position to extend or renew the current Demonstration, except for purposes of phasing out the Demonstration.

2. Please tell me about HHS's main reasoning behind its review for the current Texas waiver request? Is this reasoning consistent with other waiver requests for similar health programs from other states?

Answer: Initially implemented in January 2007, Texas' Women's Health Program 1115 Medicaid Family Planning Demonstration was set to expire on December 31, 2011. CMS granted Texas a temporary extension of the Demonstration until March 31, 2012. As the State has elected to move forward with a State rule that restricts freedom of choice of health care providers for women enrolled in the Women's Health Program, CMS is not in a position to extend or renew the current Demonstration, except for purposes of phasing out the Demonstration.

3. In the past, hasn't HHS allowed states to make decisions about who can be a qualified provider? Has HHS ever tried to overturn a state law about who can be a qualified provider?

Answer: One of the fundamental aspects of the Medicaid program is the statutory provision at section 1902(a)(23)(A) of the Social Security Act which provides that Medicaid beneficiaries may obtain covered services from any qualified provider willing to undertake the service. Section 1902(a)(23)(B) sets forth additional protections for a beneficiary's free choice of family planning providers. Texas requested approval to limit access to specific providers for reasons not related to their qualifications to provide such services.

4. Is the waiver being refused because of Texas law that prohibits state money from going to Planned Parenthood?

Answer: CMS was unable to extend or renew the current Demonstration, except for the purposes of phasing out the Demonstration, because the State has elected to move forward with a State rule that will restrict the freedom of choice of health care providers for women enrolled in the Women's Health Program.

The Honorable Dave Reichert

1. Lymphedema affects an estimated 1.5 to 3 million Medicare beneficiaries. Individuals often need constant care to avoid recurrent infections. While Medicare does cover and pay for statutorily limited therapy and sequential compression pumps, many patients suffer from recurrent infections, progressive degradation in their condition and eventual disability because they cannot afford the compression bandages and garments required for everyday self-care. I have heard from patients and providers that state compression garments are a necessary form of treatment for patients with Lymphedema. They state compression garments help to improve the quality of life and stave off reoccurring infections for patients. Why does CMS not cover these treatments? Does CMS need a statutory change in order to provide coverage for these garments?

Answer: Currently, Medicare covers durable pneumatic compressors, referred to as lymphedema pumps, and appliances used in conjunction with these pumps under the Part B benefit for durable medical equipment. These equipment and accessories are used to treat lymphedema and are covered because they fall under a defined Medicare benefit category. In order for items to be covered by Medicare, they must meet the definition of a Medicare-covered benefit defined in the statute. However, it is important to note that although Medicare provides coverage for certain items, it does not provide coverage for every item with potential use for a person with a medical problem, even if a physician prescribes the item. Other devices used to treat lymphedema, such as sleeves and stockings, are not covered by Medicare because they do not meet the definition of durable medical equipment or any other Medicare benefit category established by law.

2. It's my understanding that there is currently no benefit category for coverage of disposable negative pressure wound therapy even though such technology was approved by the FDA in 2009. I understand that this disposable technology can save Medicare money because, unlike the currently covered durable medical equipment which is paid for on a monthly rental basis, it does not require payment for unused medical days. Where is CMS in the process of revising the benefit category so that Medicare beneficiaries have access to disposable negative pressure wound therapy devices?

Answer: In order for items to be covered by Medicare, they must meet the definition of a Medicare-covered benefit. However, it is important to note that although Medicare provides coverage for certain items, it does not provide coverage for every item with potential use for a person with a medical problem, even if a physician prescribes the item. Disposable negative pressure wound therapy devices are not covered by Medicare because they do not meet the definition of durable medical equipment.

The Honorable Vern Buchanan

1. Following up on our discussion on the deadly outbreak of prescription drug abuse.

In addition to going after "pill mills," is it wise to examine ways to keep people off these addictive prescription drugs from the start?

Can you tell me why, with such a focus on limiting the use of narcotic pain killers, that the Centers for Medicare and Medicaid Services (CMS) has initiated a coverage review to possibly limit access to a cost-effective, non-invasive alternative for pain treatment for Medicare patients called TENS or Transcutaneous Electrical Nerve Stimulation?

This therapy has been available to Medicare patients for decades and has even been supported by CMS thru a National Coverage Determination in 1995. TENS is available to all federal employees through the government health plans, to Veterans thru the VA and Tricare, and to most Americans thru their private health insurance.

Is it wise to be pushing more people toward addictive substances when other options are available?

Answer: CMS recognizes the burden of chronic pain and the importance of supporting pain management strategies that are founded on scientific evidence. Following the publication of a report by the American Academy of Neurology in 2010, which found that TENS was ineffective for chronic lower back pain, we believed it was important to open a national coverage analysis to review the available evidence.

A description of the proposed review was posted on the CMS coverage website on September 13, 2011, as the first step in the national coverage determination process. Public comments were invited on the review proposal for a 30 day period and 359 comments were received. We are continuing to review the comments received and will move forward with the coverage determination process in the future.

The Honorable Peter Roskam

1. Please confirm that CMS's broad demonstration authority would permit the development and utilization of a physician medical necessity template in some or all areas of the demonstration project?

Answer: CMS has the authority to develop a template for Medicare-funded items or services that comply with all applicable rules, policies, and regulations.

2. Please confirm that, under CMS's broad demonstration authority, the agency would not need Paperwork Reduction Act (PRA) approval to develop/utilize such a template?

Answer: CMS demonstration authority, Section 402 of the Social Security Amendments of 1967, permits the Secretary to waive only certain requirements from Titles XVIII and XIX of the Social Security Act. The waiver authority does not extend to the Paperwork Reduction Act.

As noted above, CMS does not believe the development of a clinical template is necessary to implement the demonstration. Nevertheless, CMS continues to work collaboratively with its industry partners to explore ways to ensure compliance with existing coverage guidelines including those related to the documentation of the face-to-face encounter.

3. Is it not accurate that many private payers and Medicaid programs utilize a medical necessity physician template?

Answer: Many private payers and Medicaid programs utilize a medical necessity physician template.

4. Please confirm that the model template that I have previously sent to your office meets all of the requirements described in CGS's *Dear Physician* letter.

Answer: There is no single diagnosis that confirms the need for a power mobility device (PMD). This makes it difficult to create a standard generalized form to ensure that the beneficiary's clinical condition meets the Medicare requirements. To be covered by Medicare, a beneficiary must require a PMD to complete their activities of daily living in the home. CMS and its contractors have created a series of educational materials to assist physicians with establishing medical necessity when completing the congressionally mandated face-to-face examination. However, forms such as the one previously sent tend to be too general to show a beneficiaries' clinical condition. Medicare policy requires a more detailed narrative assessment that provides a clinical picture of the beneficiary's condition related to mobility needs.

5. Will CMS include a template in the demonstration program and if not, why not?

Answer: CMS does not believe the development of a clinical template is necessary to implement the demonstration. This demonstration is not introducing new Medicare documentation requirements; instead, it is simply collecting the documentation earlier in the

process. The documentation requirements are outlined in the existing local coverage determination (LCD).

CMS looks forward to continuing to engage stakeholders in exploring ways to clarify existing coverage guidelines, including those related to the documentation of the face-to-fact encounter. Any clinical template resulting from these discussions would be available for nationwide use.

The Honorable Adrian Smith

1. The President's budget proposes a 17 percent spending increase for the Food and Drug Administration over 2012. However, 98 percent of that increase comes from a new regulatory tax on food producers. Under this proposed registration fee, companies would pay the government merely for existing as a food producer or manufacturer. In Nebraska alone this new tax would hit 1,754 facilities. At USDA, Secretary Vilsack has been discussing for weeks the savings he procured from increased operational efficiencies within USDA. He reduced travel, utilized early retirement programs, and consolidated cell phone contracts. Secretary Vilsack saved approximately $90 million with these actions. Have you and the leadership at FDA considered any actions like these, as opposed to raising taxes on food makers? Why is a food tax on consumers the only answer?

Answer: I assure you that HHS also has been looking at operational efficiencies and other belt-tightening measures. As part of our cost-saving measures, HHS is implementing the Executive Order on Promoting Efficient Spending to achieve savings related to travel, vehicles, IT, printing, and other costs.

Regarding FDA, the FY 2013 President's Budget includes significant savings related to FDA's information technology (IT) expenditures. The estimate of IT savings for FDA for FY 2013 is $19.7 million, and the savings will occur in three areas.

First, FDA has been working to consolidate its IT infrastructure into more modern data center facilities. During FY 2013, we will realize $6.0 million in savings as due to our consolidation efforts.

Second, FDA is launching an initiative to reduce the number of redundant laptops and other IT devices. This effort will produce $5.1 million in savings.

Finally, other initiatives across all FDA programs will yield an additional $8.6 million in IT savings. The other initiatives include retiring legacy IT systems, modifying IT business processes, and other forms of IT database savings.

Regarding the proposed registration fee, FDA is still engaging with industry to design a user fee program related to food facilities. We believe that the result of this engagement will be a fee program modeled on other successful user fee programs that Congress enacted for FDA. As FDA intends for the user fee to support food safety activities that provide benefit to the industry paying the fee, it would be considered a "user fee" rather than a "tax."

These fees will allow FDA to reduce the risk of illness associated with food and feed, decrease the frequency and severity of food- and feed-borne illness outbreaks, reduce instances of contamination, and greatly diminish the burden on American businesses and the U.S. economy due to foodborne illness events. Without sufficient and reliable fee revenue, we can expect the unacceptably high human toll of foodborne illness to continue, with the resulting disruptions to the food system and the economic burdens to the food industry that result from foodborne illness outbreaks.

These proposed user fee investments are quite modest compared to the economic value of the nation's food and feed supplies and the costs that the public, industry, government, and the health care system experience during an outbreak. FDA is engaging with the food industry and other food safety stakeholders to develop a workable fee structure that will have broad support within the food industry, other stakeholders, and Congress.

The Honorable Tom Price

1. Madam Secretary, I was pleased to see the sections of the recently released 2013 Call Letter pertaining to medication therapy management. The improvements included a greater focus on outreach and education, to ensure Part D beneficiaries are aware of the MTM benefit, as well as an expansion of the number of targeted conditions. I think access to MTM services from local pharmacists is critical to controlling prescription drug expenditures in Medicare Part D, and to keeping seniors healthy. The Call Letter also states that CMS will be conducting an analysis of the Part D MTM program. With respect to that analysis, I understand that the agency has contracted with an outside firm to investigate the benefits of MTM on the current eligible population. Can you help me to understand why we have been told it may take another few years for this study to be available? Under current restrictions, seniors must suffer from "multiple chronic conditions" and be prescribed "multiple medications" before they are eligible for Part D MTM services. This study could be instrumental in helping us to determine how we can best target Medicare beneficiaries who would benefit the most from MTM services. What can we do to speed up to timeframe for study results?

Answer:: Thank you for your inquiry regarding the Part D Medication Therapy Management (MTM) and your support for the improvements to the program CMS is instituting for the 2013 plan year. CMS is evaluating the impact of MTM in a chronically ill population through a two year study that began in August 2011. A final report is due at the end of the study, with an interim report due to CMS after the first 14 months.

While I understand your enthusiasm for moving forward expeditiously with this study, this is a very labor intensive study that involves both quantitative and qualitative analyses.

For additional information, I invite you to review the scope of work for the project available at the following address: https://www.fbo.gov/?s=opportunity&mode=form&tab=core&id=cffd547191ee03de49aade9b9ed20405&_cview=0. (Once at this address, click on "SBRAD_IDIQ_Sections_B_thru_M.docx." The SOW for the MTM project starts on page 68 of the document.)

2. Secretary Sebelius, as you know, Congress, first through the Deficit Reduction and later through the Affordable Care Act, changed the way in which pharmacies would be reimbursed for generic drugs in the Medicaid program. Federal Upper Limits are to be calculated using Average Manufacturer Price. The intent of Congress was to more accurately reimburse pharmacies for the cost of generic drugs. It is the role of states however, to adjust dispensing fees to ensure pharmacies are also accurately reimbursed for the cost to dispense prescription drugs to Medicaid patients. Can you tell me what steps you are taking to ensure that states adjust pharmacy dispensing fees before Federal Upper Limits based on Average Manufacturer Price go into effect?

Answer: We agree that pharmacists should be appropriately reimbursed for the cost to dispense prescription drugs to Medicaid patients. Payment for Medicaid covered drugs is dependent on the methodologies set forth in each State's individual Medicaid State plan, and a State can

exercise its flexibility in determining the actual reimbursement for a specific drug. Further, while CMS does not establish specific criteria for States to use when setting their dispensing fees, dispensing fees must be approved by CMS as part of the Medicaid State plan. States are responsible for setting reasonable dispensing fees to appropriately reimburse pharmacy providers for the services they provide in dispensing a prescription to a Medicaid beneficiary.

We have proposed in our recently published notice of proposed rulemaking (NPRM) ("Medicaid Program; Covered Outpatient Drugs" (CMS-2345-P), that once the reimbursement for the drug is properly determined, the dispensing fee should reflect the pharmacist's professional services and costs.

3. Secretary Sebelius, Thank you for responding to the December 9, 2011 letter I sent along with 39 bipartisan House Members regarding the U.S. Preventive Service Task Force draft recommendation against prostate-specific-antigen (PSA) based screening. We were concerned that PSA screening, while imperfect, has been enormously helpful in improving men's chance of survival of prostate cancer by more than 40 percent since its widespread adoption.

In your response, you stated that "The Department has the discretion to modify or eliminate coverage for the PSA test based on the Task Force recommendation, (but) I do not intend to eliminate coverage of this screening test under Medicare at this time."

I would like you to clarify what benefits the statute actually allows the Secretary to "modify or eliminate," as it appears the PSA test is not one of them. The Secretary was granted authority under section 4105 of PPACA to modify or eliminate Medicare coverage of any preventative service as defined in 1861(ddd)(3) that "has not received a grade of A, B, C, or I by [the] Task Force." However, Section 4105 explicitly states that the Secretary's new authority does not apply to the coverage of diagnostic or treatment services. Because the PSA test is a diagnostic blood test categorized in a separate section of the statute -- 1861 (00)(2)(B) of the Social Security Act -- they are, therefore, outside the scope of the Task Force and Secretary's ability to modify Medicare coverage. How then can you write a letter saying that you have discretion to eliminate or alter coverage of this vital test from our seniors, but just have chosen not to do it at this time?

Although HHS has touted its "exemption" to the preventive services mandate as mirroring those of the states, unlike the newly imposed federal mandate, many states do not require coverage for all FDA-approved contraceptives and multiple states have explicitly chosen to reject certain FDA-labeled "contraceptives" from their mandates. For example, Arkansas and North Carolina clearly exclude from their mandates so-called "emergency contraception," while Texas' law excludes "abortifacients or any other drug or device that terminates a pregnancy."

Other state laws - including Georgia, Maine, and Rhode Island - clarify that their mandates are not to include abortion-inducing drugs. Keeping in mind that these laws explicitly exclude the ab0l1ion drug RU-486 and pre-date the approval of a substantially similar

drug, ella, that the FDA has labeled as "contraception," the HHS mandated coverage preempts the principles, if not the letter, of these laws.

Was any consideration given by your office to the conflict between the broad new federal contraceptive mandate and the clear, duly enacted exclusions of so-called "emergency contraceptives" and "abortifacient drugs" contained in the laws of these several states?

Request that any communication/discussion regarding state exclusions of so-called "emergency contraceptives" and "abortifacient drugs" be disclosed to the Committee.

Answer: We have taken into consideration the input of States, religious organizations, women's groups and others, and comments we received on an amendment to the 2011 Interim Final Rules regarding women's preventive services, and considered before we finalized that amendment, which provides for a religious employer exemption from the contraceptive coverage requirement.

With respect to your comment about Medicare coverage of services that the USPSTF does not recommend, Section 4105 of the Affordable Care Act provides authority to modify or eliminate coverage of certain preventive services that are described in section 1861(ddd)(3). Such "preventive services" include, among other things, "the screening and preventive services described in 1861(ww)(2)," other than an electrocardiogram. Prostate cancer screening tests are included by this cross-reference because those tests are listed in section 1861(ww)(2)(D). While the Department has discretion to modify or eliminate Medicare coverage for the screening PSA test based on the US Preventive Services Task Force's recommendation, I do not intend to propose any changes to coverage of this screening test under Medicare at this time. With respect to private plans, the Affordable Care Act permits plans or issuers to provide coverage for services in addition to those recommended by the Task Force, thereby allowing coverage for PSA screening to continue. As indicated by the Affordable Care Act, the USPSTF recommendations are an important source of information regarding the modification or elimination of coverage for certain preventive services. I expect providers would use these recommendations, as well as other information on best practices, to educate their patients on the clinical appropriateness of any service, test, or course of treatment they recommend as part of an ongoing discussion of each patient's care.

4. My office continues to have concerns with the reported 50-90% audited error rates being released by CMS' contractors. I am advised that this error rate is a direct result of confusion among physicians as to the proper paperwork needed to properly prescribe PMDs (Power Mobility Devices) on behalf of their patients. In fact, I regularly hear from stakeholders regarding a lack of clarity and consistency associated with the paperwork needed to properly file PMD claims on a beneficiary's behalf. To that end, physicians and physician associations have long recognized the significance of utilizing clinical templates for patient examinations. Likewise, several members of Congress, in an attempt to reduce the error rate, have specifically requested that CMS develop a standard template for doctors to use in prescribing a PMD. Although CMS has agreed to develop such a template, it has yet to be released. When will CMS release the PMD face-to-face evaluation template that physicians can rely on to establish medical necessity and validates that the treating

physician conducted the congressionally mandated face-to-face medical evaluation of the patient?

Answer: CMS is in the process of developing an electronic clinical template as part of provider's electronic health records (EHR). An initial draft of the template is available on the CMS website at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/ElectronicClinicalTemplate.html CMS is actively seeking input on this template and stakeholders can submit comments on the draft to eclinicaltemplate@cms.hhs.gov. In addition, CMS will host a series of Open Door Forums to allow suppliers to comment and submit feedback on the draft template; the schedule for future ODFs can be found on the CMS website.

The Honorable Aaron Schock

1. Madame Secretary, effective January 1st of 2014, the current health law (section 9010) will impose an annual fee on certain health insurance providers, including Medicaid Managed Care plans. This fee, treated as an excise tax under the tax code, will be apportioned among health insurance providers subject to the tax, which will be a set dollar amount for a given year, based on the total amount of "net premiums written" by the provider for the previous year (ex. the tax will be imposed on 2015 for net premiums written in 2014). I am concerned about the effect of this tax on states' Medicaid budgets since Medicaid Managed Care plans collect "premiums" through direct payments from state Medicaid programs instead of through individual beneficiaries. I fear this tax will impact state Medicaid budgets on a dollar for dollar basis since states are required to pay an actuarially sound rate to Medicaid plans. Thus, states who already are struggling under the burden of the current Medicaid Maintenance of Effort (MOE) agreement, will have to use additional state funds to compensate for the federal fees paid by Medicaid plans that area already in financial distress. How does the Department of Health and Human Services plan to account for the increase in Medicaid expenditures solely due to the tax both at the federal and state level without impacting Medicaid beneficiaries' access to care?

Answer: We are currently working with the Treasury Department to analyze the various provisions of section 9010 of the Affordable Care Act on Medicaid managed care plans, including the provision that exempts certain entities that focus on public programs from the fee. The statute specifies that the entity must be a non-profit organization licensed in a State, comply with lobbying provisions under IRS code 501(c)(3), and derive at least 80 percent of its revenue from Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). We are assisting the Treasury Department as they prepare to implement Section 9010.

2. My office has received many constituent communications opposing the 25% multiple procedure payment reduction to the professional component of certain advanced diagnostic imaging services interpreted by the same physician, on the same patient, during the same session. This reduction, which went into effect on January 1,2012, impacts patients who are often the most challenging, such as trauma patients or ones with possible cancer metastasis. According to a recent study published in the Journal of the American College of Radiology, any efficiencies that may exist in the professional component of advanced diagnostic imaging are in the 3-5% range. Is CMS conducting any statistical or data analysis that justifies the decision to apply a 25% cut on the professional component? As a follow up, does HHS plan to share the specific data set that was used in support of the payment reduction?

Answer: CMS based this policy on a rigorous analysis of the data, which showed that there are efficiencies when physicians take multiple images in the same session. While CMS acknowledged that efficiencies may vary across code pairs, the analysis demonstrated that a 25 percent reduction in the professional component of the payment is reasonable. In fact, the data suggest that the efficiencies may even be higher than 25 percent. This is further supported by the comments the Medicare Payment Advisory Commission (MedPAC) submitted on the CY 2012

Physician Fee Schedule proposed rule, which recommended a reduction of 50 percent in the professional component.

Medicare spending for imaging services paid under the physician fee schedule has grown dramatically in recent years due to an increase in the number and intensity of these services. MedPAC has stated that this volume growth may signal that these services are mispriced.

Further, CMS described the data and methodology it used in the Calendar Year (CY) 2012 Physician Fee Schedule final rule and met with industry representatives to further describe its methodology in December 2011 (subsequent to publication of the final rule).

3. It has come to my attention that former CMS Administrator, Dr. Donald Berwick, visited two diagnostic imaging facilities in the Midwest in August 2011. During those visits, Dr. Berwick had the opportunity to witness, first-hand the process radiologists undertake when they interpret multiple images from the challenging patients who require multiple tests during the same session, on the same day. According to individuals present, Dr. Berwick admitted that there are virtually no efficiencies within the professional component when a single radiologist interprets multiple images from the same patient, during the same session, on the same day. In light of these conclusions, would it not make sense for CMS to consider rescinding the 25% MPPR on the professional component? Would you be willing to visit a diagnostic imaging facility to see the work of radiologists' first-hand?

Answer: As mentioned above, CMS' payment policy is supported by the data CMS analyzed, as well as MedPAC analyses.

4. I was pleased to see sections of the 2013 Call Letter included a greater focus on outreach and education to Part D beneficiaries so they are aware of the medication therapy management benefit, as well as the expansion of the number of targeted conditions. I believe access to medication therapy management services from a local pharmacist is critical to controlling prescription drug expenditures while also keeping seniors healthy. The 2013 Call Letter also stated that CMS will be conducting an analysis of the Part D medication therapy management program. It is my understanding that CMS has already contracted with an outside firm in order to investigate the benefits of medication therapy management on the currently eligible population. While I understand the need for a thorough investigation, can you explain why we have been told it will take a few years for this study to be available? Given the current restrictions on Part D medication therapy management services, this study could be instrumental in helping us to determine how we can best target this service for those beneficiaries that would benefit the most. What can we do to speed up the timeframe for the study results?

Answer: Thank you for your inquiry regarding the Part D Medication Therapy Management (MTM) and your support for the improvements to the program CMS is instituting for the 2013 plan year. CMS is evaluating the impact of MTM in a chronically ill population through a two year study that began in August 2011. A final report is due at the end of the study, with an interim report due to CMS after the first 14 months.

While I understand your enthusiasm for moving forward expeditiously with this study, this is a very labor intensive study that involves both quantitative and qualitative analyses.

For additional information, I invite you to review the scope of work for the project available at the following address: https://www.fbo.gov/?s=opportunity&mode=form&tab=core&id=cffd547191ee03de49aade9b9ed20405&_cview=0. (Once at this address, click on "SBRAD_IDIQ_Sections_B_thru_M.docx." The SOW for the MTM project starts on page 68 of the document.)

5. As you know, Congress revised the formula for how pharmacies are to be reimbursed for generic drugs and multiple source drugs in the Medicaid program in recent years. Under current law, the Average Manufacturer Price (AMP) is used to set the Federal Upper Limits (FULs). Thus, an accurate calculation of both AMP and FULs are dependent on one another. We understand that CMS continues to delay action on a final AMP rule until 2013 as that is the time when providers are expected to comply with the related FULs. Current law requires CMS to implement a smoothing process for the AMP as reimbursements are calculated yet CMS has yet to comply with this statutory requirement. Why has CMS said via the proposed rule that it will not make the AMP a final rule until 2013 when the regulation was published in early 2012? Does CMS plan to publish FUL's as final based on the weighted AMPs before a final regulation has been issued? What impact analysis, if any, has CMS done on pharmacy reimbursement that is based on the most recent FULs?

Answer: Effective October 1, 2010, the Affordable Care Act modified the previous statutory provisions that provide for the establishment of a Federal Upper Limit (FUL) for multiple source drugs. The proposed rule would establish the FUL reimbursement for multiple source drugs at 175 percent of weighted monthly average manufacturer price (AMP) in the aggregate. We believe that this policy will result in adequate reimbursement for pharmacy providers, while achieving savings for the Medicaid program. A recent report from the Government Accountability Office (GAO) showed that the FUL reimbursement level under the Affordable Care Act is 35 percent higher than what pharmacists pay for the drug in the aggregate. We believe that these levels are generally in excess of the actual acquisition cost of the drug, as detailed in the analysis in the proposed rule, and that our findings are consistent with those of the GAO.

Section 2503(d) of the Affordable Care Act specifies that the FUL amendments "shall take effect…without regard to whether or not final regulations to carry out such amendments have been promulgated." In order to facilitate this change, last fall, CMS began publishing draft FUL files on our Web site for review and comment. These draft FUL prices are based on the most recently reported AMP and AMP unit data. We have stressed that the draft Affordable Care Act FUL methodology and reimbursement files are drafts, and until such time as they are made final, the December 31, 2006 FULs will remain in effect.

CMS published the proposed rule on February 2, 2012, with a 60 day public comment period. Following the comment period, CMS will carefully review and consider all comments before issuing a final rule.

The proposed rule also addresses the smoothing process for the FULs for multiple source drugs. I also note that CMS previously issued sub-regulatory guidance to manufacturers on the AMP smoothing process. This manufacturer release can be found on CMS's Web site at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Program-Releases.html.

6. Congress' intent in changing the way pharmacies are reimbursed for generic drugs in the Medicaid program, was to more accurately reimburse pharmacies for the cost of generic drugs. Current law requires Federal Upper Limits (FULs) to be calculated using the Average Manufacture Price (AMP). However, it is the role of the states to adjust their dispensing fees to ensure pharmacies can be accurately reimbursed for the cost of dispensing prescription drugs to Medicaid patients. Can you explains what steps CMS is taking to ensure that states adjust the pharmacy dispensing fees before FULs based on AMP go into effect?

Answer: We agree that pharmacists should be appropriately reimbursed for the cost of dispensing prescription drugs to Medicaid recipients. Payment for Medicaid covered drugs is dependent on the methodologies set forth in each State's Medicaid State plan, and a State can exercise its flexibility in determining the actual reimbursement for a specific drug. Further, while CMS does not establish specific criteria for States to use when setting their dispensing fees, CMS must approve dispensing fees as part of the Medicaid State plan, and States are responsible for setting reasonable dispensing fees to appropriately reimburse pharmacy providers.

CMS proposed in its recently published notice of proposed rulemaking (NPRM) ("Medicaid Program; Covered Outpatient Drugs" (CMS-2345-P), that once the reimbursement for the drug is properly determined, the dispensing fee should reflect the pharmacist's professional services and costs.

7. I continue to hear about the concerns and problems being experienced over the marketing of Part D preferred network plans for the 2012 plan year, such as employees of the Senior Health Insurance Information Program who do not inform beneficiaries that they need to go a specific pharmacy in order to receive a network discount. Additionally, the Medicare Plan Finder tool does not include any obvious information for Medicare beneficiaries to go to a specific pharmacy within their preferred network plan in order to receive a lower-prescription drug co-payment. Is this information true, and if so, why is CMS allowing employees of the Senior Health Insurance Information Program to steer patients to specific plans? Does CMS plan to reform its current policies so that the Medicare Plan Finder provides clear and obvious education, on its front page for example, that will provide beneficiaries with an explanation of preferred network plans and the cost implications of choosing one? Finally, what is the rationale for CMS not requiring a beneficiary to input both a preferred and non-preferred pharmacy network into the Medicare Plan Finder so a senior will be able to see the actual difference in costs?

Answer: The Medicare Plan Finder (MPF) is a valuable tool that allows beneficiaries, as well as the mostly volunteer counselors in the State Health Insurance Assistance Programs (SHIPs), to compare Medicare prescription health and drug plans on the basis of costs, quality and coverage.

Most Part D plans offer one network, with no preference between network and out-of-network pharmacies. Because this information is not applicable to most plans, it would not be useful to most Medicare beneficiaries. However, the MPF does provide information about preferred pharmacies at various points in the tool:

- In MPF, beneficiaries have the opportunity to select a pharmacy in Step 3 of 4: Select Your Pharmacies. Under this step there is a note: "Please select up to two pharmacies. If the beneficiary's pharmacy isn't in a plan's network, the cost they will see is the full price of the drug with no insurance. Note that some plans may charge lower drug prices at preferred pharmacies and higher prices at non-preferred pharmacies."
- Prior to April 19, 2012, if the beneficiary chose the "I don't want to add pharmacies now" button, a pop-up box displayed. The pop-up again references that selecting a pharmacy will provide a more accurate estimate of the drug costs. Beginning on April 19, 2012, the beneficiary will be required to select a pharmacy.
- The beneficiary can look at the "Your Plan Details" page under the Drug Costs & Coverage tab for pharmacy information.
- Beneficiaries can review the "What You Pay" section and click onto each pharmacy tab to see the pharmacy type. The pharmacy will be described as Preferred-Network Pharmacy, Network Pharmacy, or Out-of-Network Pharmacy.
- Additionally, under the Pharmacy & Mail Order Information, if a user clicks onto the pharmacy hyperlink, the chart shows the pharmacy name, pharmacy type and if the pharmacy is preferred. Next to the word preferred there is a question mark. If a user clicks onto the question mark, the definition of Preferred Pharmacies is indicated ("If your plan has preferred pharmacies, you may save money by using them. Your prescription drug costs (such as copayment or coinsurance) may be less at a preferred pharmacy because it has agreed with your plan to charge less."). There are three options that appear under the Preferred heading. A "Yes" displayed under Preferred Column, indicates that the pharmacy is a "Preferred" pharmacy and the beneficiary may save money by using them because it has agreed with the plan to charge less. If there is a "NO" listed, that means it is not a preferred-network pharmacy, rather a network pharmacy. However, "NO" also indicates that there are preferred-network pharmacies available in the plan's network. If a "Not applicable" displays in the column then the plan does not offer any preferred pharmacies in their network.

As mentioned above, beginning on April 19, 2012, beneficiaries will be required to select a pharmacy when using the MPF. This will assist beneficiaries and counselors in selecting the proper pharmacy and understanding how the price estimate of the Plan Finder is based on that pharmacy. CMS is continuously evaluating the MPF to ensure that beneficiaries, SHIPs, and other users have the most up-to-date and useful information to make the most informed drug plan choices based on their individual needs.

The Honorable Charles Rangel

1. I understand that in 2013 available funding for Puerto Rico Medicare Advantage (MA) in Puerto Rico is going to be cut by over $200 million. With over 70 percent of the Medicare beneficiaries in Puerto Rico being covered under MA, this could have a devastating impact on access to health care, especially services such as dental, vision, rural transportation and subsidized co-payments and deductibles that Medicare Fee for Service does not offer.

With the high poverty rate and these potential cuts what can HHS and CMS do to help the people of Puerto Rico for the 2013 MA plan year?

Answer: I understand your concern about Medicare Advantage (MA) payment rates in Puerto Rico. In the fall of 2010, CMS conducted a detailed analysis of Medicare Fee-For-Service (FFS) spending in Puerto Rico. The results of that analysis confirm that Medicare enrollment, cost, and use patterns in Puerto Rico are different than those in the States. More specifically, beneficiaries in Puerto Rico are required to opt into Part B coverage whereas on the mainland, beneficiaries are automatically enrolled in Part B and must opt out to decline it. The result of this enrollment difference is that the proportion of the Medicare population with Part B coverage is lower in Puerto Rico (46 percent) as compared to the mainland (91 percent). Given this differential, and because beneficiaries who enroll in Medicare Advantage are enrolled in both Part A and Part B, we concluded the FFS rate calculation in Puerto Rico should be based exclusively on beneficiaries who are enrolled in both Part A and Part B. This refinement was included in the FFS rates that CMS' Office of the Actuary calculated and was announced in the 2012 Rate Announcement published on April 4, 2011. This change resulted in an increase of 0.4% in the blended benchmark for Puerto Rico in 2012.

We have thoroughly reviewed the methodology used to calculate FFS rates and believe that with the refinements made last year we have achieved the best and most accurate estimate of FFS costs in Puerto Rico. Therefore, for 2013 we are already using the best methodology to calculate FFS rates in Puerto Rico, meaning as MA payments begin to be tied to FFS rates, the island has already benefited from this special and targeted methodology. I appreciate the concerns you have raised regarding Puerto Rico and look forward to working with you in the future to ensure a strong MA program exists on the island.

The Honorable Earl Blumenauer

1. Secretary Sebelius, among its many other achievements, the Affordable Care Act provided new options to improve the quality of care for Medicare patients near the end of their lives. Under the Concurrent Care Demonstration authorized under section 3140, Medicare can choose fifteen hospice providers to provide concurrent curative benefits alongside their hospice benefits, a benefit which several private insurers already offer. In designing this demonstration, it is important to ensure that hospice providers be able to participate by allowing payment for curative services to be distinct from reimbursement for hospice services. I look forward to receiving an update from your agency on the design of this demonstration program.

Answer: Thank you for your feedback; we will certainly take into consideration your ideas for payment of curative services when we begin the design phase of this demonstration.

2. Secretary Sebelius, since 2004, the Government Accountability Office has issued twelve reports documenting Medicare program vulnerabilities for improper payments and fraud. While it is impossible to calculate precisely, the cost of fraud likely runs into the billions of dollars annually. To assist your agency's tremendous efforts to limit fraud and abuse, I have introduced, together with Mr. Gerlach of Pennsylvania and Sens. Kirk and Wyden, legislation providing for a common access card for Medicare beneficiaries. The Medicare Common Access Card Act of 2011, H.R. 2925, establishes a pilot project examining the ability of smart card technology to eliminate fraud and protect beneficiary information. Replacing the paper Medicare card with a smart card that securely stores a Medicare beneficiary's personal information allows beneficiaries and providers to confirm receipt of services at the time services are rendered and helps to prevent fraudulent claims. Please provide your views on how improved transaction security can reduce fraud and abuse within the provision of Medicare services.

Answer: I share your commitment to stopping waste, fraud and abuse in the Medicare program and your interest in learning what technologies can help us achieve this goal. The Affordable Care Act provided the Centers for Medicare & Medicaid Services (CMS) with significant new authorities to enhance its oversight of Medicare, helping shift the focus to fraud prevention by providing new authorities to increase screening of providers and suppliers before they enroll in any of these health programs, implement temporary moratoria on new providers in high risk areas, and establish requirements for compliance programs. These new activities are complemented by the passage of the Small Business Jobs Act of 2010, which required CMS to implement predictive analytics technology, and provided financial resources to do so. CMS is now deploying predictive analytics technology in its Fraud Prevention System (FPS) to review all Medicare FFS claims prior to payment. For the first time, CMS has a real-time view of FFS claims across claim types and the geographic zones of its claims processing contractors. This allows CMS to more easily identify fraudulent providers by detecting patterns and aberrancies.

CMS has begun investigating the potential application of smart card technology to the Medicare program, including the possible benefits in preventing fraud, the costs of implementation, and

whether a successful pilot could be extended to meet the needs of the 50.2 million beneficiaries and 1.5 million providers we serve in 2012.

The Honorable Richard Neal

1. In April of 2009, Congress passed the Genetic Information Non-Discrimination Act of 2008 (GINA). GINA imposes underwriting restrictions on the use of genetic information on health insurers and employers only. In addition, GINA's legislative history reflects clear Congressional intent to track the HIPAA framework, and not to subject long-term care insurers to any of the substantive prohibitions applicable to health insurance.

However, in HHS' proposed rule regarding GINA, HHS explicitly extends GINA's prohibition on the use and disclosure of genetic information to long term care insurance and issuers of long term care insurance policies.

Secretary Sebelius, GINA is written to exclude long-term care insurance from the restrictions on underwriting using genetic information, and the legislative history in both the Senate and House affirm that congressional intent. This is critical to ensure the viability of the long-term care insurance product. I wrote to you in November of last year to join in the expression of congressional concern that the Department has exceeded its statutory authority by proposing to apply the GINA rule to long-term care insurers. I understand that the Department is getting close to finalizing these regulations. Can you tell me how you plan to address this issue?

Answer: I appreciate your concerns with the Department's proposed rule, which would prohibit long-term care insurers from using genetic information for underwriting purposes. As the final rule to implement the GINA protections has not yet been published, the Department is not in a position to discuss the final policies. However, be assured that in developing the final rule, the Department is carefully considering the views expressed in response to the proposed rule and the potential impact of the proposed rule on the long-term care market.

[Submissions for the Record follow:]

Comments for the Record

U.S. House of Representatives

Committee on Ways and Means

The President's Fiscal Year 2013 Budget Proposals

Department of Health and Human Services

Tuesday, February 28, 2012, 1:00 PM

By Michael G. Bindner

Center for Fiscal Equity

Chairman Camp Ranking Member Levin, thank you for the opportunity to submit these comments for the record to the House Ways and Means Committee. The beginning of the budget debate for a new year brings with it the opportunity to rethink proposals. The Center for Fiscal Equity is using this opportunity to change our proposed fix for Social Security and Health Care. As always, our proposals are in the context of our basic proposals for tax and budget reform, which are as follows:

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of $100,000 and single filers earning $50,000 per year.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

Discretionary activities of the Department of Health and Human Services would be funded by the VAT. While some of our VAT proposals call for regional breakdowns of taxing and spending, they do not for this department. While some activities, such as the Centers for Disease Control, exist outside the Washington, DC metro area, even these are site specific rather than spread out on a nation-wide basis to serve the public at large. While some government activities benefit from national and regional distribution, health research will not.

The one reform that might eventually be considered in this area is to more explicitly link government funded research with ownership of the results, so that the Department might fund some of their operations with license agreements for some of the resulting research, enabling an expanded research agenda without demanding a higher budget allocation.

Of course, regionalization is possible if the Uniformed Public Health Service is put into the role of seeing more patients, particularly elderly patients and lower income patients who are less than well served by cost containment strategies limiting doctor fees. Medicaid is notoriously bad because so few doctors accept these patients due to the lower compensation levels, although we are encouraged the health care reform is attempting to reduce that trend. Medicare will head down that road shortly if something is not done about the Doc Fix. It may become inevitable that we expand the UPHS in order to treat patients who may no longer be able to find any other medical care. If that were to happen, such care could be organized regionally and funded with regionally based taxes, such as a VAT.

The other possible area of cost savings has to do with care, now provided for free, on the NIH campus. While patients without insurance should be able to continue to receive free care, patients with insurance likely could be required to make some type of payment for care and hospitalization, thus allowing an expansion of care, greater assistance to patients who still face financial hardship in association with their illnesses and a restoration of some care that has been discontinued due to budget cuts to NIH.

The bulk of our comments have to do with health and retirement security.

One of the most oft-cited reforms for dealing with the long term deficit in Social Security is increasing the income cap to cover more income while increasing bend points in the calculation of benefits, the taxability of Social Security benefits or even means testing all benefits, in order to actually increase revenue rather than simply making the program more generous to higher income earners. Lowering the income cap on employee contributions, while eliminating it from employer contributions and crediting the employer contribution equally removes the need for any kind of bend points at all, while the increased floor for filing the income surtax effectively removes this income from taxation. Means testing all payments is not advisable given the movement of retirement income to defined contribution programs, which may collapse with the stock market – making some basic benefit essential to everyone.

Moving the majority of Old Age and Survivors Tax collection to a consumption tax, such as the NBRT, effectively expands the tax base to collect both wage and non-wage income while removing the cap from that income. This allows for a lower tax rate than would otherwise be possible while also increasing the basic benefit so that Medicare Part B and Part D premiums may also be increased without decreasing the income to beneficiaries**. Increasing these premiums essentially solves their long term financial problems while allowing repeal of the Doc Fix.**

If personal accounts are added to the system, a higher rate could be collected, however recent economic history shows that such investments are better made in insured employer voting stock rather than in unaccountable index funds, which give the Wall Street Quants too much power over the economy while further insulating ownership from management. Too much separation gives CEOs a free hand to divert income from shareholders to their own compensation through cronyism in compensation committees, as well as giving them an incentive to cut labor costs more than the economy can sustain for consumption in order to realize even greater bonuses.

Employee-ownership ends the incentive to enact job-killing tax cuts on dividends and capital gains, which leads to an unsustainable demand for credit and money supply growth and eventually to economic collapse similar to the one most recently experienced.

The NBRT base is similar to a Value Added Tax (VAT), but not identical. Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

A key provision of our proposal is consolidation of existing child and household benefits, including the Mortgage Interest and Property Tax Deductions, into a single refundable Child Tax Credit of at least $500 per month, per child, payable with wages and credited against the NBRT rather than individual taxes. Assistance at this level, especially if matched by state governments may very well trigger another baby boom, especially since adding children will add the additional income now added by buying a bigger house. Such a baby boom is the only real long term solution to the demographic problems facing Social Security, Medicare and Medicaid, which are more demographic than fiscal. Fixing that problem in the right way definitely adds value to tax reform.

The NBRT should fund services to families, including education at all levels, mental health care, disability benefits, Temporary Aid to Needy Families, Supplemental Nutrition Assistance, Medicare and Medicaid. Such a shift would radically reduce the budget needs of HHS, while improving services to vulnerable populations.

The NBRT could also be used to shift governmental spending from public agencies to private providers without any involvement by the government – especially if the several states adopted an identical tax structure. Either employers as donors or workers as recipients could designate that revenues that would otherwise be collected for public schools would instead fund the public or private school of their choice. Private mental health providers could be preferred on the same basis over public mental health institutions. This is a feature that is impossible with the FairTax or a VAT alone.

To extract cost savings under the NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit, provided that services are at least as generous as the current programs. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed. Increasing Part B and Part D premiums also makes it more likely that an employer-based system will be supported by retirees.

Enacting the NBRT is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Conceivably, NBRT offsets could exceed revenue. In this case, employers would receive a VAT credit.

The Center calculates an NBRT rate of 27% before offsets for the Child Tax Credit and Health Insurance Exclusion, or 33% after the exclusions are included. This is a "balanced budget" rate. It could be set lower if the spending categories funded receive a supplement from income taxes. These calculations are, of course, subject to change based on better models.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

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Committee on Ways and Means
The President's Fiscal Year 2013 Budget Proposals
Department of Health and Human Services
Tuesday, February 28, 2012, 1:00 PM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.

NHeLP
NATIONAL HEALTH LAW PROGRAM

TESTIMONY BEFORE THE HOUSE COMMITTEE ON WAYS & MEANS

FOR THE HEARING ON THE PRESIDENT'S FISCAL YEAR 2013 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

February 28, 2012

BY THE

NATIONAL HEALTH LAW PROGRAM

The National Health Law Program ("NHeLP") submits this testimony to the House Committee on Ways & Means. NHeLP protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state levels. Consistent with this mission, NHeLP works to ensure that all people in the United States—including women—have access to quality health care including preventive health services. The Patient Protection and Affordable Care Act ("the ACA") similarly recognizes that preventive health services are critical to individual and community health, and that cost is often a barrier to accessing needed preventive services. The ACA also acknowledges the critical role that a woman's health plays in the health and well-being of her family and her community, as well as women's disproportionately lower earnings, by explicitly requiring that women's preventive health services be covered without cost-sharing.

Healthcare coverage decisions should be based on accepted standards of medical care recognized by the various professional medical academies. "Standards of care" are practices that are medically appropriate, and the services that any practitioner under the circumstances should be expected to render. Every person who enters a doctor's office or hospital expects that the care he or she receives will be based on medical evidence and meet accepted medical guidelines – in other words, that care will comport with medical standards of care. Refusal clauses and denials of care, however, violate these standards. They undermine standards of care by allowing or requiring health care professionals and institutions to abrogate their responsibility to deliver services and information that would otherwise be required by generally accepted practice guidelines. Ultimately, refusal clauses and institutional denials of care conflict with professionally developed and accepted medical standards of care and have adverse health consequences for patients. NHeLP's publication, *Health Care Refusals: Undermining Quality Care for Women* (Appendix A), is an extensive analysis of medical standards of care for women's health and the impact of refusal clauses and institutional denials of care on health access and quality.[1]

[1] Susan Berke Fogel & Tracy A. Weitz, *Health Care Refusals: Undermining Quality Care for Women*, Nat'l Health Law Program (2010), http://www.healthlaw.org/images/stories/Health_Care_Refusals_Undermining_Quality_Care_for_Women.pdf.

NHeLP strongly supports the Department of Health and Human Services (HHS) requirement that most new health insurance plans cover women's preventive health services, including contraception, without cost-sharing. The decision significantly benefits millions of women who are currently insured or who will obtain health insurance through the ACA—and one that will ensure that most women have access to contraception without expensive co-pays, saving some women up to $600 per year. The Administration recently adopted a religious employer exemption that would allow certain religious employers to refuse to cover contraception, as they would otherwise be required to do, and also announced that it will develop rules to ensure that women can obtain contraceptive coverage at no additional cost while also allowing non-profit religiously-affiliated employers, such as hospitals or universities, to refuse to provide contraceptive coverage. Despite these accommodations, the drive to deprive women of the right to obtain affordable birth control continues. NHeLP strongly opposes efforts to undermine the health and autonomy of women. Every woman should be able to make her own decisions about whether or when to have children based on her own beliefs and needs. Employers and insurance companies should not be able to impose their ideology to override the health care decisions of individual women.

A. THE REQUIREMENT TO COVER CONTRACEPTIVES AS A COMPONENT OF PREVENTIVE CARE IS EVIDENCE-BASED.

The ACA requires group health plans and health insurance issuers to cover certain preventive services without cost-sharing.[2] Among other things, the ACA requires new group health plans and health insurance issuers to cover such additional women's health preventive care and screenings as provided for in guidelines supported by HHS.[3] By doing so, the ACA recognizes that women have unique reproductive and gender specific health needs, disproportionately lower incomes, and disproportionately higher out-of-pocket health care expenses. HHS commissioned the independent Institute of Medicine of the National Academies ("IOM") to conduct a scientific review and provide recommendations on specific preventive measures that meet women's unique health needs and help keep women healthy. HHS charged the IOM with convening a committee to determine the preventive services necessary to ensure women's health and well-being.[4]

To this end, the IOM convened a committee of 16 eminent researchers and practitioners to serve on the Committee on Preventive Services for Women.[5] The Committee met five times in six months.[6] It reviewed existing guidelines, gathered and reviewed evidence and literature, and considered public comments.[7] In reaching its recommendations the IOM also relied on the input

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[2] Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (2010), § 2713(a), 42 U.S.C. § 300gg-13.
[3] ACA § 2713(a)(4), 42 U.S.C. § 300gg-13.
[4] Inst. of Medicine of the Nat'l Academies, *Clinical Preventive Services for Women: Closing the Gaps* (2011), www.iom.edu/~/media/Files/Report%20Files/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps/preventiveservicesforwomenreportbrief_updated2.pdf.
[5] *Id.*
[6] *Id.*
[7] *Id.*

of independent physicians, nurses, scientists, and other experts. With respect to women, the IOM identified gaps in the coverage for preventive services not already addressed by the ACA, including services recommended by the United States Preventive Services Task Force, the Bright Futures recommendations for adolescents from the American Academy of Pediatrics, and vaccinations specified by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices. The IOM recommended that, among other things, women receive coverage for all United States Food and Drug Administration ("FDA")-approved methods of contraception free of cost-sharing because: (1) pregnancy affects a broad population; (2) pregnancy prevention has a large potential impact on health and well-being; and (3) the quality and strength of the evidence is supportive of the recommendation to provide contraceptive coverage free of cost-sharing.[8] HHS recently adopted the eight recommendations submitted by the IOM, which include the recommendation that women receive coverage for all FDA-approved methods of contraception free of cost-sharing.[9] Requiring coverage of all eight preventive services recommended by the IOM, including coverage of all-FDA approved methods of contraception, is good medical and economic policy.

B. CONTRACEPTION EFFECTIVELY PREVENTS UNINTENDED PREGNANCIES, AND WOMEN NEED TO BE ABLE TO SELECT THE METHOD THAT IS MOST APPROPRIATE.

Family planning is an essential preventive service for the health of women and families. In 2008, there were sixty-six million women of reproductive age (ages 13-44) in the United States.[10] Over half of these women—thirty-six million—were in need of contraceptive services and supplies because they were sexually active with a male, capable of becoming pregnant, and neither pregnant nor seeking to become pregnant.[11] Each year, nearly half of the pregnancies in the United States are unintended—meaning they were either unwanted or mistimed.[12] Forty-two percent of unintended pregnancies end in abortion.[13] By age 45, more than half of all women in the United States will have experienced an unintended pregnancy, and four in ten will have had an abortion.[14] Unintended pregnancy disproportionally impacts women of color: sixty-seven percent of pregnancies among African American women, fifty-three percent of pregnancies among Latina women, and forty percent of pregnancies among white women are unintended.[15] A

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[8] *Id.*
[9] U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., Women's Preventive Services: Required Health Plan Coverage Guidelines, http://www.hrsa.gov/womensguidelines.
[10] Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Inst., *Contraceptive Needs and Services: National and State Data, 2008 Update* 3 (2010), http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.
[11] *Id.*
[12] Lawrence B. Finer & Stanley K. Henshaw, *Disparities in Rates of Unintended Pregnancy in the United States, 1994 and 2001*, Perspectives on Sexual & Reprod. Health, Vol. 38, No. 2 (2006), http://www.guttmacher.org/pubs/psrh/full/3809006.pdf; Guttmacher Inst., *Facts on Induced Abortion in the United States* (Aug. 2011), www.agi-usa.org/pubs/fb_induced_abortion.html.
[13] Inst. of Medicine of the Nat'l Academies, *supra* note 4.
[14] Guttmacher Inst., *Fact Sheet: Facts on Induced Abortion in the United States* (Aug. 2011), http://www.guttmacher.org/pubs/fb_induced_abortion.html.
[15] Lawrence B. Finer & Mia R. Zolna, *Unintended Pregnancy in the United States: Incidence and Disparities, 2006*, Contraception, Vol. 84, No. 5 (2011).

woman has an eighty-five percent chance of an unintended pregnancy if she uses no method of contraception.[16] More than fifty percent of unintended pregnancies in the United States occur among the sixteen percent of women at risk for unintended pregnancy who are not using any contraceptive method.[17] According to the Guttmacher Institute, in the United States publicly funded family planning services and supplies alone help women avoid approximately 1.5 million unintended pregnancies each year.[18] If these services were not provided in 2008, unintended pregnancy rates would have been 47 percent higher, and the abortion rate would have been 50 percent higher.[19] Increased access to, and use of, contraceptive information and services could reduce the rate of these unwanted pregnancies.

However, as the IOM report recognized, not all contraceptive methods are right for every woman, and access to the full range of pregnancy prevention options allows a woman to choose the most effective method for her lifestyle and health status. Current methods for preventing pregnancy include hormonal contraceptives (such as pills, patches, rings, injectables, implants, and emergency contraception), barrier methods (such as male and female condoms, cervical caps, contraceptive sponges, and diaphragms), intrauterine contraception, and male and female sterilization. As the IOM reported, female sterilization, intrauterine contraception, and contraceptive implants have failure rates of less than one percent.[20] Injectable and oral contraceptives have failure rates of seven and nine percent, largely due to misuse.[21] Failure rates for barrier methods are higher.[22]

C. CONTRACEPTIVES ARE WIDELY USED IN THE UNITED STATES.

Most sexually active women in the United States use contraception to prevent pregnancy. Contraceptive use is nearly universal in women who are sexually active with a male partner: more than 99 percent of women 15–44 years of age who have ever had sexual intercourse with a male have used at least one contraceptive method. [23] This is true for nearly all women, of all religious denominations.[24] Indeed, the overwhelming majority of sexually active women of all denominations who do not want to become pregnant are using a contraceptive method.[25] Approximately 98 percent of sexually active Catholic women have used contraceptive methods

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[16] *Id.*
[17] Rachel Benson Gold *et al.*, Guttmacher Inst., *Next Steps for America's Family Planning Program: Leveraging the Potential of Medicaid and Title X in an Evolving Health Care System* (2009), http://www.guttmacher.org/pubs/NextSteps.pdf/.
[18] Jennifer J. Frost, Stanley K. Henshaw & Adam Sonfield, Guttmacher Inst., *Contraceptive Needs and Services: National and State Data, 2008 Update* 5 (2010), http://www.guttmacher.org/pubs/win/contraceptive-needs-2008.pdf.
[19] *Id.*
[20] Inst. of Medicine of the Nat'l Academies, *supra* note 4.
[21] *Id.*
[22] *Id.*
[23] Williams D. Mosher & Jo Jones, *Use of Contraception in the United States: 1982–2008*, Nat'l Ctr. for Health Statistics, Vital and Health Statistics, Series 23, No. 29 (2010).
[24] Rachel K. Jones & Joerg Dreweke, Guttmacher Inst., *Countering Conventional Wisdom: New Evidence on Religion and Contraceptive Use* (2011), http://www.guttmacher.org/pubs/Religion-and-Contraceptive-Use.pdf.
[25] *Id.*

banned by the Catholic Church.[26] Even among those Catholic women who attend church once a month or more, only two percent rely on natural family planning methods to prevent unintended pregnancies.[27] Consistent with the data establishing that there is nearly universal use of birth control, a recent poll by Public Policy Polling ("PPP") shows that fifty-six percent of voters, and fifty-three percent of Catholic voters, support the decision to require plans to cover birth control with cost-sharing.[28] Further, according to the PPP poll, fifty-seven of all voters, and fifty-three percent of Catholic voters, think that women employed by Catholic hospitals and universities have the same rights to contraceptive coverage as other women.[29]

D. COST PREVENTS WOMEN FROM ACCESSING CONTRACEPTIVE INFORMATION AND SERVICES.

One of the major barriers to consistent contraceptive use for women - who are also disproportionately low-income - is the high out-of-pocket cost that ranges from $30 to $50 per month. Women who are poor also have unintended pregnancy rates that are more than five times the rate for women in the highest income level.[30] In fact, unintended pregnancy rates are highest among poor and low-income women, women aged 18-24, cohabiting women and minority women.[31] Low-income women are the least likely to have the resources to obtain reliable methods of family planning, and yet, they are most likely to be impacted negatively by unintended pregnancy.[32]

Increased use of longer-acting, reversible contraceptive methods, which have lower failure rates, could further help women reduce unintended pregnancy. These more effective methods of contraception, however, also have the most up-front costs, which put them outside of the reach of many women.[33] In 2008, for example, only 5.5 percent of women using contraception chose the more effective and longer-term methods.[34] As the IOM recognized, the "elimination of cost sharing for contraception . . . could greatly increase its use, including use of the more effective and longer-acting methods, especially among poor and low-income women most at risk for unintended pregnancy."[35] In this regard, the California Kaiser Foundation Health Plan's experience is informative. The California Kaiser Foundation Health Plan eliminated

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[26] *Id.*
[27] *Id.*
[28] Pub. Policy Research Inst., *February PRRI Religion & Politics Tracking Poll* (Feb. 2012), http://publicreligion.org/research/2012/02/january-tracking-poll-2012/.
[29] *Id.*
[30] Lawrence B. Finer & Stanley K. Henshaw, *supra* note 12.
[31] Lawrence B. Finer & Kathryn Kost, *Unintended Pregnancy Rates at the State Level*, Perspectives on Sexual & Reprod. Health Vol. 43, No. 2 (2011).
[32] Sheila D. Rustgi, Michelle M. Doty & Sara R. Collins, The Commonwealth Fund, *Women at Risk: Why Many Women are Forgoing Needed Health Care* (2009), http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Women%20at%20Risk/PDF_1262_Rustgi_women_at_risk_issue_brief_Final.pdf.
[33] Inst. of Medicine of the Nat'l Academies, *supra* note 4.
[34] Jennifer J. Frost & Jacqueline E. Darroch, *Factors Associated with Contraceptive Choice and Inconsistent Method Use,* Perspectives on Sexual & Reprod. Health, Vol. 40, No. 2 (2008).
[35] Inst. of Medicine of the Nat'l Academies, *supra* note 4.

copayments for the most effective contraceptive methods in 2002.[36] Prior to the change, users paid up to $300 for 5 years of use; after elimination of the co-payment, use of these methods increased by 137 percent.[37]

E. PREVAILING MEDICAL STANDARDS OF CARE REQUIRE THAT WOMEN HAVE ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES.

The government should make *health care coverage decisions* based on scientific evidence and good economic policy, not on the religious and moral beliefs of some institutions. Health care refusals and denials of care, also known as "conscience" clauses, are based on ideological and political justifications that have no basis in scientific evidence, good medical practice, or patient needs. These policies violate the essential principles of modern health care delivery: evidence-based practice, patient centeredness, and prevention. "Standards of care" are practices that are medically necessary and the services that any practitioner under the circumstances should be expected to render. Refusal clauses and denials of care undermine standards of care by allowing or requiring health care professionals and/or institutions to abrogate their responsibility to provide services and information that would otherwise be required by generally accepted practice guidelines. Refusal clauses and denials of care allow employers and insurers companies to "opt-out" of meeting medical standards of care.

Women consider a number of factors in determining whether to become or remain pregnant, including: age, educational goals, economic situation, the presence of a partner and/or other children, medical condition, mental health, and whether they are taking medications that are contraindicated for pregnancy. For example, a number of commonly prescribed pharmaceuticals are known to cause impairments in the developing fetus or to create adverse health conditions if a woman becomes pregnant while taking them. Approximately 11.7 million prescriptions for drugs the FDA has categorized as Pregnancy Classes D (there is evidence of fetal harm, but the potential may be acceptable despite the harm) or X (contraindicated in women who are or may become pregnant) are filled by significant numbers of women of reproductive age each year.[38] Pregnancy for women taking these drugs carries risk for maternal health and/or fetal health.[39] Women taking these drugs who might be at risk for pregnancy are advised to use a reliable form of contraception to prevent pregnancy.[40]

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[36] Kelly Cleland et al., *Family Planning as Cost-Saving Preventive Health Service*, New Eng. J. Med, Vol. 37., No. 1 (April 2011), http://healthpolicyandreform.nejm.org/?p=14266.
[37] *Id.*
[38] Eleanor B. Schwarz et al., *Documentation of Contraception and Pregnancy When Prescribing Potentially Teratogenic Medications for Reproductive-Age Women*, Annals of Internal Med., Vol. 147, No. 6 (2007); Eleanor B. Schwarz et. al., *Prescription of Teratogenic Medications in United States Ambulatory Practices*, Am. J. of Med., Vol. 118 (2005).
[39] *Id.*; David L. Eisenberg et al., *Providing Contraception for Women Taking Potentially Teratogenic Medications: A Survey of Internal Medicine Physicians' Knowledge, Attitudes and Barriers*, J. Gen. Internal Med., Vol. 25, No. 4 (2010).
[40] *Id.*

Unintended pregnancy is associated with maternal morbidity and mortality. The World Health Organization recommends that pregnancies should be spaced at least two years apart.[41] Pregnancy spacing allows the woman's body to recover from the pregnancy. Further, if a woman becomes pregnant while breastfeeding, the health of both her baby and fetus may be compromised as her body shares nutrients between them. According to the American College of Obstetricians and Gynecologists, women who become pregnant less than six months after their previous pregnancy are 70 percent more likely to have membranes rupture prematurely, and are at a significantly higher risk of other complications.[42] Recognizing the importance of family planning, HHS included family planning as a focus area of the Healthy People 2020 health promotion objectives.[43] Healthy People 2020 aims to increase the proportion of intended pregnancies and to improve pregnancy spacing. Specific indicators of goal achievement include increasing: (1) intended pregnancies from 51 percent to 61 percent; (2) pregnancy spacing to 18 months; (3) the proportion of women at risk for unintended pregnancy who use contraceptives to 100 percent; and (4) the proportion of teens who use contraceptive methods that both prevent pregnancy and prevent sexually transmitted disease to 73.6 percent.[44]

Millions of women live with chronic conditions such as cardiovascular disease, diabetes, lupus, and epilepsy, which if not properly controlled, can lead to health risks or even death during pregnancy. Denying these women access to contraceptive information and services does not comport with medical standards that recommend pregnancy prevention for these medical conditions.

Refusal clauses increase health disparities by imposing significant burdens on the health and well-being of affected women and their families. These are burdens that fall disproportionately and most harshly on low-income women, severely impacting their health outcomes and their ability to give informed consent for medical care. Low-income women, and low-income women of color already experience severe health disparities in reproductive health, maternal health outcomes, and birth outcomes. Cardiovascular disease, lupus, and diabetes, for example, are chronic diseases that disproportionately impact women of color. The incidence rate for lupus is three times higher for African American women than for Caucasian women.[45] Similarly, although an estimated 7.8 percent of Americans have diabetes, the prevalence rate (the number of cases in a population at a specific time) is higher for women of color in all age groups, with obesity and family history being significant risk factors for Type II diabetes.[46] Nearly one out of ten African American women and one in fourteen Latinas of reproductive age experience

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[41] Cicley Marston, *Report of a WHO Technical Consultation on Birth Spacing*, World Health Organization, (June 13-15, 2005).
[42] Am. Coll. of Obstetricians & Gynecologists, *Statement of the Am. Coll. of Obstetricians & Gynecologists to the U.S. Senate, Comm. on Health, Educ., Labor & Pensions, Pub. Health Subcomm. on Safe Motherhood* (April 25, 2002).
[43] U.S. Ctrs. for Disease Control & Prevention, Health People 2020 Summary of Objectives: Family Planning, http://healthypeople.gov/2020/topicsobjectives2020/pdfs/FamilyPlanning.pdf.
[44] *Id.*
[45] U.S. Dep't of Health & Human Servs., Office on Women's Health, *Lupus: Frequently Asked Questions* (June 13, 2001), http://www.womenshealth.gov/publications/our-publications/fact-sheet/lupus.pdf.
[46] U.S. Dep't of Health & Human Srvs., Nat'l Diabetes Information Clearinghouse, *Diabetes Overview*, *http://diabetes.niddk.nih.gov/dm/pubs/overview/#scope*; Ann S. Barnes, *The Epidemic of Obesity and Diabetes*, 38 Tex. Heart Inst. J. 142 (2011).

an unintended pregnancy each year. [47] Inaccessible and unaffordable contraceptive counseling and services contribute to these disparities.

Heart disease is the number one cause of death for women in the United States.[48] The American College of Cardiology and the American Heart Association Task Force on Practice Guidelines issued specific recommendations for management of women with valvular heart disease.[49] They conclude that individualized preconception management should provide the patient with information about contraception as well as maternal and fetal risks of pregnancy.[50] Some cardiac conditions in which the physiological changes brought about in pregnancy are poorly tolerated include valvular heart lesions such as severe aortic stenosis, aortic regurgitation, mitral stenosis, and mitral regurgitation all with III-IV symptoms, aortic or mitral valve disease, mechanical prosthetic valve requiring anticoagulation and aortic regurgitation in Marfan syndrome.[51]

The American College of Obstetricians and Gynecologists and the American Diabetes Association have developed practice guidelines for the preconception care for women with pregestational diabetes. According to the American Diabetes Association, planned pregnancies greatly facilitate diabetes care. Their recommendations for women with diabetes with childbearing potential include: (1) use of effective contraception at all times unless the patient is in good metabolic control and actively trying to conceive; (2) counseling about the risk of fetal impairment associated with unplanned pregnancies and poor metabolic control; and (3) maintain blood glucose levels as close to normal as possible for at least two to three months prior to conception.[52] The American College of Obstetricians and Gynecologists further recommends that "[a]dequate maternal glucose control should be maintained near physiological levels before conception and throughout pregnancy to decrease the likelihood of spontaneous abortion, fetal malformation, fetal macrosomia [excessive birthweight], intrauterine fetal death, and neonatal morbidity." [53]

Similarly, contraception plays a critical role in preparing a woman with lupus for pregnancy. Lupus is an auto-immune disorder of unknown etiology which can affect multiple parts of the body such as the skin, joints, blood, and kidneys with multiple end-organ involvement. Often labeled a "woman's disease," nine out of ten people with lupus are women.[54] Women with lupus who become pregnant face particularly increased risks. A large review of United States hospital data found the risk of maternal death for women with lupus is twenty

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[47] Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 Guttmacher Policy Review 3 (Summer 2008), http://www.guttmacher.org/pubs/gpr/11/3/gpr110302.html.
[48] Lori Mosca, et al., *Tracking Women's Awareness of Heart Disease: An American Heart Association National Study*, 109 J. Am. Heart Ass'n 573 (Feb. 4, 2004).
[49] Robert O. Bonow et al., *Guidelines for the Management of Patients with Valvular Heart Disease*, Am. Coll. of Cardiology/Am. Heart Ass'n Task Force on Practice Guidelines (Comm. on Mgmt. of Patients with Valvular Heart Disease), 98 J. Am. Coll. of Cardiology 1949-1984 (Nov. 1998).
[50] *Id.*
[51] *Id.*
[52] Am. Diabetes Ass'n, *Standards of medical care in diabetes-2006*, 29 Diabetes Care S4 (2006).
[53] Am. Coll. of Obstetricians & Gynecologists, *ACOG Practice Bulletin No. 60: Pregestational diabetes mellitus*, 115 Obstetrics & Gynecology 675 (2005).
[54] U.S. Dep't of Health & Human Srvs., Office on Women's Health, *supra* note 46.

times the risk of non-lupus pregnant women. [55] These women were three to seven times more likely to suffer from thrombosis, thrombocytopenia, infection, renal failure, hypertension, and preeclampsia.[56] Women who suffer from moderate or severe organ involvement due to lupus are at significantly higher risk for developing complications during pregnancy, and the guidelines discussed above regarding chronic disease apply to women with those co-morbidities.[57] This should be taken into consideration in the decision to become pregnant or to carry a pregnancy to term.[58]

Historically, women with lupus were discouraged by the medical community from bearing children. This is no longer always true, however, pregnancy for women with lupus is always considered high risk, and should be undertaken when, if at all possible, the disease is under control. The National Institute of Arthritis and Musculoskeletal and Skin Diseases ("NIAMS") recommends that a woman should have no signs or symptoms of lupus before she becomes pregnant.[59] In addition, NIAMS directs women as follows: "Do not stop using your method of birth control until you have discussed the possibility of pregnancy with your doctor and he or she has determined that you are healthy enough to become pregnant."[60]

F. DENYING WOMEN ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES UNDERMINES QUALITY OF CARE FOR WOMEN.

Ideological restrictions occur at various levels, including the institutional and health system level and the political level. Refusal clauses are statutory or regulatory "opt out" provisions that impede patient access to necessary and desired health care services and information. At the institutional level, the restrictions that have the greatest impact on access to care are those imposed by institutions controlled by religious entities. In particular, the Catholic health system has the broadest religion-based health care restrictions. The U.S. Conference of Catholic Bishops has issued *The Ethical and Religious Directives for Catholic Health Care Services* for all Catholic medical institutions. The Directives specify a range of services that are prohibited, including contraception. Refusal clauses at the institutional level undermine medical standards of care by allowing health care systems and facilities to prohibit even willing providers from delivering medically needed care, even in emergencies. At the political level, legislation enacting refusal clauses impose restrictions unrelated to health and safety on women's ability to access reproductive health care services. These restrictions are driven by political ideology, electoral politics, and other political considerations that have nothing to do with evidence-based medicine.

Broad refusal clauses fail to account for (or even consider) the significant burdens that denials of care have on patients. Existing law already protects health care providers and religious

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[55] Megan E. B. Clowse, et al., *A national study of the complications of lupus in pregnancy*, 199 Am. J. Obstet. & Gynecol. 127e. 1, e.3 (Aug. 2008).
[56] *Id.* at 127e.3-e.4.
[57] *Id.*
[58] Nat'l Inst. of Arthritis & Musculoskeletal & Skin Diseases, *Lupus: A Patient Care Guide for Nurses and Other Health Professionals* 27-62, Patient Information Sheet 4-5 (3d ed. Sept. 2006).
[59] *Id.* at 45-46, Patient Information Sheet No. 11.
[60] *Id.* at Patient Information Sheet No. 4.

employers who object to providing certain services based on their religious or moral beliefs. The new HHS contraceptive coverage requirement exempts houses of worship and other religious non-profits that primarily employ and serve people of their faith. Over 330,000 houses of worship will likely fall under HHS' exemption. The requirement that most new health plans fully cover contraception without cost-sharing helps ensure that an individual woman can make her own decision about whether to use birth control. A woman who opposes contraception need not use it. The criticism of the preventive services rule distorts these facts. No one will be compelled to use birth control (of course contraceptive use is nearly universal in women who are sexually active with a male partner, irrespective of religious affiliation). No one will be forced to condone contraceptive use. The rule concerns *contraceptive* coverage only, not abortion. Twenty-eight states already require employers to provide contraceptive coverage; the ACA ensures that women across the country will have the same benefits.

A more expansive refusal clause is therefore not only unnecessary, but would also dangerously threaten women's health and well-being—subjugating a woman's access to health care to the ideological desires of her employer or insurer. Recently proposed refusal clauses, such as S. 2043, S.2092, and S. Amendment 1520 to S. 1813, would expand what an employer or insurance company—religiously affiliated or not—can refuse to cover. S.B. 2043, for example, would permit *any* person, even the owner of a grocery store or car repair shop, to deny his employee coverage for contraception or sterilization services. S.B. 2092 seeks to deny women even access to *information* about birth control and sterilization. S. Amendment 1520 is even broader and allows any employer or insurer to refuse to provide coverage for virtually *any* service otherwise required by the ACA. Not only do these proposals discriminate against women, they undermine the whole point of health insurance, which is to pool and minimize risk. An insurance program that fails to cover services that meet standards of medical care fails at its essential task. It is also inadequate and unsafe.

These proposals are not just bad policy; they also contravene § 1557 of the ACA and Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e *et seq*. Section 1557(b) of the ACA provides that, "Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under . . . Title VII of the Civil Rights Act of 1964 (42 U.S.C. § 2000e *et seq.*)." In 2000, the Equal Employment Opportunity Commission made clear that an employer's failure to provide insurance coverage for prescription contraceptives, in an otherwise comprehensive prescription drug plan, constitutes unlawful discrimination under Title VII.[61] Longstanding and settled law recognizes the right of women to have contraception covered in the same way that other drugs are covered by health insurance.

In sum, expansive refusal clauses are inconsistent with medical evidence and the right of all people to access health care that meets modern standards of appropriate medical care. Most women are covered by health insurance offered by their employer.[62] While most American

[61] U.S. Equal Emp't Opportunity Comm'n, Decision on Coverage of Contraception (Dec. 14, 2000), http://www.eeoc.gov/policy/docs/decision-contraception.htm.
[62] Usha Ranji & Alina Salganicoff, The Henry J. Kaiser Family Foundation, *Women's Health Care Chartbook: Key Findings from the Kaiser Women's Health Survey* 10 (2011), http://www.kff.org/womenshealth/upload/8164.pdf.

women of reproductive age have some form of private insurance, the extent to which they have contraceptive coverage can differ dramatically depending on their type of insurance.[63] The ACA recognizes the importance of preventive services to the health and well-being of individuals, their families and their communities. Preventive services are required to be covered without cost-sharing in order to ensure that all foreseeable barriers to access to preventive services are removed. Allowing employers or insurers to erect new barriers in the form of refusal clauses vastly undermines the promise of the ACA to improve the health of the nation. Every woman should be able to make her own decisions about whether or when to prevent pregnancy based on her own beliefs, not the beliefs of her employer or insurer.

G. CONCLUSION

Refusal clauses and denials of care should be evaluated using the same measurements used to evaluate quality generally, with the goal of providing care that is evidence-based, patient-centered, and preventative. All women should have access to the health care services they need based on medical evidence, their personal health needs, and their own beliefs. Low-income women and low-income women of color are disproportionately burdened by refusal clauses, and existing health disparities are exacerbated. Employers, insurers, and hospital corporations should not be allowed to impose their ideology on women.

For more information or questions, please contact Susan Berke Fogel, Director of Reproductive Health, at fogel@healthlaw.org or (818) 621-7358.

Thank you.

[63] The Henry J. Kaiser Family Found., *Key Findings from the Kaiser Women's Health Survey* (July 2005), http://www.kff.org/womenshealth/upload/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf.

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