THE PRESIDENT'S FISCAL YEAR 2012 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

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THE PRESIDENT'S FISCAL YEAR 2012 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

WEDNESDAY, FEBRUARY 16, 2011

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

The Committee met, pursuant to call, at 10:05 a.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
February 9, 2011

CONTACT: (202) 225–1721

Chairman Camp Announces a Hearing on the President's Fiscal Year 2012 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 2012. **The hearing will take place on Wednesday, February 16, 2011, in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear the witness, oral testimony at this hearing will be from the invited witness only. The sole witness will be the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services (HHS). 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 14, 2011, the President is expected to submit his fiscal year 2012 budget proposal to Congress. The proposed budget will detail his tax, spending and policy proposals for the coming 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, **"This hearing will give us an opportunity to examine the Democrats' new health care law, its implementation, and the resulting cost increases and market disruptions already being felt across the country. Equally important, we will be able to address the looming expiration of the historic 1996 welfare reform law and what plans the Administration has to build on its successes in breaking the cycle of dependency and moving more Americans off of welfare and into private sector employment."**

FOCUS OF THE HEARING:

U.S. Department of Health and Human Services Secretary Sebelius will discuss the details of the President's HHS 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 requested information. ATTACH your submission as a Word document, in compliance

with the formatting requirements listed below, **by the close of business on Wednesday, March 2, 2011.** 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 TTD/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. I want to thank everyone for being here this morning, especially our honored guest, the Secretary of the Department of Health and Human Services, Kathleen Sebelius. Madam Secretary, I trust you and the Members of this Committee have everything you will need to proceed smoothly with this hearing. But that in large part is due to the hard work of our staffs, and of one gentleman in particular, Reginald B. Green, or as he has been known to all of us who wander the halls of the first floor of Longworth Building, particularly those who enter this room, as Reggie. Yesterday Reggie marked his 29th year with this Committee. And in those years, Reggie has helped many Members, including myself, as he has new Committee staff, with the ways of the Ways and Means Committee. And with a simple look or a discrete shake of the head or subtle gesture, Reggie has kept this Committee, its witnesses, and the audience on course. So Reggie, thank you, and we look forward to your continued service to this Committee, the House, and the Nation.

Madam Secretary, thank you for joining us today. We are pleased to be the first committee to welcome you to the House of Representatives for a discussion of the 2012 budget. And as I looked through your testimony in preparation for today, I noticed that you referenced comments made by President Obama in last month's State

of the Union Address. Speaking about the health care law, he said, and I quote, "Let me be the first to say that anything can be improved. If you have ideas about how to improve this law by making care better or more affordable, I am eager to work with you." And the refrain from that night is becoming a familiar one for this Administration: If you don't like it, we can fix it.

Some in the Administration have said the 1099 reporting provision is too burdensome on small business, and it is. Some in the Administration have acknowledged that the health care law prevents millions from being able to keep the care they have and like, and it does. And still others, most notably you, have gone so far as to say that certain new entitlement programs, like the CLASS program, are financially unsustainable. And I would say you are right. And while I appreciate your willingness to fix some flaws here and there, the reality is the law is a mess, and so is the budget that is meant to finance its implementation.

As I look through this budget, I see gimmick after gimmick, temporary patches paid for with permanent tax increases, a Medicare doc fix that is absent of any policy details, and hundreds of billions of dollars in exchange subsidies that can't be accounted for. And as I noted to Secretary Geithner yesterday, I am also disappointed that this budget also lacks any mention of entitlement reform. Presumably from this budget, Medicare is doing just fine. And I think the facts suggest otherwise.

So Madam Secretary, I hope that during your time with us today we can account for some of the missing items in this budget, and that you will be able to help us all fill in the blanks. And I look forward to your testimony.

I will recognize the Ranking Member, Mr. Levin, for the purposes of an opening statement.

Mr. LEVIN. Thank you very much, Mr. Chairman. For our opening statement, I now yield to the Ranking Member on the Health Subcommittee, Mr. Stark.

Mr. STARK. Thank you, Mr. Levin. Thank you, Chairman Camp, for holding this hearing to review the President's budget in regard to Health and Human Services, and I look forward to hearing from Secretary Sebelius and thank her for joining us today.

The President outlined a tough budget on a number of fronts. I wouldn't have made all the same choices, but I commend the President for trying to walk the fine line of reducing the deficit and continuing to meet people's needs. In contrast, the House Republicans are debating a job-killing continuing resolution that independent analysts confirm would destroy 800,000 private and public sector jobs, cause the firing of thousands of police officers, firefighters, other public servants around the country, and kick more than 200,000 children out of Head Start. Of particular concern for today's audience is that we would endanger the ability of Medicare to pay doctors, hospitals, and other health care providers who treat Medicare patients, threatening seniors' access to health care.

I am pleased that, in his budget, the President proposed improvements to several vital programs within our jurisdiction, including foster care, child support enforcement, and child care. We look forward to working with the Administration to ensure these programs are protecting children, lifting families out of poverty.

In crafting his budget, the President acknowledges that the health reform law includes significant entitlement reforms to Medicare, improvements that will extend the lifetime of Medicare by 12 years, according to CBO, and the Affordable Care Act, which reduces the deficit by $230 billion between now and 2019 and more than $1.2 trillion in the following decade.

My friends on the other side of the aisle have been talking out of both sides of their mouths. In a hearing last week they are talking about how health care reform did too much to cut Medicare, and this week they are saying we need to cut even more out of Medicare and supporting a Republican roadmap that would turn Medicare into a voucher system.

Taken together, Medicare changes in the health reform law add up to a significant, meaningful entitlement reform, but reform that protects taxpayers, the program, and the beneficiaries. The health reform law makes Medicare stronger, improves benefits for all beneficiaries. Senior citizens, people with disabilities who receive care through Medicare will have lower premiums for medical care and pay less when they go to the doctor or pick up prescriptions.

Given the historic health reform effort and its deficit reduction achievements, it comes as no surprise that the President took a light touch to the health programs in his budget. As we might say, we already gave at the office. I look forward to hearing from the Secretary about why the President made the choices he did in this budget, and I am sure we will have a lively discussion after that, Mr. Chairman. Thank you very much.

Chairman CAMP. Thank you. Again, Secretary Sebelius, welcome to the Ways and Means Committee. Your written statement will be made part of the record. And you have 5 minutes to summarize your statement. And you may begin. Thank you.

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

Secretary SEBELIUS. Well, thank you, Chairman Camp, and Ranking Member Levin, and Members of the Committee. It is my pleasure to be here today to discuss the President's fiscal year 2012 budget for the Department of Health and Human Services.

I want to start with a personal aside. I am a constituent of two Members of this Committee. Our family has a house in Chairman Camp's district, and Congresswoman Jenkins is my Congresswoman from the great State of Kansas. So I want to recognize them. I also want to add my congratulations to one of your Members, Congressman Lewis, who yesterday was given the Presidential Medal of Freedom. And congratulations for that enormous honor.

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

The budget also recognizes that we can't build lasting prosperity on a mountain of debt. Years of deficits have put us in a position where we need to make some tough choices. We can't invest in the

future unless we also live within our means. So developing our budget, we looked at every program, we cut waste, we redesigned programs to put a focus on results, and in some cases cut programs that we wouldn't have cut in better fiscal times.

Now, I look forward to answering your questions, but I want to share some of the highlights. Over the last 10½ months, we have worked around the clock with our partners in Congress and States to deliver on the promise of the Affordable Care Act to the American people. Now, thanks to the law, children can no longer be denied coverage because of their preexisting health conditions. Families have the protections of the new Patients' Bill of Rights. Businesses are getting some immediate relief from health costs, and seniors have lower cost access to prescription drugs and preventive care.

Later today, our Department will announce the award of seven new grants, creating a $241 million partisanship with States that will design and implement the information technology infrastructure needed to operate the new health insurance marketplaces, the State-based exchanges, allowing individuals and small business-owners to pool their purchasing power and negotiate lower rates. The budget builds on efforts like this one by supporting innovative new models of care that improve patient safety and quality, while reducing the burden of rising health costs on families, businesses, cities, and States.

As Secretary Geithner said yesterday, the Affordable Care Act makes a significant step toward slowing down rising health care costs, and includes major delivery systems reform. For the first time ever, we are tackling some of the significant long-term problems. We make new investments in our health care work force, in community health centers, to make quality, affordable care available to millions more Americans, and create hundreds of thousands of new jobs around the country.

At the same time, the budget includes additional proposals that will strengthen program integrity in Medicare, promote lower pharmaceutical costs, improve Medicare program operations, and reform the quality improvement organizations which help providers improve care.

The budget also includes savings proposals to strengthen Medicaid and funding for the Medical Assistance program and Medicare part D premium assistance for low income beneficiaries.

To make sure that America continues to lead the world in innovation, our budget increases the funding for the National Institutes of Health. New frontiers of research like cell-based therapies and genomics have the promise to unlock revolutionary treatments and cures for diseases, ranging from Alzheimer's to cancer to autism. The budget allows the world's leading scientists to pursue their discoveries, while keeping America at the forefront of biomedical research.

Now, nothing is more important to our future than healthy development of our children, and our budget includes a significant increase in funding for child care and Head Start, following the science that shows that success in school is significantly enhanced by early learning opportunities, which makes these investments some of the wisest we can make. But our budget does more than

provide resources. It aims to raise the bar on quality child care programs, supporting key reforms to transform the Nation's child care system into one that fosters both healthy development and gets children ready for school. We have a new Early Learning Challenge Fund, a Department of Education partnership that promotes State innovation in early education.

The budget also supports a child support and fatherhood initiative that promotes strong family relationships by encouraging fathers to take responsibility for their children, changing policies so that more of that child support reaches the children, and maintains a commitment to vigorous enforcement, promoting healthy relationships between fathers and their children. There are funds for new performance-driven incentives for States to improve outcomes for children in foster care, such as reducing long term foster care stays and rates of child maltreatment reoccurrence. These children deserve to be part of our better future.

Our budget also recognizes that at a time when so many Americans are making every dollar count, we need to do the same, and that is why we provide new support for President Obama's unprecedented push to stamp out waste, fraud, and abuse in our health care system, an effort that more than pays for itself, returning a record of $4 billion to taxpayers in 2010 alone.

We have a robust package of administrative improvements that conservatively deliver over $32 billion over the next 10 years in Medicare and Medicaid savings. They enhance prepayment scrutiny, expand auditing, increase penalties for improper actions, strengthen CMS ability to implement corrective actions, and address State schemes that increase Federal spending.

We have made eliminating waste, fraud, and abuse a priority across our entire Department, but we know that is not enough. So we have programs in here that we have reformed and discontinued. Just an example is the CDC funding to help States reduce chronic diseases. Previously, those funds were split into disease categories, a grant for each disease area. It didn't make sense, since a lot of the conditions have the same risk factors, like smoking and obesity. We want to give States one comprehensive grant that will allow them more flexibility to address chronic disease more effectively.

So the 2012 budget we are releasing today, Mr. Chairman, makes tough choices smart, targeted investments so we can have a stronger, healthy, and more competitive America tomorrow. That is what it will take to win the future, and that is what we will determine to do.

With that, Mr. Chairman, I would be pleased to answer your questions.

[The prepared statement of Secretary Sebelius follows:]

THIS TESTIMONY IS EMBARGOED UNTIL 10:00 AM FEBRUARY 16, 2011

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

THE PRESIDENT'S FISCAL YEAR 2012 BUDGET

BEFORE THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVE

FEBRUARY 16, 2011

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 16, 2011

Chairman Camp, Ranking member Levin and Members of the Committee, thank you for the invitation to discuss the President's FY 2012 Budget for the Department of Health and Human Services (HHS).

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

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

Our 2012 budget does all of this.

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

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

My discretionary budget is slightly below the 2010 level. Within that total we cover the increasing costs of ensuring the safety of our food supply, providing medical care to American Indians and Alaska Natives, managing our entitlement programs, investing in early childhood, and advancing scientific research. We contribute to deficit reduction and meet the President's freeze to non-security programs by offsetting these investments with over $5 billion in targeted reductions. These reductions are to real programs and reflect tough choices. In some cases the reductions are to ineffective or outdated programs and in other areas they are cuts we would not have made absent the fiscal situation.
The Budget proposes a number of reductions and terminations in HHS.

- The Budget cuts the Community Services Block Grant in half by $350 million and injects competition into grant awards.
- The Budget cuts the Low Income Home Energy Assistance Program by $2.5 billion bringing it back to the 2008 level appropriated prior to energy prices spikes.

- The Budget eliminates subsidies to Children's Hospitals Graduate Medical Education focusing instead on targeted investments to increase the primary care workforce.
- The Budget reduces the Senior Community Services Employment Program by $375 million, proposes to transfer this program from the Department of Labor to HHS, and refocuses the program to train seniors to help other seniors.

The Budget also stretches existing resources through better targeting.

- The Budget redirects and increases funding in CDC to reduce chronic disease. Rather than splitting funding and making separate grants for heart disease, diabetes, and other chronic diseases, the Budget proposes one comprehensive grant that will allow States to address chronic disease more effectively.
- The Budget redirects prevention resources in SAMHSA to fund evidence-based interventions and better respond to evolving needs. States and local communities will benefit from the additional flexibility while funds will still be competed and directed toward proven interventions.

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

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

That starts with giving Americans more freedom in their health care choices, so they can get affordable, high-quality care when they need it.

TRANSFORM HEALTH CARE

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

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

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

Ensuring Access to Quality, Culturally Competent Care for Vulnerable Populations: The Budget includes $3.3 billion for the Health Centers Program, including $1.2 billion in mandatory funding provided through the Affordable Care Act Community Health Center Fund, to expand the capacity of existing health center services and create new access points. The infusion of funding provided through the Affordable Care Act, combined with the discretionary request for FY 2012, will enable health centers to serve 900,000 new patients and increase access to medical, oral, and behavioral health services to a total of 24 million patients.

Improving Health Care Quality: The Affordable Care Act contains numerous provisions designed to ensure that patients receive safe, high quality care. Innovative payment and delivery reforms such as bundled payments for a single episode of care and the formation of Accountable Care Organizations will promote better coordinated and more efficient care. New value-based purchasing programs for hospitals, Medicare Advantage plans, and other health providers will reward those who deliver high quality care, rather than simply encouraging a high volume of services. The new Center for Medicare and Medicaid Innovation ("Innovation Center") will design, test, and evaluate new models of payment and delivery that seek to promote higher quality and lower costs. Similarly, the new Centers for Medicare & Medicaid Services' (CMS) Federal Coordinated Health Care Office will complement these efforts to provide higher quality and better integrated care for those who are eligible for both Medicare and Medicaid.

Reducing Health Care Costs: New innovative delivery and payment approaches will lead to both more efficient and higher quality care. For example, provisions in the Affordable Care Act designed to reduce health care acquired conditions and preventable readmissions will both improve patient outcomes and reduce unnecessary health spending. The Innovation Center, in coordination with private sector partners whenever possible, will pursue new approaches that not only improve quality of care, but also lead to cost savings for Medicare and Medicaid. Rate adjustments for Medicare providers and insurers participating in Medicare Advantage will promote greater efficiency in the delivery of care. Meanwhile, new rules for private insurers, such as medical loss ratio standards and enhanced review of premium increases, will lead to greater value and affordability for consumers.

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

Health Services for 9/11 World Trade Center Attacks: To implement the James Zadroga 9/11 Health and Compensation Act, the FY 2012 Budget includes $313 million in mandatory funding to provide medical monitoring and treatment to responders of the September 11, 2001 World Trade Center attacks

and initial health evaluations, monitoring, and treatment to others directly affected by the attacks. In addition to supporting medical monitoring and treatment, HHS will use funds to establish an outreach program for potentially eligible individuals, collect health data on individuals receiving benefits, and establish a research program on health conditions resulting from the World Trade Center attacks.

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

ADVANCE SCIENTIFIC KNOWLEDGE AND INNOVATION

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

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

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

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

ADVANCE THE HEALTH, SAFETY, AND WELL-BEING OF THE AMERICAN PEOPLE

Child Support and Fatherhood Initiative: The Budget includes $305 million in FY 2012 and $2.4 billion over 10 years for the Child Support and Fatherhood Initiative. This initiative is designed to promote strong family relationships by encouraging fathers to take responsibility for their children, changing policies so that more of fathers' support reaches their children, and continuing a commitment to vigorous enforcement. The Budget increases support for States to pass through child support payments to families, rather than retaining those payments, and requires States to establish access and visitation arrangements as a means of promoting father engagement in their children's lives. The Budget also provides a temporary increase in incentive payments to States based on performance, which continues an emphasis on program outcomes and will foster enforcement efforts when state budgets are stretched.

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

TANF Reauthorization: The President's Budget continues existing funding for the TANF program in FY 2012. The Budget also includes resources to fund the FY 2011 Supplemental Grants for Population Increases at the level provided in prior years. When TANF reauthorization is considered, the Administration would be interested in exploring with Congress a variety of strategies to strengthen the program's ability to improve outcomes for families and children, including helping more parents succeed as workers by building on the recent successes with subsidized employment, using performance indicators to drive program improvement; and preparing the program to respond more effectively in the event of a future economic downturn.

Enhancing the Quality of Early Care: The Budget provides $6 billion in combined discretionary and mandatory funding for child care. These resources will enable 1.7 million children to receive child care services. The Administration also supports reforms to the child care program to serve more low-income children in safe, healthy, and nurturing child care settings that are highly effective in promoting early learning; supports parental employment and choice by providing information to parents on quality; promotes continuity of care; and strengthens program integrity and accountability Additionally, the President's Budget includes $8.1 billion for Head Start, which will allow us to continue to serve 968,000 children in 2012. The Administration is also working to implement key provisions of the Head Start Reauthorization, including requiring low-performing programs to compete for funding, that will improve program quality. These reforms and investments at HHS, in conjunction with the Administration's investments in the Early Learning Challenge Fund, are key elements of the broader education agenda designed to help every child reach his or her academic potential and improve our Nation's competitiveness.

Improving Health Outcomes of American Indians and Alaska Natives: The President is committed to improving health outcomes and providing health care for American Indian and Alaska Native communities. The Budget includes nearly $5.7 billion, an increase of $589 million, which will enable the Indian Health Service (IHS) to focus on reducing health disparities, ensuring that IHS services can be supplemented by care purchased outside the Indian health system where necessary, supporting Tribal efforts to deliver quality care, and funding health facility and medical equipment upgrades. These investments will ensure continued improvement to support the Administration's goal of significantly reducing health disparities for American Indians and Alaska Natives.

Transforming Food Safety: The Administration is committed to transforming our Nation's food safety system to one that is stronger and more reliable for American consumers. This Budget reflects the President's vision of a safer food safety system by including $1.4 billion, an increase of $333 million over FY 2010 for the Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) food safety activities. Coupled with the enactment of the FDA Food Safety Modernization Act (the Act), which was signed into law on January 4, 2011, HHS will continue to modernize and implement an integrated National food safety system. HHS plans to work with Congress to enact additional food safety fees to support the full implementation of the Act. CDC will improve the speed and accuracy of food borne illness outbreak detection and investigation, while FDA will focus on establishing produce safety standards and working with manufacturers to implement preventative controls in an effort to avoid an outbreak of tainted food.

Preventing and Treating HIV/AIDS: The Budget supports the goals of the National HIV/AIDS Strategy to reduce HIV incidence, increase access to care and optimize health outcomes for people living with HIV, and reduce HIV-related health disparities. The request focuses resources on high-risk populations and allocates funds to State and local health departments to align resources to the burden of the epidemic across the United States. The Budget includes $2.4 billion, an increase of $85 million, for HRSA's Ryan White program to expand access to care for persons living with HIV/AIDS who are otherwise unable to afford health care and related support services. The Budget also includes $858 million for domestic HIV/AIDS Prevention in CDC, an increase of $58 million, which will help CDC decrease the HIV transmission rate; decrease risk behaviors among persons at risk for acquiring HIV; increase the proportion of HIV infected people who know they are infected; and integrate services for populations most at risk of HIV, sexually transmitted diseases, and viral hepatitis. In addition, the Budget proposes that up to one percent of HHS discretionary funds appropriated for domestic HIV/AIDS activities, or approximately $60 million, be provided to the Office of the Assistant Secretary for Health to foster collaborations across HHS agencies and finance high priority initiatives in support of the National HIV/AIDS Strategy. Such initiatives would focus on improving linkages between prevention and care, coordinating Federal resources within targeted high-risk populations, enhancing provider capacity to care for persons living with HIV/AIDS, and monitoring key Strategy targets.

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

Preventing Substance Abuse and Mental Illness: The Budget includes $535 million within the Substance Abuse and Mental Health Services Administration (SAMHSA) for new, expanded, and refocused substance abuse prevention and mental health promotion grants to States and Tribes. To

maximize the effectiveness and efficiency of its resources, SAMHSA will deploy mental health and substance abuse prevention and treatment investments more thoughtfully and strategically. SAMHSA will use competitive grants to identify and test innovative prevention practices and will leverage State and Tribal investments to foster the widespread implementation of evidence-based prevention strategies through data driven planning and resource dissemination.

Ensuring Safety and Improving Access to Medical Products: FDA is the global leader for regulating medical products and the Administration is dedicated to ensuring that all drugs and medical devices that enter the market are safe and effective for the American consumer. The Budget provides $1.4 billion for FDA to enhance the safety oversight of medical products and to establish a pathway for the approval of generic biologics thus allowing greater access to life saving biological products that are safe and effective.

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

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

The HHS Medical Countermeasure Review described a new strategy focused on forging partnerships, minimizing constraints, modernizing regulatory oversight, and supporting transformational technologies. The request includes $665 million for the Biomedical Advanced Research and Development Authority, to improve existing and develop new next-generation medical countermeasures and $100 million to establish a strategic investment corporation that would improve the chances of successful development of new medical countermeasure technologies and products by small and new companies. The Budget includes $70 million for FDA to establish teams of public health experts to support the review of medical countermeasures and novel manufacturing approaches. Additionally, NIH will dedicate $55 million to individually help shepherd investigators who have promising, early-stage, medical countermeasure products. Finally, the Budget includes $655 million for the Strategic National Stockpile to replace expiring products, support BioShield acquisitions, and fill gaps in the stockpile inventory.

STRENGTHEN THE NATION'S HEALTH AND HUMAN SERVICE INFRASTRUCTURE AND WORKFORCE

Strengthening the Health Workforce: A strong health workforce is key to ensuring that more Americans can get the quality care they need to stay healthy. The Budget includes $1.3 billion, including $315 million in mandatory funding, within HRSA, to support a strategy which aims to promote a sufficient health workforce that is deployed effectively and efficiently and trained to meet the changing

needs of the American people. The Budget will initiate investments that will expand the capacity of institutions to train over 4,000 new primary care providers over five years.

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

INCREASE EFFICIENCY, TRANSPARENCY, AND ACCOUNTABILITY OF HHS PROGRAMS

Strengthening Program Integrity: Strengthening program integrity is a priority for both the President and myself. The Budget includes $581 million in discretionary funding, a $270 million increase over FY 2010, to expand prevention-focused, data-driven, and innovative initiatives to improve CMS program integrity. The Budget request also supports the expansion up to 20 Strike Force cities to target Medicare fraud in high risk areas and other efforts to achieve the President's goal of cutting the Medicare fee-for-service error rate in half by 2012. The proposed ten year discretionary investment yields $10.3 billion in Medicare and Medicaid savings, a return of about $1.5 for every dollar spent. In addition, the Budget includes a robust package of program integrity legislative proposals to expand HHS program integrity tools and produce $32.3 billion in savings over ten years.

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

Implementing the Recovery Act: The American Recovery and Reinvestment Act provides $138 billion to HHS programs as part of a government-wide response to the economic downturn. HHS-funded projects around the country are working to achieve the goals of the Recovery Act by helping State Medicaid programs meet increasing demand for health services; supporting struggling families through expanded child care services and subsidized employment opportunities; and by making long-term investments in health information technology (IT), biomedical research and prevention and wellness efforts. HHS made available a total of $118 billion to States and local communities through December 31, 2010; recipients of these funds have in turn spent $100 billion by the same date. Most of the remaining funds will support a signature Recovery Act program to provide Medicare and Medicaid incentive payments to hospitals and eligible health care providers as they demonstrate the adoption and meaningful use of electronic health records. The first of these Medicaid incentive payments were made January 5, 2011. More than 23,000 grantees and contractors of HHS discretionary programs have to submit reports on the status of their projects each calendar quarter. These reports are available to the public on Recovery.gov. For the quarter ending December 31, 2010, 99.6 percent of the required recipient reports were filed timely. Recipients that do not comply with reporting requirements are subject to sanction.

CONCLUSION

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

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

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

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

But, we need to make sure we're cutting waste and excess, not making across the board, deep cuts in programs that are helping our economy grow and making a difference for families and businesses. We need to move forward responsibly, by investing in what helps us grow and cutting what doesn't.

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

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

Chairman CAMP. All right. Thank you. Thank you very much.

Madam Secretary, this is the first budget, this 20 pounds of documents is the first budget that we have received since the health care law was passed. And I was just wondering what is the cost of the exchange subsidies? I can't find it anywhere in the budget. I wonder if you could tell us what that cost is.

Secretary SEBELIUS. Well, Mr. Chairman, the exchange subsidies really haven't started yet because the exchanges don't start until 2012. And it is a mandatory part of the funding in the ACA budget. We have had some planning grants that have gone to States in terms of—I think we have 48 States that have received about a million dollars to begin the planning for exchange grants. We are announcing $240 million today for early innovation in terms of IT pieces of it. But there are not subsidies that start until the exchanges are up and running.

Chairman CAMP. It is a 10-year budget. And certainly you expect the exchanges will be running within that time period. And what is the estimate of the cost of the exchange subsidies over that time?

Secretary SEBELIUS. Mr. Chairman, I really cannot give you an accurate cost until States figure out what they want to do. As you know, the law also includes the possibility that States, as many of you have suggested, will be working across State lines to put together exchanges. We really don't even know at this point how many States will have an exchange, if there will be regional exchanges, what they will look like. So we do not have a cost estimate at this point.

Chairman CAMP. So there is no estimate of what might be projected based on an analysis of what States might do?

Secretary SEBELIUS. At this point I think it is preliminary because States are just beginning their planning process, and we do not have their plans.

Chairman CAMP. All right. So given that there is no really accounting or number in the budget to account for these exchange subsidies, then would the deficit be understated if these exchange subsidies certainly will cost something?

Secretary SEBELIUS. Well, I think, Mr. Chairman, the plan is that there is startup money in the Affordable Care Act, anticipating that the planning apparatus and setting up the infrastructure will be part of the funding of the Affordable Care Act. From that point on, the premiums provided by beneficiaries and participants in the exchanges will pay the ongoing costs.

Chairman CAMP. By my count, the President is proposing about $55 billion in new Medicare spending and about $12 billion in Medicare spending reductions, so about a $40 billion increase on net. Given that Medicare is one of the largest contributors to our long-term deficit, do you think that it is a good idea that the President's proposal is actually increasing overall Medicare spending?

Secretary SEBELIUS. Well, Mr. Chairman, as you probably know, the first of the baby boomers are eligible for Medicare this year. The beneficiaries are expected to rise every year for the next number of years. And also the Affordable Care Act for the first time includes, I would say, a different approach to Medicare. It doesn't assume that Medicare costs have to go up year in and year

out, but has over a 10-year window a decrease in the cost increase of Medicare, which is unheard of in the history of the program. So that we are looking at not harming any of the guaranteed benefits, but at the same time having a much more efficient and effective and quality-driven Medicare Program for the millions of additional beneficiaries who will come of age over the next several years.

Chairman CAMP. There is a proposal to freeze Medicare physician payments for 2 years, and that is at about a $54 billion cost. Then the budget proposes over the 7 years after that, from 2014 to 2021, spending an additional $315 billion to provide SGR, or physician payment formula relief from 2014 onward. And obviously, many of us are interested in a long-term solution to the physician payment issue, and to do that in a fiscally responsible way. But my question is there is no mention of how this is paid for in the budget. And I wondered if you could mention how is this long-term fix going to be paid for? I don't see any details or solutions in the budget. And what ideas might you have in that area?

Secretary SEBELIUS. Well, Mr. Chairman, as you said, the budget includes more than 2 years of suggested pay-fors, about $62.5 billion of what would cover—I think the estimated costs of a 2-year fix is about $54 billion. So the President has put on the table suggestions for getting us started toward a long-term solution. He looks forward to working with Congress on the solution into the future.

As you know, the SGR issue dates back to 2002. It has never been addressed in a permanent fix. We think that is very important to do, and we look forward to working with you and your Committee to come up with solutions as we move forward. But there is more than 2 years of pay-fors included in the President's budget.

Chairman CAMP. Yes, for that initial $54 billion. But I am sure you can understand our concern. $315 billion is a lot of spending to have absolutely no detail on how it is going to be reached. It is a big promise, but I don't see how, from this budget document, how we will address that. So I look forward to trying to find those answers in the future.

Secretary SEBELIUS. Well, again, I think the payment covers 2011, 2012, and then into 2013. And we would hope that we could work very diligently to fulfill the promise to America's doctors that they will actually be paid for the Medicare services they deliver. And I think that is a promise that has been not able to be fulfilled long term for a long time. And we need to fix that strategy going forward.

Chairman CAMP. Do you anticipate other reductions in Medicare to meet that $315 billion obligation under the SGR? Other cuts to Medicare?

Secretary SEBELIUS. Again, Mr. Chairman, I think it is important that we be accurate about what is happening with the Medicare Program. What the Affordable Care Act did, for the first time in a very long time, is make suggestions about ways to slow down the growth rate of Medicare. It is still anticipated that Medicare costs will increase at about the rate of 6 percent as opposed to 8 percent increase year in, year out, which is where they were estimated to do. That is where the $500 billion comes from. Not a single guaranteed benefit is touched in that $500 billion. And in fact,

as you know, this year we are making a major step toward closing the gap in part D coverage, the donut hole that 8 million seniors find themselves in every year. So they will have a 50 percent reduction in brand name drugs this year. They also this year for the first time will have a new wellness benefit as part of their yearly Medicare benefits. And there is no copay for seniors any longer for preventive care. So in fact, we are making proposals that slow down the growth rate, which is I think what entitlement reform is about, slow down the growth rate of Medicare spending, and keep all of the guaranteed benefits very much in place.

Chairman CAMP. Yeah, but I am sure you can understand our perspective with the almost half a trillion dollar cuts assumed in the health care law, then an unpaid for over $300 billion in payments for a new physician payment formula, if that is going to come out of other reductions in Medicare, we are over $800 billion without any real detailed plan of how to get there.

So it is a major issue, and I know we will have to engage further on it. I appreciate your comments today, though. At this point I will yield to Mr. Levin for 5 minutes for the purpose of inquiring.

Mr. LEVIN. Thank you, Mr. Chairman. I want to pick up those two threads. You know, the SGR is a problem created in part by someone who chaired this Committee. He led the efforts. He was then in the majority. And it has to be resolved. But I think we should remember that this hole was dug by one of our predecessors, at least he was partially responsible for it.

Mr. Chairman, you said the law is a mess. I just want to say that the notion that the law is a mess is a myth. Among the myths that are being spread, one is that health care reform interferes with the patient-doctor relationship. Another myth is that it is essentially creating dictates from Washington. Another myth, and I hope we will touch on this, relates to Medicare Advantage and the notion that its role will be dramatically diminished.

Another myth that was spread some months ago and continues to be spread, is that health care reform cuts Medicare payments. Another myth is that this law doesn't involve entitlement reform.

And so I would like to ask you, Madam Secretary, and welcome, to discuss how this new law attempts in a serious way to address the rate of increase in Medicare costs and payments. Clearly, there will be some increase in Medicare payments because many, many more people are going to be covered, as you mentioned.

On page 4 of your testimony, you discuss, under improving health care quality and reducing health care costs, steps that are in this law. Could you review why really for the first time there are major efforts to try to bend the curve in terms of costs?

Secretary SEBELIUS. Certainly, Congressman. I think that this Committee has had the opportunity to hear from Dr. Berwick, who is the new Administrator of the Centers for Medicare and Medicaid Services, and probably one of the leading experts in the country on quality care for patients combined with efficiency of payment. And the health care law for the first time gives Medicare some additional tools that we really didn't have to look at not only innovative models of care, which help improve the patient-centered care and provider choices, but also lower costs. The Accountable Care Organization, which allows providers to come together, or providers and

hospitals, or health centers and hospitals to deliver better care in a coordinated fashion we know will lower costs because it is doing that in parts of the country, and this gives us an opportunity to drive that care. We know that having an initiative on hospital-based infections has a significant impact not only in improving patient outcomes, but significantly lowering costs. And those tools are all part of the efforts moving forward to stop Medicare being a volume purchaser, where doing more pays more, but really looking at patient outcomes as one of the key features, and making sure that high quality care is delivered to patients according to their doctors' wishes day in and day out, which is why I think we have so many providers who are very enthusiastic about the new opportunity practicing medicine the way they think it should be practiced, and the opportunities to really be compensated for what is high quality patient care day in and day out.

Mr. LEVIN. And innovation centers?

Secretary SEBELIUS. The innovation center has opened its doors. We look forward to everything from modeling programs of the dual eligibles, the so-called dual eligibles who are eligible for Medicaid and Medicare simultaneously and now navigate two very cumbersome programs in order to get care, and their providers are often handicapped, as well as a huge effort on waste, fraud, and abuse that has never been tackled in this way, with partnerships at Justice that, as I say, has already yielded last year over $4 billion. But we think that is just the tip of the iceberg, that we have a real opportunity to return dollars to the Medicare Trust Fund and to States' Medicaid budgets.

Mr. LEVIN. Thank you.

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

Mr. HERGER. Thank you, Secretary Sebelius, for your testimony. In an auxiliary report to the Medicare trustees 2010 report, the CMS actuaries predicted that in large part because of the Democrats' health care overhaul, Medicare payment rates will be lower than current Medicaid rates by 2019. If this were allowed to occur, the actuary said that, quote, "Medicare beneficiaries would almost certainly face increasingly severe problems with access to care." And in CMS Chief Actuary Foster's recent testimony before the House Budget Committee, he confirmed that the best case scenario under the current law is that Medicare rates will be equal to Medicaid rates in just 10 years.

In my State of California, Medicaid's reimbursement rates are so low that it is virtually impossible for many enrollees to find physicians who are willing to see them. Hospitals in my district lose far more money on Medicaid patients than they do treating the uninsured. People on Medicaid in California may technically have coverage, but they often do not have access to quality care. Under the new health law, Medicare beneficiaries will be in the same position in just a few years.

Madam Secretary, how will you expect to preserve access to care for Medicare beneficiaries in the years ahead?

Secretary SEBELIUS. Well, Congressman, I think there is no question that the pact made with the seniors in this country and the most disabled population 45 years ago, when Medicare was passed, is an important contract to keep. What is also very clear

is that if nothing changes in Medicare the trust fund will be out of money in a very near future. And in fact, passage of the Affordable Care Act added an additional dozen years to the trust fund, which we think is an important step forward.

More importantly, I think, is the change in the overall program. I share your concerns that Medicaid rates in many States across the country are significantly low, and often jeopardize access to care, and part of that approach has been just to slash rates and not to reform the care delivery system. What the Affordable Care Act contains is for the first time some significant steps to look at the delivery of health care by Medicare, and hopefully by Medicaid also, making sure that we focus on what can be the best possible care to patients at a much reduced cost.

We know that can happen because it is happening across the country. And Kaiser in your State, Kaiser Permanente, is one of the leaders in strategies to deliver high quality care at a significantly lower rate than many other parts of the country. So I would suggest that the kinds of delivery system reforms, combined with the efforts on waste, fraud, and abuse, can actually not only save the Medicare Program and make sure that we are fulfilling that commitment to seniors long term, not only this year and next year but 10 years and 20 years from now, but also end up with a much higher quality care for all of the beneficiaries than we have right now.

Mr. HERGER. Well, thank you. And that is certainly our goal to move in that direction. The concern is maybe we want to make sure we are not going in the wrong direction.

The health care law provided $1 billion to implement the health care overhaul. However, CBO estimated that implementation of a law of this magnitude would require up to $20 billion. My staff was informed by yours that almost all of the $1 billion in implementation funding will be exhausted by the end of this year. In fact, I am told the Center for Consumer Information and Insurance Oversight intends to spend $760 million this year alone to implement the new health care law.

I fail to understand how HHS can go through this kind of money when many of the provisions it is supposed to implement do not take effect until 2014. And I would like you to provide the Committee in writing, and by hopefully early March, a detailed accounting of how HHS spent $161 million in 2010 and plans to spend $760 million this year to implement the new health care law.

Chairman CAMP. The gentleman's time has expired. The Secretary may respond in writing to that, but we do have to keep the hearing moving because there are other Members who are interested. If you want to respond just very briefly.

Secretary SEBELIUS. Well, Mr. Chairman, I would just correct one thing, and we would be happy to provide it in writing. The $161 million is across all agencies, Congressman. We have spent about 125 at HHS. Treasury has some and OPM has some. The 760 projected expenditure is also across all agencies, it is not HHS. But we would be happy to provide those details in writing.

[The information follows: Did not receive.]

Mr. HERGER. Thank you. I appreciate that.

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

Mr. JOHNSON. Thank you, Mr. Chairman. Well, it seems to me you are doing a lot of increases in personnel. And you know, the President's budget proposes the Department of Health and Human Services add 4,700 new positions. And every HHS division will see an increase in the number of Federal bureaucrats employed. CMS is going to add more than a thousand full-time positions, an increase of 21 percent compared to 2010. We are cutting payments to doctors and other health care services, yet increasing administration costs here in D.C.

I am all for creating jobs, but how many Federal bureaucrats do we need to get the job done? I think we can all agree it is critical to pursue policies that create jobs, not eliminate them, but the health care reform law places significant restrictions on physician ownership of hospitals. Many projects in planning had to stop, and expansions were curtailed. And every one of those decisions had a negative impact on jobs in States like Texas. Industry experts tell me at least 30,000 jobs would have been created if this provision had not been enacted.

Can you explain how the Administration can support a provision that negatively impacts well-paying health care jobs in many communities while advocating for a ton more Federal employees?

Secretary SEBELIUS. Well, Congressman, the President's budget does include employee additions at the Department of Health and Human Services that, as you say, will be in virtually every agency because we have had significant new duties assigned to our Department. Certainly implementation of the Affordable Care Act is one, but not nearly the scope of our new duties. The Food and Drug Administration has a new Food Safety Act that was passed by this Congress to implement new tobacco regulations, new translational science. The National Institutes of Health has new duties in terms of researching cutting-edge cures and strategies to keep Americans healthier. We are administering new programs in early childhood.

Mr. JOHNSON. If you would make your answers short, I would appreciate it, because we have a limited amount of time. Why do you need that many more employees in your agency? You are trying to tell me, but you are telling me it is other agencies.

Secretary SEBELIUS. No, these are all within the Department of Health and Human Services. These are our agencies. We have 11 agencies that have a wide scope of programs.

Mr. JOHNSON. So you are expanding government. Is that true?

Secretary SEBELIUS. Pardon me?

Mr. JOHNSON. So you are expanding government based on this health care bill.

Secretary SEBELIUS. This has little to do with the health care bill, Congressman. What I am trying to explain to you is that over the scope of just the 2 years that you are comparing, the fiscal year 2010 baseline and now, we have a host of new——

Mr. JOHNSON. I understand that. But here we are trying to reduce the size of government, and you are expanding it. Can you answer why you have to do that? Because you ought to be able to operate with the people you have.

Secretary SEBELIUS. Well, I tried to explain that we have a host of new duties that have nothing do with the Affordable Care Act. That is certainly one of our new responsibilities. But food safe-

ty, delivery of health care to American Indians, child care, Head Start.

Mr. JOHNSON. Thank you. Austan Goolsbee, Chairman of the Council of Economic Advisers, said the Administration would be willing to work with us on a provision for physician-owned hospitals provided quality care and reduced costs. Physician-owned hospitals have a well-established reputation for quality care measured by CMS, Health Grades and Consumer Reports. MedPAC has found that specialty hospitals may be an important competitive force that promotes innovation.

Shouldn't we work to bring patients more options for quality care in their community and allow that kind of competition and innovation instead of dictating from the Federal Government?

Secretary SEBELIUS. Well, Congressman, my understanding is that the provision that you are referring to continues a sort of moratorium that had been in place. But I know from my home State of Kansas there are numbers of doctor-owned facilities. I know in your State of Texas there are numbers of doctor-owned facilities. And I would look forward to having this continued discussion with you about what can be done to make sure patients have adequate choices.

Mr. JOHNSON. Thank you. I wish you would do that.

CBO scored the provision as saving $500 million over 10 years, with no savings in the first 5. Yet CMS actuaries did not find any savings from the provision that cuts doctor-owned hospitals. And you might look at the difference in the scoring while you look at that.

You have acknowledged there are parts of the recently enacted health care law that needs to be fixed. Do you think prohibition on physician-owned hospitals is one of those parts that we can look at? Yes or no.

Chairman CAMP. If you could answer briefly.

Secretary SEBELIUS. I said, Congressman, I would be happy to have this discussion with you.

Chairman CAMP. All right. Thank you. Mr. Rangel is recognized.

Mr. RANGEL. Thank you, Mr. Chairman. And welcome, Madam Secretary. As I often said, as rough as this has been on you personally, I think it is good for the Nation to better understand the program that the President has offered us. I don't think that any person that is ill, that the doctor would ask whether they are Republican or Democrat. And everybody here on the Committee certainly knows that it will be a stronger, more productive America if we make certain that it is a healthier America. And so it would seem to me that now is the time, the campaign is over, to try to improve and correct and get a broad-based consensus as to how we can better serve America in terms of health care.

Having said that, I just want to share with you the importance of the wellness provisions and the community health centers. I don't know how many people have come from communities that are medically underserved. But when I was a kid, if my mom was taking the three kids to see a doctor and the neighbors would say, well, what's wrong with your children, and she said there is nothing wrong with them, it is time for their checkup, they would think she has lost her mind. It almost is a part of the culture that you

don't go to the hospital, you don't see a doctor until you are sick. And of course the painful listening to the doctor says why didn't you come earlier? If only you had let us know, this could have been prevented. And the number of people that ended up in intensive care only because they didn't have a place in their community to go just for an examination.

I don't know how you interpret this in dollars and cents. And it just amazes me how this issue became polarized with parties. Because doctors don't make partisanship a part of their career. So I want to thank you for persevering. And perhaps if you can share with us in talking with the opponents of this bill, not those that just oppose because of political reasons, what can we do to take down the firewall and to say we all want the same thing, a better, stronger, healthier America? Has there been anything that you have found from opponents that they are willing to say can we talk?

Secretary SEBELIUS. Well, Congressman, I think that your mention of community health centers has certainly been traditionally a very bipartisan effort that has been supported by the previous Administration and this Administration as a critical part of the health infrastructure of the country. Right now about 20 million people, often in very underserved rural and urban areas, have high quality preventive primary care at a community health center. And through the investments both in the Recovery Act and the Affordable Care Act, that number will double to closer to 40 million Americans. These are community health centers which often are not only providing health advice and checkups to the family, but often have child care, and labor advice, and really are in the heart of communities.

We are also, as you know, through the Affordable Care Act doubling the number of primary care physicians who will be available at those community health centers, and nurse practitioners, and mental health professionals to make sure that that high quality care is delivered. And then you reduce the number of people who inappropriately come through the doors of an emergency room to try and access health care at the least effective, most expensive juncture, and have a healthier America, healthier kids who can study in school and a healthier work force.

Mr. RANGEL. These centers are not Democratic centers or Republican centers, they are based on need, aren't they?

Secretary SEBELIUS. Community health centers are located in the least served communities, whether they are rural or urban.

Mr. RANGEL. You said earlier that before there used to be bipartisan support. There is an implication here that if you look at the votes of Democrats and Republicans, the Republicans would normally be protecting the insurers. And then you find Democrats fighting, as we do, in trying to protect the patient. As much as we would want to get back to bipartisanship, can you say now that we enjoy the same bipartisanship after the election as we did before?

Secretary SEBELIUS. Well, I think that the——

Chairman CAMP. If the answer could be brief, because the red light is on.

Secretary SEBELIUS. We look forward to working with both parties to improve the health of America.

Chairman CAMP. All right. Thank you. Mr. Brady is recognized.

Mr. BRADY. Thank you, Mr. Chairman. Madam Secretary, thanks for joining us. I think the incentives in ObamaCare are flawed and will drive the budget numbers higher. For example, the requirement, obviously, that almost all businesses offer government-approved health care or pay a tax is flawed. Under the law, if you offer health care today but it doesn't end up government-approved, you face a fine or a tax of $3,000 a worker. But if you just don't offer it at all to your workers, you pay a tax of $2,000 per worker. It is an incentive for businesses to drop their health care and move their workers into the exchanges, which will drive up the costs of this plan.

The incentives for individuals to buy health care I think are flawed as well, too low as a matter of fact. And I fear what we will see is the Massachusetts effect, where coverage of individuals went up, but new plans were purchased for an average of 5 months. So individuals were buying the plans when they were sick, dropping them when they were ill, driving up the costs. And I noted in the last numbers we got from Massachusetts, ER visits are actually up 9 percent in that State.

So this health care plan I think will drive workers out of the plans they have into the more expensive exchanges, not solve the problem, in fact drive up costs for those who are insured long term, and drive numbers in ERs at the local hospitals as well.

Final point. We had our local small businesses' health care insurers in our office yesterday. One of them was from Aetna, which has by their indication laid off up to 3,500 U.S. workers due in part to the medical loss ratio mandate. We had by estimates anecdotally losses within the industry of between 100,000 and 200,000 workers, again because of the inflexibility of the medical loss ratio. Then we just had one small business that has 15 employees, laid off one because he was swept through this medical loss ratio issue. In effect, government told him he had too many workers. He has lost one, did away with one. Their point is if this health care plan is so great for the economy, why are they having to lay off their own workers? And doesn't that add to the budget deficit?

Secretary SEBELIUS. Well, Congressman, I am not quite sure what the connection between the medical loss ratio and the job loss is. As you know, the medical loss ratio is a formula which determines that 80 cents of every health premium dollar should go to pay for health costs, not insurance company overhead and not salaries. It was not anybody in the Federal Government who determined what that formula should look like and what those factors were. It was actually——

Mr. BRADY. There is no formula within the law?

Secretary SEBELIUS. It was actually the National Association of Insurance Commissioners, elected and appointed insurance commissioners from across the country who by unanimous vote gave us a recommendation of what that medical loss ratio should look like, the formula for insurers to determine what in fact could be part of that.

Mr. BRADY. So State commissioners enforced this mandate or did the Federal Government enforce it? Because if I recall——

Secretary SEBELIUS. No one is enforcing anything right now. We are collecting data. The MLR just went into effect in January. Insurers are beginning to give data to both their State commissioners and to HHS. At the end of the day, if they don't meet the ratio they will owe their policyholders a refund.

Mr. BRADY. The good news is you are saying there haven't been any jobs lost to the medical loss ratio mandate?

Secretary SEBELIUS. Well, again, the medical loss ratio is a formula about insurance premiums.

Mr. BRADY. Sure. But to your knowledge, I mean I just want to sort of stay on the point, to your knowledge you are saying we have not lost U.S. jobs because of the medical loss ratio mandate?

Secretary SEBELIUS. That is my understanding. It has not come to my attention. I don't really know how data collection could cause job loss. And that is what insurers are doing right now.

Mr. BRADY. Okay. Thank you, Mr. Chairman.

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

Mr. STARK. Thank you, Mr. Chairman. Again welcome, Madam Secretary.

There has been a lot of misinformation coming from people who would oppose the ACA, and the misinformation has been largely on the Medicare Advantage program. Yet last week we heard Administrator Berwick of CMS, that what is really happening is that Medicare Advantage is alive and well.

Can you give us your take on Medicare Advantage, where it is going, and what its status is, please?

Secretary SEBELIUS. I would be happy to. I know that there was a lot of concern and certainly speculation by some that the passage of the Affordable Care Act would mean the end of the Medicare Advantage program. And our first year of experience indicates that nothing could be further from the truth. Not only have we seen an increase in enrollment, about 6 percent more Medicare beneficiaries are in Medicare Advantage plans this year over last year, but they have some very good news. Their premiums have dropped from 2010 to 2011, largely as a result of the negotiating power that we acquired in the Affordable Care Act to make sure that excessive copays and out-of-pocket costs were not shifted to beneficiaries. Ninety-nine percent of beneficiaries have a Medicare Advantage program to choose from. And in fact, in most places there are about 26 Medicare Advantage plans per county to have as choices. Comprehensive benefits, according to our actuarial estimates, have actually been more substantial. And I think that the news is good. What will happen over time is that the overpayment to insurance companies that started to lure companies into this market decades ago is going to gradually be decreased. But we think that this year's news—again, the Medicare actuary had predicted a dramatic decrease in population for Medicare Advantage plans and a dramatic increase in premiums, neither of which has occurred this year. And we think that is the start of a very good story about choice for Medicare beneficiaries. Our goal is to have beneficiaries have choices that deliver high quality care at a lower cost.

Mr. STARK. Thank you.

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

Mr. NUNES. Thank you, Mr. Chairman. As it relates to the Medicare Advantage, the increase in enrollees this year, when did the cuts start to Medicare Advantage in the ObamaCare bill?

Secretary SEBELIUS. The rates were frozen for this year.

Mr. NUNES. Oh, so there haven't been any cuts yet?

Secretary SEBELIUS. The rates were frozen. And with inflation, I think you would have a number of Medicare Advantage plans tell you that was a cut. But they were frozen this year.

Mr. NUNES. Okay. As it relates to the exchange subsidies that the chairman pointed out are not in the budget, and you suggested that you are waiting on the States to do their analysis, when the States come in with their analysis on the costs of these exchange subsidies do you think it will be greater than zero or less than zero? The costs on the exchange subsidies?

Secretary SEBELIUS. Are you talking about—I may have misunderstood the earlier question. The subsidies that will be available to people below 400 percent of poverty?

Mr. NUNES. The chairman pointed out in the budget that was presented——

Secretary SEBELIUS. Is that what we are talking about? Because I was talking about the startup costs for exchanges.

Mr. NUNES. I think what the chairman was pointing out is there are no costs in the budget. You stated that that is because you are waiting on the analysis of the States. So in the 10-year budget window there is no costs. And so it is a simple question, do you think when those costs come in will they be greater than zero or less than zero?

Secretary SEBELIUS. Our budget actually will have no subsidies. The Treasury budget ultimately will have the subsidies in their budget. So the HHS budget will not have a bottom line for a projection of subsidies if we are talking about those that go directly to taxpayers.

Mr. NUNES. The exchange subsidies are nowhere in the budget, Madam Secretary.

Secretary SEBELIUS. I am not familiar with the Treasury budget.

Mr. NUNES. Okay. Let me move on. In ObamaCare do you think we reduced——

Secretary SEBELIUS. I am sorry, Congressman, they are in the Treasury budget. I was just given that information. So yesterday——

Mr. NUNES. Well, my assumption is they will be greater than zero when the costs come in.

Secretary SEBELIUS. I think that is accurate. But they are in the Treasury budget, not in the HHS budget.

Mr. NUNES. Okay. With passage of ObamaCare, did we increase the unfunded liabilities of Medicaid?

Secretary SEBELIUS. The bill anticipates an increase in enrollment in Medicaid, yes, sir.

Mr. NUNES. How many people?

Secretary SEBELIUS. It is projected, I think, that there will be about 16 million additional Medicaid beneficiaries around the country.

Mr. NUNES. And do you think that Medicaid payments are an appropriate amount now, average, should be better? What do you think in terms of the Medicaid——

Secretary SEBELIUS. Payments to providers?

Mr. NUNES. Medicaid reimbursement rates, yes.

Secretary SEBELIUS. As you know, Medicaid is a partnership with the States. And a State at a time decides what their reimbursement rates are. That is part of their State flexibility.

Mr. NUNES. So at a time when the States are basically having budgets that are in the tens of billions in some cases like California in the red, is this going to increase the costs to States when you add on 16 million enrollees onto Medicaid?

Secretary SEBELIUS. What the Affordable Care Act does, Congressman, is the Federal Government picks up a hundred percent of those additional enrollees for the first several years and then——

Mr. NUNES. Several years like in 2 years.

Secretary SEBELIUS. Three years.

Mr. NUNES. Oh, 3 years. Sorry.

Secretary SEBELIUS [continuing]. And then 95 percent of the cost going forward.

And I can tell you as a former Governor, the amount of uncompensated care we would carry as a State versus a 95–5 split Federal Government-State for those same uninsured people in my State would have been a wonderful bargain.

Mr. NUNES. Right now, as you are aware, Mr. Herger pointed out that Medicaid in California, in some parts of California, I think most parts of California, you have very few doctors who will want to see Medicaid patients. So I am not exactly sure how, just because you give a government card that allows people to get Medicaid to 16 million new Americans, if that is really better health care or is that just saying you are covering people.

Secretary SEBELIUS. Well, the other thing that the Affordable Care Act does is for at least the first several years increase provider, doctor rates, from Medicaid rates to Medicare rates, which is certainly something that the providers are very enthusiastic about.

Mr. NUNES. That is for 2 years only, I think.

Secretary SEBELIUS. For the first 2 years. And we would hope that Congress would take a look at that and would help us extend that.

Mr. NUNES. But that is not in this budget. Those increased costs are not in the budget.

Secretary SEBELIUS. Not past 2016.

Chairman CAMP. Time has expired.

Mr. NUNES. One more question.

Chairman CAMP. We are past the 5 minutes. We really need to go to Mr. Tiberi now.

Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today.

I want to assure my colleagues on the other side that we do care about patients. In fact, as you know, Dr. Berwick was here last week; and I mentioned specifically my concern about patients being

left off of Medicare. And, ironically, 2 days later, my godmother got a note from her OB–GYN. She is on Medicare fee-for-service, and she was informed in writing that she would no longer—the doctor, a woman, would no longer be taking Medicare patients, including my godmother. And that is a trend that we continue to see, at least in Ohio. I can't speak for any other part of the country.

And as you know, Madam Secretary, the Medicare Advantage program is one that has, at least in central Ohio, high marks by seniors, incredibly high marks by seniors.

The cut that we are speaking about has not occurred. You are absolutely right. But my understanding is in 2012 we will see the actual first cut over a 6-year period. In fact, the cut, my understanding is—and correct me if I am wrong—is $200 billion. That will encourage—the largest Medicare provider in my district is not an insurance company. It is a Catholic hospital. And they are reassessing whether or not they are going to continue in the Medicare Advantage program. That means all those Medicare Advantage beneficiaries, those seniors who chose to go into that Catholic hospital not-for-profit Medicare Advantage program will be back in the Medicare fee-for-service.

As you know, Madam Secretary, a majority—a huge majority of seniors who are on Medicare fee-for-service have some sort of other coverage, whether it be retiree coverage, whether it be a MediGap plan, or Medicaid; and the largest MediGap provider in the country is AARP which supported the bill. So my constituents who are on this large Medicare Advantage program that may not exist after 2012 or 2013 face the choice of buying a MediGap coverage probably from AARP, which obviously benefits AARP.

And so the fact of the matter is—and I would love to have your comment on this—if we actually cut Medicare Advantage, Medicare Advantage providers are telling me that aren't insurance companies, that they will be forced to choose to no longer be in the program. If that happens, what happens to the beneficiary?

Secretary SEBELIUS. Well, again, Congressman, I think that there is not a lot of evidence that that will happen. And I share your concern that Medicare beneficiaries have a choice.

But, right now, we have about 75 percent of the beneficiaries who are subsidizing about a thousand dollars a year more for those who are choosing Medicare Advantage, with no real health benefits to the Medicare Advantage customers. So that we are trying to address, as has been raised here and I think is certainly a concern that the Administration shares with all of Congress, that we address the rising health care costs which are well in excess of all inflationary costs. We spend two and a half times of what any nation on Earth spends, and we don't have good health results.

Mr. TIBERI. But during the debate on the health care bill, we were told that we were going to have greater access, that patients would have greater access.

Secretary SEBELIUS. And as the data this year shows, we won't. Six percent more in Medicare Advantage.

Mr. TIBERI. I can give you a real-life example. My godmother on Friday who got a letter from her long-time OB-GYN that they are not taking Medicare patients anymore because of reimbursement issues.

Now it is great that we are going to increase Medicaid reimbursements, but doctors in Columbus, Ohio—and I know you are visiting soon—are telling me that this is a huge problem; and we haven't even began the debate in Ohio where the Governor and legislature are facing a $1.6 billion hole on Medicaid. And they have—I know you say they have flexibility, but the flexibility they have is based upon a basic benefit. They can go above that basic benefit, but they can't have any flexibility below that basic benefit on Medicaid.

So we have providers telling me and patients telling me that Medicaid and Medicare are broken, and part of the fixes in the bill are expediting physicians from backing off both programs.

Secretary SEBELIUS. Well, Congressman, again, I think we talked earlier about the sustainable growth rate. And at least what I have heard from doctors as I travel around the country is that their primary concern about Medicare deals with the uncertainty that has been created really since 2002 with any kind of addressing the payment rate.

And I think that the President shares that concern. He has made it a 2-year pay-for, 2½-year pay-for going forward. That would be the longest fix in the SGR in a very long time. We think it should be a permanent fix. We would look forward to—I think this is an area that should have a lot of bipartisan support.

I would agree with you the uncertainty about payment for Medicare doctors has caused a huge concern throughout the country, and that is why the President is recommending that we fix it.

Mr. TIBERI. My time has expired. Thank you.

I will just tell you that patients and doctors are telling me it is not just the uncertainty, it is the bill that was passed.

Chairman CAMP. Thank you.

Mr. McDermott is recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman; and welcome, Secretary Sebelius. Thank you for being here.

This past Friday, the Republicans put out their plan to cut a hundred billion dollars from the Federal budget. The proposal clearly highlights Republican priorities related to the health and wellness of Americans as well as jobs and the economy. Three quick examples:

The Republicans want to cut $1.3 billion from community health centers. If this cut is made, according to analysis from the Senate, more than 2.8 million people will lose access to their current primary care provider and over 5,000 health center staff will lose their jobs.

Number two, Republicans propose cutting $850 million from the CDC. This is central to protecting America against flu outbreaks and other epidemics. If an infection were to break out, a decreased CDC funding would stand in a way of an effective response. This would devastate our economy and jobs.

And, finally, the example of Republican priorities, they propose cutting $1 billion from the National Institutes of Health. Now this cut is just plain stupid. For every dollar spent by NIH, $2 are returned; thousands of jobs are created; and NIH research is keeping our country at the forefront of innovation.

A hundred billion dollar pledge was simply political theater with no merit whatsoever behind it. The cuts will actually hurt our economy and destroy jobs. What really accounts for Federal spending is mandatory Federal programs like Medicare and Social Security.

Given that our witness today is the Secretary, I am going to focus on Medicare and what Republicans hope to do with these important programs.

Republicans have always hated Medicare. A majority of them voted against it with the original passage in 1965. Speaker Gingrich said he hoped it would wither on the vine. And in the months to come, the Republicans are going to try to dismantle and eventually try to do away with Medicare. You don't have to take my word for this. Republicans outlined their plan in a document called the Roadmap to America's Future. The Republican plan would end Medicare as we know it, making it a voucher system. The plan would force seniors to go out and shop around for private health insurance coverage with a government voucher.

Republicans want to force seniors to put more skin in the game when it comes to their health care, but seniors are already putting a third of their income into their health care. They can't afford any more skin.

Now, when it comes to priorities, I happen to believe that Medicare should be preserved. We extended its solvency by 12 years as I looked at the bill we passed. I believe we should focus improving on it.

But I would like you, Secretary, to explain—you are formerly an insurance commissioner and you have been a Governor. Now tell me what you anticipate, if the Republican roadmap for the future passes and every senior is handed a $8,000, $9,000 voucher, whatever, and sent out into the insurance world, what will be the effect of that?

Secretary SEBELIUS. Well, Congressman, I share your belief that the passage of Medicare was an important compact with the American people. In fact, I have a bit of a personal connection with that. My father was a Member of the Energy and Commerce Committee and helped to write the Medicare bill, and he will turn 90 in 3 weeks and is now a beneficiary of that bill. So I start this conversation as a daughter.

I think that we are responsible to do a couple of things. One is to help make sure that Medicare is here for generations to come, and 12 years of additional solvency is a step in that direction. I think that some of the delivery system reforms that are anticipated are another big step in that direction to make sure that we deliver high-quality care.

I also have the experience, as you say, as an insurance commissioner and understand that people who are shopping on their own often do not have any market leverage, which is why people in the individual market are often penalized. They pay 18 to 20 percent more than those who are in large employer pools. One of the reasons for the health exchange is to help group people into pools so that they would have some purchasing power.

So insurance experience, as you balance risk and if you are shopping on your own, there is no risk to balance but your own.

Mr. MCDERMOTT. Can you imagine your father at age 90 going out looking for a health insurance plan with a voucher?

Secretary SEBELIUS. No, I cannot.

Mr. MCDERMOTT. What would happen to him?

Secretary SEBELIUS. Well, I think that the benefits of the Medicare program are having access to high-quality care that is there year in and year out, and that is something that we have committed ourselves to for 45 years. And the opportunity that the Affordable Care Act gives us and that the President is very committed to is making the kinds of not only payment reforms but delivery system reforms that can be instrumental in delivering that high-quality care for generations to come.

Mr. HERGER [Presiding]. The gentleman's time has expired.

The gentleman from Kentucky, Mr. Davis, will inquire for 5 minutes.

Mr. DAVIS. Just before moving forward I would like to correct a pleasant fiction being shared by my colleague from Washington State. The roadmap is one person's idea. It is not representative of the party and Members such as myself, Chairman Camp, almost everybody I know in this Committee who has worked for years to bring Medicare into the 21st century and to leverage technologies.

And I wish that you had taken me up on the invitation that you accepted when you were before the Committee 2 years ago to come and visit across the river from Cincinnati in Covington. Some tremendously innovative process ideas that were going on.

Before my colleagues were removed from the majority and they jammed through the PPACA, the so-called health care reform, it eliminated this expansion or this ability to expand and lower costs to health care dramatically because of the provisions in the bill. And had you seen that firsthand I think that we might have had—actually had a bipartisan dialog on health care.

Moving to an equally important subject under your jurisdiction and one that is personally important to me because of my own background growing up, as you know, the 1996 Welfare Reform Law replaced the former welfare system with a new Temporary Assistance for Needy Families, or TANF, block grant program. And the program has worked to promote and increase earnings, reduce poverty, independence. Still, we all acknowledge there continue to be issues such as a large number of adults continuing to collect TANF benefits without engaging in work and other productive activities. States have also learned how to game the system to avoid work requirements for such adults, among other concerns.

As chairman of the Human Resources Subcommittee, this issue is of great personal interest to me; and I know that you state in your written testimony an interest in working with the Congress on TANF reauthorization. However, this budget is the second in a row in which the Administration has punted in terms of issuing specific recommendations for a comprehensive multi-year reauthorization of the TANF program. Why does the President's budget not include a comprehensive multi-year TANF reauthorization proposal for the second year in a row?

Secretary SEBELIUS. I think, Congressman, we are engaged in a broad outreach to stakeholders; and particularly in the recent recession we saw opportunities to have TANF be a more effective and

productive program. Work subsidies for instance were used in many, many States around the country including—I was going to say Ohio. I am not sure that they were implemented in Kentucky. But we want to make sure that, as TANF is reauthorized, we really take into account the very recent experience and work with Congress on a long-term strategy that reformats this program and makes it effective into the future. We learned some lessons in the last 2 years that I think have to be part of the principles going forward, and we are still in the process of collecting that information.

Mr. DAVIS. On that same note, would you say in terms of welfare work rates, work and education requirements, the time limits over this 2-year hiatus, that the Administration feels the current law is fine?

Secretary SEBELIUS. No, sir. I think we feel that it absolutely is an essential program but actually needs reformatting. But the recent downturn made it even more obvious that there were areas that needed to be addressed; and, again, we would look forward to working with you and your Subcommittee in terms of having that long-term discussion.

Mr. DAVIS. We would like to have that discussion very much to rationalize assistance rates and make sure people get the help that they need, certainly, but also be able to have—would you agree that it would be helpful to have a comprehensive score not unlike on how we roll up costs in the private sector in all forms of assistance that an individual receives in a database that would be supportive of that so that we can get a good read from a fiscal perspective? To me, this is not partisan. It is simply process like we would do as good financial stewards.

Secretary SEBELIUS. Well, I think to be informed by all of the information is important as we move——

Mr. DAVIS. So you would support that?

Secretary SEBELIUS. I am not quire sure exactly what you are asking me.

Mr. DAVIS. Well, basically, some of these benefit allocations are done without reference to other benefits that folks get or sometimes folks can fall off the cliff in one area and be forced into paying exorbitant taxes when in fact they are not really rational for where their level is. And the one way to do this is to get these programs connected and that would begin by having common metrics so we could see every program that a person is in receipt of. It would go a little bit outside your jurisdiction, but I think it would be helpful.

Final question. Based on this desire to move forward and address some of these issues, do you believe—do you support—does the Administration support the current work requirements for welfare recipients that are included in the Deficit Reduction Act of 2005?

Secretary SEBELIUS. I am not sure I can answer that question comprehensively.

Mr. DAVIS. I tell you what we will do. We will get you that information, and you can comment, and we look forward to working with you on those reforms.

Secretary SEBELIUS. I would be happy to do that. Yes.

[The information follows: Did not receive]

Chairman CAMP. Thank you.

Mr. Lewis is recognized.

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

Madam Secretary, welcome. Thank you for your service, for your vision, for your leadership, and your commitment to health care for all Americans.

Madam Secretary, it is my understanding that over 3 million seniors and individuals living with disability received assistance with their prescription drug costs last year as a result of the Affordable Care Act. If the Affordable Care Act were repealed, would those seniors have to pay the government back?

Secretary SEBELIUS. I think that question is uncertain, Congressman. There is some belief that they may have to pay it back.

Mr. LEWIS. Thank you.

Something has been sort of bothering me for a while. I keep hearing some of my colleagues, especially on the other side, referring to the Affordable Care Act as ObamaCare. Now, if I am President of the United States, if I am Mr. Obama, I would embrace it. I would be very proud that people are referring to ObamaCare, the Affordable Care Act as Obama Care. Do you have any reaction to it?

Secretary SEBELIUS. Well, Congressman, I think that there has been an effort to portray the Affordable Care Act as government takeover of health care; and I would just suggest that nothing could be further from the truth. This is a very State-based system, as you know. The expansion of health insurance to approximately 30 million people will be private plans, State-based exchanges, run and chosen by the States. The regulation of insurance will stay a State-based mechanism. The oversight will be provided by States. The consumer outreach is provided by States.

So I think the attempt of renaming the bill is to mischaracterize the efforts under way of somehow the Federal Government dictating health care. I would suggest this is a very provider- and patient-centered health reform.

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

Thank you, Mr. Chairman. I yield back.

Chairman CAMP. Thank you very much.

Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

I have, in the last few hearings we have had, had an opportunity to question Mr. Goolsbee and Dr. Berwick on some issues—and we will just talk through the buzzer. I kind of want to follow the same line of questioning. Did you get a chance to see their interviews at all in their appearance here?

Secretary SEBELIUS. I did not.

Mr. REICHERT. I am concerned. There are a lot of promises in the health care bill. And you have listed off a number of them today. There is a promise to lower the cost for businesses, lower the cost for seniors; and I am not sure the American people really are buying all of the promises, promises to pay doctors. And I think part of the problem is we are getting mixed messages.

I just thought—I want to just share a little quote with you that you gave in a press conference in June of 2010. You said, together what these rules mean is exactly what President Obama told the

American people from the start. Under the Affordable Care Act, if you like your doctor and your plan, you can keep it.

I have asked Mr. Goolsbee and I have asked Dr. Berwick those same questions, and I can't get a straight answer.

Do you still believe that statement in this bill, you are able to keep your health care bill and your doctor if you like it? Is that an accurate statement? Just say yes or no.

Secretary SEBELIUS. Congressman, it is accurate to the point that we are not tampering with the existing system. Employers make choices of plan changes and doctor changes that, right now, employees don't control.

Mr. REICHERT. Madam Secretary, please. My time is limited.

Here is the problem. The people in America just want to know—I go to church on Sunday, and I hear from my senior citizens. They just want to know, can I keep my doctor? And I say, well, the plan says, yes, you can. The President, though, you may recall, said a year ago—and I was present, most of the Republican Members were present when he addressed our conference—and he said there may have been some language that snuck into the bill that runs contrary to that premise. Now how does that——

Secretary SEBELIUS. I don't think there is any language in the bill that interferes with the current system.

Mr. REICHERT. The President was inaccurate then when he made that statement?

Secretary SEBELIUS. Congressman, I did not hear the President's statement. What I can tell you, employers choose care for 180 million Americans. That doesn't change.

Mr. REICHERT. Madam Secretary, please.

If the President said that there is language in the bill that runs contrary to that promise and your quote in June, 2010, will you work to change the language in the bill to ensure that the American people can keep their doctor and keep their health plan?

Secretary SEBELIUS. Congressman, I would be happy to work with you on that. But, as you know, we don't order doctors to take care Medicare patients. You just heard of a doctor who did not—or take Medicaid patients. We don't order employers to keep the same plan with the same network. That has never been part of the promise.

Mr. REICHERT. Madam Secretary, you just made my point.

The language in the bill over years will result in the American people having to leave their doctors that they like and leave their health care plans. We know that is going to be a fact.

Secretary SEBELIUS. I would strongly disagree that that is the language in the bill. That is the current system.

Mr. REICHERT. You believe that the current bill allows people to keep their health care plan and their doctor. That is what you said in June, 2010.

However, there is another interesting quote that comes from your own agency's regulation on grandfathered health plans, and it states that seven out of ten employers will not be able to maintain their grandfathered status. How is that consistent with your statement in 2010 that you can keep your health care plans if you like them? That is very inconsistent.

You see why the American people are so skeptical of this health care plan? Not only is it over 2,400 pages long, but they are being promised promises, and they don't see the promises coming through true. They are already falling apart. You need to help us understand.

Secretary SEBELIUS. I would be happy to work with you to help you understand.

Mr. REICHERT. Thank you. I yield back.

Chairman CAMP. Thank you.

Dr. Boustany is recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today.

As you know, many Americans are really opposed to the idea of being required to purchase or to have insurance or Washington-mandated insurance.

The new health law also requires participating employers to auto enroll all workers in the new CLASS entitlement program. Unless a worker pays very close attention, it takes time to opt out of this program. You call the program voluntary even though some enrollees might not want to join this. So if CLASS is truly voluntary, why did Washington Democrats allow American workers—why didn't they allow all American workers to exclusively opt in instead of being automatically enrolled in this program?

Secretary SEBELIUS. Well, sir, I need to correct something.

First of all, there is no program that is together yet. There is no automatic auto enrollment. That is one of the considerations being discussed. But there is no framework yet for the CLASS program. One of the issues is how to get a take-up rate that is a sustainable program. There is no mandate for auto enrollment.

Mr. BOUSTANY. Let me ask you this. If you do assume that fewer Americans would enroll in CLASS, if you gave them to freedom to opt in instead of forcing them to jump through the hoops to opt out, I mean, what do you think they are going to do? Are they going to opt in or op out?

Secretary SEBELIUS. Well, again, I think CLASS has the potential of offering Americans a product that they currently don't have available, which is to set aside their own money and pay for residential services, allowing them to age in place. It isn't available in the private market. It isn't available in the public market. We have heard from consumers across the country how incredibly valuable this would be to not be faced with a choice of forced nursing home or leaving their home.

Mr. BOUSTANY. I understand the benefits of the program.

Let me ask you this. I understand many employers plan to avoid CLASS participation due to what they foresee as administrative hassles and certainly the projected insolvency of this program. The U.S. Chamber, the President's own deficit commission both have called for repeal of the program before implementation.

You recently announced a massive $93.5 million PR program targeting employers. But what is the contingency plan if you cannot pressure enough employers to auto enroll workers in a program that Democratic Senator Kent Conrad calls a Ponzi scheme? I mean, are you going to have warnings in this from CBO and the

Medicare Actuary who have expressed major concerns about future deficits and this program being clearly unsustainable?

Secretary SEBELIUS. Congressman, we very much share the concerns that have been expressed that, as written into the law, the framework of the program was not sustainable into the future. The deficit commission actually said it should be repealed or corrected.

Mr. BOUSTANY. So should it be repealed?

Secretary SEBELIUS. No, sir. We are actually in the process of correcting the framework so it can be solvent into the future and so we not only keep the commitment to the American people but also make sure that taxpayer——

Mr. BOUSTANY. Madam Secretary, would you share the information that you—the discussions you have had with Treasury on this on the mechanisms for enrollment and how the premiums are going to be collected?

Secretary SEBELIUS. We would be happy to share.

Mr. BOUSTANY. Thank you. And do you know when the first CLASS premiums will be collected?

Secretary SEBELIUS. They are not scheduled to be started until 2012.

Mr. BOUSTANY. And will it begin prior to the establishment of the CLASS independence benefits plan?

Secretary SEBELIUS. No, sir, because we can't enroll anybody unless they know what it is that they would be setting money aside from.

Mr. BOUSTANY. Okay. Thank you.

Mr. Chairman, also, we heard a lot of discussions about delivery system reforms; and we heard vague platitudes by Dr. Berwick the other day to our questioning across the dais here. I have deep concerns as somebody who has really worked in delivery system reforms and quality issues in that area; and I haven't heard anything specific from you today, either. I deliberately avoided the question. But I am going to send a letter to you in writing requesting a meeting with your experts at HHS to start extensive discussions on this. Because, clearly, this is at the heart of how we really manage costs in this; and I have not heard anything in public or in testimony to the effect that you guys understand what you need to do in that area.

Secretary SEBELIUS. Well, we would be delighted to have those discussions.

And let me just assure you, Congressman, that delivery system reforms initially are entirely voluntary, are coming to us from providers. This is not something that is being directed by CMS. It is a provider-driven, innovative approach, strategies that are in place and work. But we would be happy to have those extensive discussions.

Mr. BOUSTANY. I will send you a formal letter requesting those meetings.

Chairman CAMP. Mr. Neal is recognized.

Mr. NEAL. Thank you very much, Mr. Chairman; and thank you, Madam Secretary.

I want to thank you, first of all, for the productive meeting that you and the staff had with Caritas Christi. You went a long way

toward reassuring them of many of the issues that were raised earlier by my friend, Mr. Tiberi.

I want to thank my friend, Mr. Brady, for looking out for those hospitals in Massachusetts, very important. I assure him right now, if he is ever ill, we will make sure that he has a space in that Mecca of medical care. I know that was on your mind.

I will point out something else that I think is really important, Madam Secretary, and that is the customer satisfaction rate in Massachusetts with the health care plan that became the national model is above 77 percent. It is not limited to Democrats or Republicans. It is the population of the State that is very happy with access.

And emergency room care everywhere is a drag on medical costs because of the issue of preventative care which they might have received at an earlier stage which in this legislation that you are explaining once again this morning addresses.

Let me talk to you about the issue of children's hospitals and graduate medical education that has had broad bipartisan support. Could you offer some clarity on how you see the future on that initiative?

Secretary SEBELIUS. Well, I would say, Congressman, that was a very difficult budget decision, as you know. The 2012 budget does eliminate the GME for the 60-plus children's hospitals and instead I would say focuses resources on programs that specifically train primary care doctors, recognizing that that is a huge need that has been long under attended in the past.

In a better budget time, that would not have been the recommendation going forward, but that was the direction that the President wanted to take.

Mr. NEAL. So it is front and center in your office still, the issue of how to address the program?

Secretary SEBELIUS. Yes.

Mr. NEAL. And I want to thank you on behalf of that 9-year-old who visited my office recently who has hemophilia. And maybe you could address, in light of that, the issue of lifetime caps.

Secretary SEBELIUS. Well, I hear from parents and others all over the country who were terrified that their disease was going to cause them to run out of care or treatment at a very critical time. I actually participated on a health panel with a mother of a hemophiliac in Connecticut who told some incredible, compelling stories. As a parent, I can't imagine what she and her husband are trying to go through.

It is a very limited, as you know, percentage of the population. But for that percentage it is a life-or-death situation where they were confronted with a cap on life-or-death care or treatment going forward.

So the removal of that cap, both gradually removing the yearly cap but the removal of the lifetime cap won't affect a lot of people, but the people it affects have—we have literally provided them some lifesaving hope for the future.

Mr. NEAL. And virtually every spring I have a group of visitors from my constituency, parents who have children with diabetes, and I want to assure you that they are very happy with the idea

that those children now can access not only care but, just as importantly, insurance. That is a huge victory.

Secretary SEBELIUS. Well, I had the experience as a parent when my sons got out of school neither of them was headed for a job with insurance coverage. So I experienced personally keeping the young adult on a family plan would have been a huge help to my husband and me.

But, also, one of our son's great friends had some childhood illnesses; and what his father told me is that graduating from college for him was a very dangerous situation because his son was confronted with the insurance market and enormous blockades to getting any kind of insurance due to his health conditions when he was 9 and 10. Heath's parents and others won't have to worry about that anymore, and that is a big step forward.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman CAMP. Mr. Roskam is recognized.

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

Madam Secretary, one of the issues that has come up in my congressional district is this notion of waivers and the process by which waiver decisions are made, who is the beneficiary of a waiver. I know that there are all kinds of accounts out there.

I am informed, from information from your office, that there is 948 waivers that are presently in place. And you know this story. You know the criticism of it. It seems like there is almost a line-of-scrimmage, audible feeling to this. In other words, well, you know, come in and make your pitch and maybe you get a waiver and maybe you don't. The other criticism is that the waivers are for a short time duration.

So I represent a district west to northwest suburbs of Chicago. McDonalds Corporation gets a waiver, and I am not a critic of that waiver. But what do you say to the tool and dye manufacturer in the suburbs of Chicago who has a hundred employees that doesn't have the political stick, isn't a big story, doesn't have the ability to come in and make a pitch for a waiver? Where are those employers being served in the waiver process?

Secretary SEBELIUS. Congressman, there are really two categories of employer-based plans and other plans where the waiver situation has come up.

One is, as you said, the McDonald's area, where there are a number of employers, large and small, who offered very limited health benefit plans, the so-called mini-med plans. And early on there was notice given and information on the Web site, information available in the preliminary rule to recognize the fact that those plans will cease to exist in 2014 when there are affordable, viable competitive options in State-based exchanges.

But, in the interim, the law gave our office the flexibility of collecting the first year of data. Because there really isn't any data about how many are out there and what they look like and if indeed it meant losing coverage for employees who had some coverage even though they didn't have comprehensive coverage to grant a waiver, and those waivers have been put in place.

The other, the 900 that you referred to, is really a different category. It deals with one feature of the plan and that is the

$750,000 overall benefit, back to Congressman Neal's question, about the lifetime cap. A number of plans were not able to reach that in a year's period of time. And again the law says that our office is given the flexibility to look at serious market disruption and rate increases.

The rule was published. The Web site is published. I would say I think, on average, 95 percent of the waiver requests that we received actually were given waivers. It was a fairly rapid turnover. Most plans have a January 1—or a bulk of plans have a January 1 turnaround time, which is why we saw a big increase in that final quarter. And that again is a 1-year waiver to get a graduated movement toward that benefit ceiling that currently wasn't in the plan.

Mr. ROSKAM. So in that second group—am I interpreting this correctly—if you are the tool and dye manufacturer and your problem doesn't line up with the problem that, let's say, SEIU has, then, because your problem is different, the department is not willing to contemplate a waiver?

Secretary SEBELIUS. It isn't that the problem is different. That waiver authority was very specifically outlined in the bill for that one provision, and we are following the law.

Mr. ROSKAM. So does the waiver provision limit your authority then to only those two areas and you have got to find within those two areas, either the mini-med or the short time duration, and beyond that you don't have the authority to make a waiver?

Secretary SEBELIUS. We don't have the authority to waive the law—I mean, we have rulemaking authority, which we are using. We are doing extensive outreach with everybody from tool and dye makers——

Mr. ROSKAM. I understand. I am short on time.

I just want to direct your attention. So is the two categories of waivers, Madam Secretary, are those categories of waivers?

Secretary SEBELIUS. No, there is waivers of authority in the medical loss ratio that can be granted to an entire State; and there likely is other waiver authority. But those are the two that you mentioned in your opening comments.

Mr. ROSKAM. Right. So it is an overstatement to say that your authority to make waivers is limited to the two things that we have discussed; isn't that right?

Secretary SEBELIUS. That would be correct.

Mr. ROSKAM. So you are making decisions then based on how you are interpreting the statute; isn't that correct?

Secretary SEBELIUS. I am trying to follow the law, as is our staff, yes.

Mr. ROSKAM. I yield back.

Chairman CAMP. Time has expired.

Mr. Becerra is recognized.

Mr. BECERRA. Thank you, Madam Secretary; and congratulations to you for all of the work that you have engaged in over the last 2 years. It has probably been an interesting ride for you as Secretary. Obviously, your preparation, from being a Governor to having been an insurance commissioner, certainly put you in a good position to be able to be where you are today; and we thank you for all of the work that you have done.

We continue to hear the myths about the Affordable Care Act and what it meant to have this historic reform of health care to make our system far more productive, given that it is the most expensive in the world. And we are beginning to now have it seen through to the American people that the talk of these death panels was simply myth, that the talk of a government takeover of a system that relies on private health insurance companies to offer health care is difficult to swallow as truth, and, again, that one is myth. In fact, you and I and every Member on this Committee as Members of Congress receives, essentially, government-sponsored, taxpayer-sponsored health care through the Federal Employee Health Benefit Program.

In fact, the support, the subsidy that you and I and every single Member, who I believe every single Member here has accepted that government-sponsored health care, the support we get through subsidy is greater than the support and subsidy that we provide in the Affordable Care Act to the 30 some odd million Americans who would qualify. So if there has been a takeover, the first people who should defy that are probably the Members of Congress who are receiving that same government-sponsored health care.

But having heard about all of the myths, we are now beginning to see the reality, the facts coming through. I think you mentioned one of those, the myth that we were going to see seniors lose their health care if they got their health care through Medicare HMO, which is the Medicare Advantage Program. The myth was they were going to lose it. The fact I believe you mentioned was that we have actually seen an increase in the number of people who are receiving coverage and a reduction—am I correct—a reduction of the costs, 6 percent increase and a 6 percent in the number of people participating, and was it a 6 percent drop in the actual premiums that seniors under Medicare HMO receive have to pay?

I believe as well, and Mr. Neal, my colleague, also pointed out, that the myths were that we were going to be denying people health care. The facts now are becoming evident that a lot of our children who are adults who are having a hard time finding insurance are able to qualify for insurance through our—in other words, through their parents health insurance policy. That is now a right that we as parents have.

The Affordable Care Act, I believe—and you may have the number—how many seniors is it that qualify for the $250 support check they received because they fell into this donut hole, what we call the donut hole of prescription drug coverage where all of a sudden, having received support from the Federal Government to help pay for their prescription drugs, they all of a sudden fell into this black hole where they no longer received support. So, last year, they received $250 to support them from the Federal Government under the Act.

Do you know how many people, seniors got that?

Secretary SEBELIUS. As of the year's end, about 3 million seniors had received that one-time check.

Mr. BECERRA. So, without that Affordable Care Act, 3 million seniors would have had to put out of pocket another $250 to pay for their prescription drugs. And we know for many of these seniors on fixed income that could have been the difference between mak-

ing the payment for the rent or perhaps buying the food for the month as well.

We know, for example, that small businesses are beginning to take advantage of the tax credit that they are offered under the Affordable Care Act. Do you remember how much the credit is for small businesses?

Secretary SEBELIUS. It starts at 30 percent, but it graduates up, thirty percent of the cost of employees' health coverage. And, yes, indeed, that is causing an up-tick for the first time in a very long time in small businessowners purchasing insurance coverage.

Mr. BECERRA. So we hear the myth. The cry is that small businesses are going to find this impossible to deal with and that we will find small businesses losing the opportunity to offer coverage to their employees. The facts are beginning to show that, with this credit, $3 out of $10 in providing the cost of health care to your employees will be covered through the Affordable Care Act, that a lot of small businesses are beginning to take advantage of that opportunity, many for the first time being able to tell their employees that they will be able to offer health care insurance to them.

But I think one of the greatest achievements of the Affordable Care Act—and I thank you for having pushed for this—is that the whole process of discriminating against individuals because of their health condition that we saw by insurance companies is now going to be something of the past. So discrimination based on preexisting conditions will now be prohibited. So we thank you for all that help.

And I thank you, Mr. Chairman, for the time.

Chairman CAMP. Thank you.

Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chairman; and welcome, Madam Secretary, to the Committee.

We hear a lot of talk on the other side about myths that don't exist. In fact, there is a lot of truths to what they call myths out there. As a physician, when I talk about health care, I like to talk about principles; and one of the principles is accessibility to health care. Everybody wants citizens across this great land to have accessibility to health care; and, in fact, accessibility is decreasing for a variety of reasons. One of them is we think the bill that was passed.

But when physicians aren't able to care for people because of reimbursement or because of all sorts of regulatory apparatus or the lawsuit abuse issues that exist out there that aren't being addressed, then patients can't find a doctor. And, as you know, in your former State, in your previous State where you were Governor, there are doctors who aren't taking new Medicare patients for a variety of reasons, but they are not. So new Medicare patients are having difficulty finding a physician.

In terms of affordability, premiums are increasing for people because of this law specifically. I know that you don't want them to say that, but that is the truth. I would suggest to you that the quality of care is harmed and threatened by this law because it removes the ability of patients and families and doctors to make medical decisions, and I look forward to working with you on that, because I know that is not your goal. I know that is not your goal.

You mentioned about Medicare Advantage that, because it was frozen, that that was a cut in the fees that were being utilized for Medicare Advantage. Do you remember saying that just about an hour ago?

Secretary SEBELIUS. I said that it has been portrayed by a number of companies who deliver Medicare Advantage that we did not keep up with the cost of inflation and they would characterize it as a reduction.

Mr. PRICE. Would the same hold true for SGR, for physician reimbursement rates which for the past 9, 10 years have not increased relative to inflation at all?

Secretary SEBELIUS. I definitely know that there are physicians who consider that a cut, yes, sir.

Mr. PRICE. There are a lot of physicians that I—one of my former colleagues that I talk to, and they say they are not going to be able to continue in the Medicare Program anymore because of reimbursement rates and a variety of things. There are some who believe that as access to physicians decrease it is because of the rules and because of the reimbursement, that patients won't be able to find physicians in a large number and that the response of the Federal Government will be to make certain to require that physicians have to participate in the Medicare program or the exchanges and base that upon licensure.

Does the Administration support requiring physicians to participate in the program as a component of being able to get licensed in the State?

Secretary SEBELIUS. As you know, licensure is a State issue. We have never had that discussion. I don't have any idea, again, where that conversation is coming from, but that certainly——

Mr. PRICE. Would you support the Federal Government requiring physicians?

Secretary SEBELIUS. No, sir.

Mr. PRICE. And the Administration would not, you don't believe?

Secretary SEBELIUS. I can speak for myself. No, sir.

Mr. PRICE. Well, I am curious.

Secretary SEBELIUS. I can't speak for anyone else.

Mr. PRICE. You represent the Administration.

Secretary SEBELIUS. I have never heard that conversation raised by anyone. So I find it difficult to be asked what people think about it, because I don't know. But licensure is a State issue, as you know, and that is not a conversation.

Mr. PRICE. There are some people who support Federal licensure of physicians, correct?

Secretary SEBELIUS. I assume so.

Mr. PRICE. And there are some individuals who believe that the Federal Government ought to require physicians to participate in these programs as a——

Secretary SEBELIUS. Congressman, as you know, though, that was never a part of anybody's conversation to establish somehow mandatory participation and anything would be tied to this program. That is just not part of the reality of the bill.

Mr. PRICE. You wouldn't support that?

Secretary SEBELIUS. I have said no.

Mr. PRICE. Okay. Medicare, in essence, price fixes the reimbursement that physicians are able to receive for services provided to patients. Do you believe that that is an appropriate thing, as, of necessity, prices will have to be decreased?

Secretary SEBELIUS. Well, I think what is very appropriate is, for the first time, decoupling what physicians are paid from what they do in terms of volume of procedure. And that delivery system reform is something that I think has been long overdue. It will more appropriately provide physician payment for care delivery.

Mr. PRICE. You think physicians ought to be able to charge outside of the reimbursement that they are provided by the Federal Government?

Secretary SEBELIUS. To the patients?

Mr. PRICE. Yes.

Secretary SEBELIUS. They can in some instances, and in a lot of instances they cannot. And I think that is part of the Medicare pact, is that patients will not have additional expenses beyond their co-pays and payments.

Mr. PRICE. Thank you, Mr. Chairman.

Chairman CAMP. Thank you.

Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman, for this important hearing; and, Madam Secretary, appreciate you being here today.

I represent southwest Florida—Sarasota, Bradenton area.

I want to talk a little bit about tort reform. I have noticed the last couple of days the President mentioning that, and he understands the importance of it. Could you just expound for a minute on that, and then I have got a couple of questions I want to follow up with.

Secretary SEBELIUS. Certainly.

Congressman, last year, the President directed our agency to use the authority we had to implement a series of grant programs which are now in place in 20 different areas, some with health systems, some with States, to look at a variety of measures that could increase patient safety, reduce frivolous lawsuits, reduce liability premiums, and ensure fair compensation. So we have planning grants and demonstration grants around the country and are monitoring those closely.

This year's budget includes a recommendation that under the Department of Justice there be an additional $250 million in grants to States to do health courts, safe harbors, early disclosure, and offer programs.

Mr. BUCHANAN. All of our time is limited.

Let me mention a couple of things.

One, you are aware of the figures CBO came up with, a savings of $55 billion that we would save if we got incorporated in terms of the health care bill.

But let me just say, as it relates, I work with our medical society because it is big. I have probably more seniors than any other district in the country, around 280,000 55 and older. But in dealing with a lot of doctors I know in terms of one neurosurgeon he is paying $200,000 a year in medical liability insurance.

One of the lawyers—we don't—this is back a couple of years ago—was telling me that he has a practice in bankruptcy. And I

was asking him who his clients were, because we don't have a lot of large companies there. He said, primarily doctors. They are looking for asset protection. So I talked a little bit more, and he said many of the doctors come to him simply because they have practiced as surgeons for 20 years, they have created some net worth, and they are afraid that is exposed every day that they do any kind of surgery.

And then also testing in terms of defensive medicine, people are very concerned. I have got to believe you talked to doctors and others. Everybody gets a test. Everybody gets a CAT scan, almost. And the cost that is there because of defensive medicine is really affecting the cost of doing business. And I am sure in Medicare, we are spending a lot more money than we need to.

So I know it is something that you are looking at. I would just say we need to look at that much more aggressively. I don't know of any doctors that don't think it is a big problem.

The other thing I just want to say in terms of the Affordability Act is, I don't know—you know, I brought this up, and I continue to bring it up—what businesses that you are talking to, but I would love to have you come down to Sarasota, Bradenton and talk to our businesses.

I don't know—and I have been in business for 30 years. I chaired the Florida Chamber. I don't know of any businesses that have any confidence that their premiums, number one, none of them are going down. Most of them are going up. One guy, a gentleman I talked to the other day, went up a million and a half. Another—but it is typically 20 percent, 25 percent. Then they look for ways to cut their expenses.

If we are really looking to try to grow jobs as we need to—that is my number one priority—we have got to deal with bending the curve on health care for companies. I know the health care program we got out there, many feel that is a large entitlement, but it does little or nothing for small business. And I am just telling you the businesses are just being strangled; and many times they have got to pass it on to families, the working families in our area.

So when you talk about the Affordability Act, tell me what businesses, based on what research you have done, are really seeing any savings.

Secretary SEBELIUS. Well, Congressman, I think there is no question that particularly the small businessowners have been at the vortex of the cost increase in health care, which is, as you know, exceeding all other inflationary costs. And what we find—you know, I saw this in Kansas, I saw it across the country, small businessowners often pay 18 to 25 percent more for exactly the same coverage that the large employers have because they don't have the market strength. They won't see a big relief in that market strength until they have the option of the new exchanges, which have a much larger purchasing pool and much more ability to actually leverage those costs for providers.

Mr. BUCHANAN. When do you see those exchanges——

Secretary SEBELIUS. Right now they are experiencing the assistance with employee coverage of the tax credits. And we are seeing in the Kansas City area, Blue Cross Blue Shield has said their small business market has actually increased for the first time in

years because people are linking the tax credit and coming back into the marketplace.

Mr. BUCHANAN. Let me just say I have Blue Cross, we work a lot with Blue Cross, my companies have Blue Cross, 25 percent a year for the last 5 or 7 years. Nobody believes, other than you and maybe a few others in the Administration, that health care costs are coming down. They don't see it. I walk into businesses and they will show me their bill just went up 22 percent. But I just want to bring that to your attention.

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

Mr. DOGGETT. Thank you, Mr. Chairman. And thank you, Madam Secretary. I know a number of our Republican colleagues think they can defeat health insurance reform through anecdote. But fortunately, the facts really support the testimony that you have and the reform that we have underway.

While I think that Dr. Berwick did an outstanding job last week in explaining the increased costs that seniors will face if what they call repeal and what I would call the Republican Senior Insecurity Act were to be approved. It means seniors pay more out of their pockets for prescription drugs. It means seniors pay more out of their pocket for a cancer screening. It means seniors pay more out of their pocket for health insurance premium increases. It means that seniors pay more out of their pocket for copays. And all we get out of that, other than seniors having to pay more, is that the solvency of the Medicare Trust Fund declines by over a decade if they are successful with their Senior Insecurity Act.

I want to touch on some of the anecdotes, though, as well that they mentioned about Medicare. As far as the availability of physicians to seniors, something that we provide incentives for, in fact availability for all of Americans through our primary health care incentives in the new act, isn't it correct that last year 96 percent of American physicians had Medicare participation agreements?

Secretary SEBELIUS. I think that is a correct number.

Mr. DOGGETT. So there may be some anecdotes out there, but it is according to CMS, almost all physicians in America have signed up to participate in Medicare. And I would offer for the record at this point a report prepared by our Ways and Means Democratic staff concerning Medicare beneficiaries reporting reliable access to physician services, Mr. Chairman.

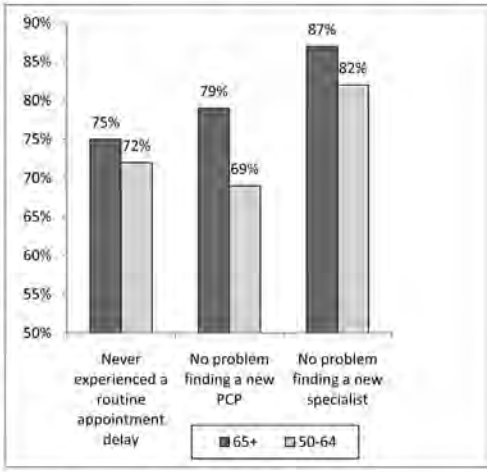
Chairman CAMP. Without objection.

[The information follows: Mr. Doggett]

Medicare Beneficiaries Report Reliable Access to Physician Services

What MedPAC says...

- Medicare beneficiaries (65+) report fewer delays getting a routine appointment than individuals with private insurance (aged 50-64).
- Medicare beneficiaries report fewer difficulties finding a new primary care physician than individuals with private insurance.
- Medicare beneficiaries report fewer difficulties finding a specialist than individuals with private insurance.



Source: MedPAC 2010 Beneficiary Access Survey

- Access to physician services in Medicare continued to be stable in 2010 despite limited anecdotal reports of physicians leaving the program.

What other surveys say...

- Physician participation in Medicare is higher than ever before, with 96 percent of physicians signing participation agreements with Medicare in 2010 (CMS).
- 88 percent of beneficiaries are "always" or "usually" able to schedule timely appointments for routine care (CAHPS Fee-For-Service Survey, 2010).
- 95 percent of beneficiaries who are not in an institutional setting have a usual source of care – like a doctor's office or doctor's clinic (Medicare Current Beneficiary Survey, 2008).
- Medicare beneficiaries are less likely to report going without care or delaying care than privately insured individuals (Center for Studying Health System Change, 2007).
- 90 percent of physicians accepted (at least some) new Medicare patients (NAMCS, 2008).

Prepared by the Democratic Staffs of the Committees on Ways & Means and Energy & Commerce

Mr. DOGGETT. And it shows that actually while this is an issue we need to keep working on, that seniors tend to have more access than some people do within the private health insurance system. While the focus on seniors is very important, I want to also be sure we have touched on the effect of this important health insurance reform that you are helping to implement on the rest of the population. If the Republicans were successful in satisfying the desire of the big insurance monopolies to undermine health insurance law reform, about how many young people age below 26 would lose health insurance coverage that they gained through the reform? Aren't we talking about a couple million or so?

Secretary SEBELIUS. Yes. Yes, sir. I think 2 to 3 million are the up to 26-year-olds who now can stay on their family's policy.

Mr. DOGGETT. That didn't have it before.

Secretary SEBELIUS. That is correct.

Mr. DOGGETT. So they can call it repeal, but to a young person who is counting on that insurance, it means terminate their insurance coverage. What about the study that your Department did concerning preexisting conditions? Do you have an estimate of about how many Americans will now, if they are successful with repeal, will now see their coverage either terminated or limited as a result of a preexisting condition if we don't have the guarantees that this new health insurance law provides?

Secretary SEBELIUS. It is close to half of our population has a preexisting condition that by insurance companies' terminology either changes their rate or actually could lock them out of the system.

Mr. DOGGETT. So there are millions of Americans that really have a stake in not going back to the old system——

Secretary SEBELIUS. Hundreds of millions.

Mr. DOGGETT [continuing]. Of letting the insurance company decide that you are not going to get insurance, or your insurance will be largely meaningless because of some preexisting condition that they have defined.

And then as it relates to our small businesses, if they are successful in undermining health insurance reform, about how much in tax subsidies will our—tax incentives for providing health insurance coverage, about how much will small businesses across America lose?

Secretary SEBELIUS. Well, we have right now about 4 million small businessowners who qualify for the graduated tax incentives that provide some help for them to provide employee coverage. So we will know at this year's tax time how many actually took advantage of that. But there are 4 million potential businessowners. And again anecdotally, we know that a lot are beginning to connect with those benefits and come back into the marketplace.

Mr. DOGGETT. Thank you very much for the important work you are doing in implementing this act. I believe we will see the original objectives of this act fulfilled with the work that you are doing.

Chairman CAMP. All right. Thank you. Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman. Thank you, Madam Secretary, for sharing your expertise and insights here today.

I have heard concerns from constituents, one in particular who has a diabetic child. And this is not an anecdotal scenario, but the concern from this parent is that the employer-provided plan under which her family is covered may be subject to the so-called tax on Cadillac plans. Is that a conceivable scenario?

Secretary SEBELIUS. I assume there are plans that will be subject, the very high benefit plans could be subject to a tax.

Mr. SMITH. Can you paint a picture of what that might be?

Secretary SEBELIUS. According to the economic experts, the goal really is to again slow down the growth of health care costs and targeted plans that are significantly in excess of an average plan, to say that over a course of the next 4 or 5 years before that tax is implemented——

Mr. SMITH. What will the threshold be, basically?

Secretary SEBELIUS. I don't want—$30,000 I think, but I really don't want to give you incorrect information. I would rather do that in writing. I am sorry.

[The information follows: Did not receive]

Mr. SMITH. Okay. But all plans above that level?

Secretary SEBELIUS. Up until that threshold, wherever it ultimately was set in the bill, would again be available for the tax deduction that every other plan gets. The goal is to either apply taxes or discourage plans from offering the so-called Cadillac benefits.

Mr. SMITH. So then above that threshold they would be subject to the tax?

Secretary SEBELIUS. That is correct.

Mr. SMITH. All plans would be subject to that tax?

Secretary SEBELIUS. That is correct.

Mr. SMITH. Okay. Now, it was characterized earlier that shopping for a plan may be considered a penalty. And I understand the complexity and the elderly perhaps having to review some of the complex conditions of various plans. I certainly understand that. But I would hate for the American people to be prohibited from shopping around. And our Tax Code basically does prohibit shopping around by requiring taxes being paid on something that is a health care benefit, health insurance benefit that is taken outside of an employer.

Do you see any accommodation eventually of how we might be able to accommodate an individual being able to shop around as he or she might wish?

Secretary SEBELIUS. Actually, the Affordable Care Act makes that not only feasible, but I would say encourages that with the State-based exchanges that will be up and running in 2014. For the first time ever, an individual, entrepreneur, small businessowner will have available, as one of a myriad of choices, two or three competitive programs with benefits offered that are in a large pool marketplace which he or she doesn't have to join.

Mr. SMITH. Would they be tax-deductible? That health insurance benefit policy premium, would that be tax-deductible?

Secretary SEBELIUS. To the employer, yes, sir.

Mr. SMITH. No, for someone wishing to purchase it.

Secretary SEBELIUS. An individual?

Mr. SMITH. Yes.

Secretary SEBELIUS. That did not change in the Tax Code. There is an individual—again, I don't want to speak out of school, and I apologize, I don't know the individual tax rate. There is a certain portion of health care that is deductible, but I don't know where it stops.

Mr. SMITH. Okay. The concern is that the personal prerogative in many ways, and the courts are weighing in on part of this, but the personal prerogative relating to health insurance may be eroding given the mandates, the individual mandate, and other things. And I don't want to spend our time today on the legal intricacies of the individual mandate. But I am concerned that in the aggregate maybe some of the priorities aren't in the proper order. For example, the SGR, we are talking about bipartisan concern, took a lower priority than the Affordable Care Act. And that is very discouraging when we know that there are issues out there that need to be addressed. Yet that was outside of the Affordable Care Act. And we can speculate on the reasons why, but it is very, I think, concerning.

Now, adding 16 million people to the Medicaid rolls I think has not only short-term concerns but long-term concerns as well. So I offer that up, if you might respond outside of today's meeting. I know my time has expired. But if you might be able to offer how we could encourage fewer Medicaid beneficiaries down the road rather than more.

Thank you.

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

Mr. THOMPSON. Thank you, Mr. Chairman. Madam Secretary, thank you for being here. You know, an important part of the health care delivery system in my district, and a very important job creator, are the community health centers. And not only do they create jobs and provide great health care, I think they are reflective of the change in the delivery of health care. They deliver incredibly important primary health care, preventive care, they do it in a cost-effective way. And it is very, very high quality. It is, I think, great that we are here today talking about these things. At the same time, our Republican colleagues are on the floor debating a continuing resolution that would cut over $1 billion from community health centers across the country.

As I understand this, if this were to become law, that nearly 130 community health centers across the country would have to close their doors. It would mean thousands of lost jobs, and I believe it would lead to a very steep increase in health care costs. Because these folks wouldn't have these facilities to go to; they would be seeking their care in emergency rooms and other inefficient delivery systems for this type of health care. And again, it would mean a huge loss of jobs.

Do you read this the same way that I do? And would the President, if this thing were, this misguided effort were to pass Congress, would the President allow that to become law?

Secretary SEBELIUS. Well, Congressman, I know that the President and I share your not only support of the community health centers as being an absolutely critical part of the public health infrastructure in this country, but data will show without doubt that the care delivered is at a much lower cost than care delivery cer-

tainly through the doors of an emergency room. Along with a community health center of course is the National Health Service Corps, which is training additional primary care docs, nurse practitioners, mental health technicians, dentists to be in the community health centers. So the complication of access, which was mentioned by one of your colleagues earlier, would be severely hampered and compounded by any closure of community health centers. And certainly the physician pipeline and the health care pipeline that is so important, regardless of whether we had a new Affordable Care Act or not, we have a looming shortage of health care providers. And I think anything done to either hamper that training pipeline or eliminate these critical centers of care delivery is a huge step backward.

Mr. THOMPSON. Thank you. I am glad you brought up the National Health Service Corps, because that was my second question. And as I understand this, the continuing resolution cuts over $140 billion from that program. And not only does that truncate the pipeline, and everybody knows that we need more providers, and when you represent a district such as mine or any rural district in the country, it is very difficult to attract providers. And this is one of the many great things that the health care reform measure put in place to help us in underserved areas. And even urban underserved areas suffer from this.

So these cuts on the heels of all of the gains that we have made are a bit hard to take. And I also want to raise the issue of the increase in reimbursement rates. Because access has been raised today. The amount that we pay Medicare providers has been raised today. And the health care reform bill increased reimbursement rates to primary care physicians, which is extremely important if we are ever going to get our arms around the soaring costs of health care. And there was also an increase for rural providers, which is very, very important.

And what can we expect if these increases in these two critical areas are not realized?

Secretary SEBELIUS. Well, I think, Congressman, you have identified, again, areas that we know are missing. If we truly are going to shift focus into a wellness and prevention and health system as opposed to a sickness care system, we are lacking the pipeline of primary care providers. We are also lacking the primary care providers who can be essential in the health home concept, which is built into the Affordable Care Act, which we know delivers better care to chronically ill patients, can dramatically decrease the number of hospital visits by wrapping care around patients. And that will be hard to fulfill.

So I think that the shift in focus to addressing care before it gets chronic, addressing appropriate care in rural and urban areas is severely jeopardized by not only the lack of funding for a new provider pipeline and community health centers, but certainly the incentive pay for rural health providers and others who serve in critically underserved areas.

Chairman CAMP. Thank you. Ms. Jenkins is recognized.

Ms. JENKINS. Thank you, Mr. Chairman. And I just want to thank my fellow Kansan for joining us today. While we have disagreed about the repeal of the entire health care law, the Adminis-

tration has recently decided it agreed with Republican Members in Congress that the 1099 requirement should be repealed. However, as I understood the budget language, it would only repeal the requirement for goods, but keep it for services. And this seems to contradict the President's strong support for repeal.

So I was just hoping you could clarify the position of the Administration and provide any other caveats related to 1099s that we will need to know as we continue with our efforts this week on 1099s.

Secretary SEBELIUS. Well, I think that the President has made it clear not just recently, but for months, that he very much supported elimination of the 1099, which on balance has far more burdens than benefits for small businessowners and supports, as you know, the 1099 repeal passed on the Senate side. We supported that effort. I know there is consideration on this side. So we look forward to working with you to eliminate that burdensome requirement.

Ms. JENKINS. But did I understand the language right, that he has just taken it out for goods and not services in the budget?

Secretary SEBELIUS. I am not sure.

Ms. JENKINS. Okay.

Secretary SEBELIUS. You, Congresswoman, are an accountant, I am not. So I hesitate to—my understanding was we favored the entire repeal. I didn't realize there was a delineation.

Ms. JENKINS. Okay. Great.

President Obama stated to the American Medical Association back in 2009 that he doesn't support caps on medical liability claims. However, in his State of the Union Address just a few weeks ago he was willing to take a look at other ideas to bring down the costs, including medical malpractice reform to rein in these frivolous lawsuits.

I am hoping just to get a sense from you today that despite your prior experience in working as the Director of the Kansas Trial Lawyers Association, you, like the President, have come around to the idea that liability reform is needed and cannot only decrease the deficit, but can also ensure continued access to care for Medicare patients, particularly in our rural areas.

As you know, Kansas currently has a $250,000 cap on noneconomic damages. That was enacted back in the late '80s. Prior to passage of the cap, Kansas liability premiums paid by physicians had increased to among the highest in the country. So given your experience as our insurance commissioner and Governor, do you believe that this cap served the State of Kansas well over the last 20 years? Do you think it might be a good model for the country to use? And would you support a specific cap such as our $250,000 cap? Or what other reforms do you think might work well?

Secretary SEBELIUS. Well, I, like the President, do not support caps, which I think unfairly penalize injured patients. I do support, and have aggressively followed his directive in terms of exploring lots of other possibilities for liability reform.

As you may know, across the country there is no direct connection between those States which have instituted various mechanisms and their liability payments. In fact, the data is hardly conclusive. One of the areas that is being funded right now by our of-

fice and is enhanced by the President's 2012 budget is the so-called safe harbor approach, creating a set of protocol whereby a physician would be essentially immunized from liability suits going forward if the practice fell within that. It shows a lot of promise. There are various health systems that have adopted that. And those are the kinds of reforms that I think the President supported when he was a Member of the U.S. Senate and is encouraged about supporting going forward.

Ms. JENKINS. Okay. And then maybe just finally, as a follow-up to Congressman Buchanan's line of questioning as it relates to the Justice Department grants to provide incentives for State medical malpractice reform, I was just curious if you will be supporting Kansas being chosen as one of the demonstration grants.

Secretary SEBELIUS. Well, since, as you say, Kansas has had full tort reform since the '80s, it is difficult to know what it is that they will be proposing. But I assume the Justice Department would certainly look at whatever it is and see if that is meritorious.

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

Mr. BLUMENAUER. Thank you, Mr. Chairman. Thank you, Madam Secretary. I appreciate you and Dr. Berwick helping focus on what has actually happened in an area of deep concern, Medicare Advantage. It was comforting in the Budget Committee to hear him talk about how enrollment actually is increasing, that premiums are decreasing. And it appears that benefits are stable or even increasing.

But I would like to just have you walk us through one other area of controversy, because some of my friends talk about hundreds of thousands of people, Medicare beneficiaries enrolled in Medicare Advantage who must change their plans due to health care reform. Now, my understanding is that this shakeout was a result of bipartisan legislation that we passed in 2008, and actually passed by a large overwhelming bipartisan majority over the veto of President Bush that has prompted a reassessment in dealing with some of the Medicare Advantage private fee-for-service plans that were of poor quality and had significant overpayments.

Am I correct that the shakeout is due to prior legislation and is dealing to try and contend with some of the problems of delivery and overcharge?

Secretary SEBELIUS. That is correct, Congressman. The Medicare fee-for-service, as you say, were not only some of the highest cost plans with the highest cost share for beneficiaries, but had the lowest outcomes value in terms of the whole spectrum of Medicare services. And as you know, one of the things that was done with the passage of the Affordable Care Act that you and your colleagues insisted on was not only to make sure that Medicare beneficiaries had access to choices like Medicare Advantage, but also that we ensured quality. So part of the new program is instituting the five-star rating for Medicare Advantage based on health quality. And in fact we are seeing already consumers appreciating that notice, because we have had a 5 percent increase in the number of beneficiaries who are enrolling in four- and five-star plans, giving consumers for the first time some real ability to choose plans based on health outcomes.

Mr. BLUMENAUER. Well, I must say I deeply appreciate what the Department has done in the administration of the new health care reform. I come from an area that is high value, low cost, and I appreciate the work that is being done to try and zero in on how we deal with some of these regional disparities, but that is based on rewarding value, not being penalizing at all. But it does seem to me that this is an area that all of us on the Committee ought to embrace. It is the reform of Medicare. And you were tireless in working with us to make sure that this legislation had virtually the entire smorgasbord of proposed reforms. They weren't as strong perhaps as some of us would have liked in some areas, but isn't that an argument for our working together to strengthen and accelerate the reforms rather than to put sand in the gears?

Secretary SEBELIUS. Well, certainly you and your colleague Mr. Kind and others were, I would say, ferociously insistent during the course of this discussion that we not just add money to the system, that we actually look at ways that higher quality care could be delivered at a more effective rate, and capture some of the best practices around the country. So that is definitely a part of this reform effort, and we have an opportunity for the first time to accelerate those best practices, to highlight them, and to actually implement them across the system if they are shown to work.

Mr. BLUMENAUER. Well, I am happy to convey again the commitment from our newly elected Governor, Dr. John Kitzhaber, to work with you so that our State can be a laboratory to accelerate, squeeze extra value, improve performance, and perhaps help with a national model that would make people more comfortable with the direction we are on. The fact is if we don't change the direction we are on, all the budget cutting isn't going to make any difference.

Thank you so much.

Chairman CAMP. Thank you. Just one moment. I think we are trying to get an answer here. We are going to reduce time to 3 minutes. And I want to thank the Secretary for her willingness to stay for just a few extra minutes. We just have 5 Members left who may inquire. So we will reduce the time to 3 minutes.

Mr. Paulsen may inquire.

Mr. PAULSEN. Thank you, Mr. Chairman. And Madam Secretary, thank you for being here today as well.

I remember a couple weeks ago when the President had his State of the Union speech he talked about winning the future. And the budget that he also laid out claims one of his highest budget priorities is encouraging innovation. And I couldn't agree more, coming from a State like Minnesota, where we have a high industry in medical device technology, for instance, which is very, very critical for jobs, critical for health care, and innovation that is there. Knowing that that is the message the President delivered not only in the State of the Union but also in the budget, why would we place a new $20 billion tax on medical technology products and device manufacturers? I am very concerned about that. You know, I was hoping there might be a repeal mechanism as a part of the budget, for instance, to kind of match some of the words that we heard recently. Why would we do that new tax?

Secretary SEBELIUS. Well, I think the President believes certainly in accelerating innovation, and there is no doubt that med-

ical innovation is a major component of that. I think the balance is that as we move forward, the medical device companies will also have access to a large pool of new customers who they don't currently serve and that the additional costs will be balanced amply by the additional customers in the pool of insured Americans.

Mr. PAULSEN. Well, and I have heard that argument before. I know that the vast majority of device procedures are not elective, they are performed on older patients, for instance, the majority of whom have insurance with Medicare. And in Massachusetts, which has been mentioned this morning, it is the model upon which much of the new health care law was built. There was no increase in device utilization like you suggest. I just know that this tax is really going to affect, I think, the competitiveness of our companies. I tour these companies every week. We all know the larger companies that exist, and they may be able to withstand it. But there are smaller companies that are not yet profitable that are really working on these life-saving technologies that are going to be, I think, stifled to create new innovation. I think that is going to be a problem. And they have told me directly that they are worried about having to ship their research and development overseas. And I think this spills right into the mantra we have heard from the Administration about shipping jobs overseas.

So I don't know if you have any other feedback in there, but I know it is absolutely going to be a concern going forward. And I think if we eliminate this pipeline of venture capital and innovation, it is going to be very difficult, if not impossible, to get back.

Secretary SEBELIUS. Well, again, Congressman, we share your view that accelerating innovation is important. It is one of the reasons that assets to the Food and Drug Administration and some of their translational science is so critical, that they have developed a new pipeline to accelerate devices coming to market as well as ensuring the safety of those devices. So we certainly share the balance, and think again that the additional consumers will again compensate for the modest tax increase.

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

Mr. KIND. Thank you, Mr. Chairman. Madam Secretary, thank you for being here, and for your patience. And thank you for your leadership in the implementation of the Affordable Care Act. Outside of the President, you probably have one of the most difficult, yet most important jobs in this town today. And that is moving forward on health care reform. We are having a discussion all week long about decisions we have to make in order to get these budget deficits under control. But unless or until we figure out a way to bend the cost curve in the largest and fastest growing area of spending at the Federal, State, and local level, rising health care costs, everything else would be for naught.

Now, I want to take you back to the conversation you were just having with Mr. Blumenauer about changing the way we pay for health care so it is value, not volume-based. And this is crucial, it is important, because studies show that we are spending close to one out of every three health care dollars in this country on tests and procedures that aren't working. They are not improving patient care. And oftentimes because of the overutilization or the

overuse, too many patients are being left worse off rather than better off, which is all of our goal.

Now, there are tools in place in health care reform to help us make this conversion, but it is going to take time. You don't change the way you pay for one-fifth of the entire U.S. economy and the largest area of spending in the Federal budget overnight. And one of those tools was something I worked with Representative Braley and Senators Cantwell and Klobuchar, and that is the value-based modifier for physician reimbursement. That will take effect in 2015. But on January 1 of next year, I think you are supposed to start publishing information on moving forward on this new value index for physician reimbursement.

I am wondering if you could just give us an update on where that is right now, and if work has begun in that endeavor.

Secretary SEBELIUS. Sure. I am happy to do that. As you know, there is an Institute of Medicine analysis underway directed to look at the value-based index, which I think is a critical component of moving toward a value-based payment system. We should have results back this spring, later this spring. We will be then sharing those results and having an extensive dialog as we move toward a system.

But I would suggest, Congressman, in addition to that one mechanism, which is important, I think that the work underway with providers across this country who are enthusiastic about the accountable care organization model, where they can actually have a different model of delivery, about the bundled payment opportunities for released patients to have better care and fewer readmissions——

Mr. KIND. And the medical homes and the other tools that are in the bill.

Secretary SEBELIUS. All of those I think are added together to have really the biggest transformation of the delivery system that we have ever seen.

Mr. KIND. And that is what we need is this vast experimentation to start happening and sooner rather than later. And I want to thank you for coming to La Crosse, Wisconsin, last year, visiting with Gunderson Lutheran, learning more about their highly integrated and coordinated patient-focused care system that they have set up. And these are the type of models of care that we should be trying to duplicate nationwide to get a grip on the rising costs in the health care system. Again, thank you for your leadership.

Secretary SEBELIUS. Sure.

Chairman CAMP. Mr. Berg is recognized.

Mr. BERG. Thank you, Mr. Chairman. Secretary——

Secretary SEBELIUS. If I can find you.

Mr. BERG. I am here. And obviously, being from the Midwest, it is nice to have you here. I guess my question really revolves around some of the simplicity maybe in the Midwest. In North Dakota, obviously our legislature is kind of at a standstill, waiting for a Supreme Court decision on the health care bill. And so I guess I just quickly, you know, where is that at, and what are you doing or can be done to expedite that? We need a decision. It is just wasting a lot of time.

Secretary SEBELIUS. Well, as you know, the attorney general from Virginia has asked the Supreme Court for an expedited decision. They will make a decision I assume fairly quickly whether or not to grant cert on that or not. And you will then have some clarity.

Mr. BERG. The other point that I guess I would like to make is on the insurance exchange, we need flexibility in that. What are you doing to provide the States flexibility in the insurance exchange?

Secretary SEBELIUS. Actually, there is enormous flexibility built into the original exchange model and ongoing. I am working very closely with Governors, have met with all the new Governors, have met, as I say, there are planning grants out to States, but we think all kinds of models will work, and it should be a State-based model that works in their marketplace.

Mr. BERG. Thank you. The final thing really is obviously we have got a lot of manpower tied up with the health care bill. And at the State level they are starting to see other work not as timely as it was in the past. And, you know, obviously if you are shifting work—again, I understand the workload that you have. You know, what are you doing to ensure that the normal work is getting done? And what assurances can you give back to the State that we are going to stay on the timelines that we were on before?

Secretary SEBELIUS. Well, Congressman, we are working overtime to try and fulfill the mission that we have, which is critical health care services and essential human services, and I think that our staff has been not only timely, but enormously user-friendly. As a former Governor, I have really come to the office as a recipient of HHS dialog in the past. And I think that particularly our CMS folks, who are the ones who are closest in touch with often States, have been sending teams out to States, sitting down with new Governors, analyzing budgets, trying to do an enormous amount of technical assistance and support in a very timely fashion. Because we know people are trying to get their arms around their new budgets and their services.

Mr. BERG. Thank you.

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

Mr. PASCRELL. Two points, Mr. Chairman. Madam Secretary, thank you for the day. First is if we end Medicare, because that is the only alternative on the table right now, and that is to provide a voucher system, whereby seniors would be given a voucher and they would take care of their health care.

Have you analyzed the depth or the consequences of us moving to the Republican plan of vouchers?

Secretary SEBELIUS. I have not to a great extent. But I have certainly seen a model where individuals in the marketplace attempt to purchase their own coverage, and that is typically the least effective, most expensive kind of insurance arrangement.

Mr. PASCRELL. Yeah. So those seniors are not only going to pay more money, but they are also not going to get the health care that is provided in the Health Care Reform Act.

Second issue is the work force. What is the alternative plan to doing what we have done with regard to providing the providers with more doctors, more nurses, et cetera? That is very specific.

The work force proposals in health care reform are very specific to the issue about the shortage. Could you tell me what the alternative is that we have been asked to look at? Because if you are simply going to say the Health Care Reform Act doesn't do what we wanted it to do, then what is the other side telling us about—how are we going to address the shortage in health care providers?

Secretary SEBELIUS. Congressman, I don't know that I can answer that question. What I can tell you is that the resources provided for work force first in the Recovery Act, amplified in the Affordable Care Act over time, and then followed up on in the President's budget are essential to serving the health needs of Americans. This is an issue that has been long overlooked. We need a pipeline of health care providers, and this act plays an essential role in providing that pipeline.

Mr. PASCRELL. So we all agree there is a shortage, but there is only one proposal on the table now that is going to address that proposal. So therefore, much of the criticism is not only a myth, but a fraud.

Thank you, Madam Secretary.

Chairman CAMP. Thank you. We have two Members left, and then this hearing will be over. Mrs. Black is recognized for 3 minutes.

Mrs. BLACK. Thank you, Mr. Chairman. Madam Secretary, I know that there have been statements, and actually I guess in the health care bill that there will be an opportunity for a wide variety of plans through the exchanges, including those featured in the health care savings accounts. And having been in the health care field for over 40 years now, I think that one of the mistakes that we made in the health care field was taking the consumer out of the driver's seat so that they really don't understand what the cost of care truly is. So I believe that health care savings accounts certainly will help us, for those that it is reasonable, to put them back in the driver's seat so they do understand what the cost of their care is, and they will have more freedom and choice there.

While the health care law really does not include a blanket prohibition on exchanges offering HSA programs, it does contain some new restrictions on deductibles and cost sharing that would prevent many of the current HSA plans from being offered. More importantly, the law does not specify that cash contributions made to the HSA plans will be counted toward a new minimum Federal requirement under the new actuarial value metric. That is in section 1302(D) of the statute that states very clearly that these parameters will be defined, and I quote, "under regulations issued by the Secretary."

In other words, it does not state it will determine whether they will be able to offer HSA coverage. It is the Secretary yourself that will be making those rules and regulations. And I would like for you to speak to what the intent of that is and if you think that the HSA plans are a good option as we move forward.

Secretary SEBELIUS. Well, Congresswoman, I know that there is every opportunity to include in the State-based plans, plans that are coupled with HSAs. And the preliminary analysis is that the vast majority of those plans which are in the market right now would certainly meet any kind of qualifications. Again, the States

will be the ones to make the preliminary choice. So we are not at the point of that yet. But I understand the interest in HSAs being a component of the exchanges going forward and there is certainly no prohibition in that.

Mrs. BLACK. Well, it does say that they will be defined, the parameters will be defined under the regulations issued by the Secretary. So do I understand you saying you would support regulations that would promote HSA plans?

Secretary SEBELIUS. Well, we will certainly have regulations that allow for that to be an option if the State chooses that as an option. There won't be any mandatory requirement for States.

Chairman CAMP. All right. Thank you. Our final questioner, Mr. Heller, is recognized for 3 minutes.

Mr. HELLER. Thank you, Mr. Chairman. Last but not least. Thanks for your patience.

I guess it is fair to say that you are familiar with the access to affordable care demonstration that is part of the health care bill?

Secretary SEBELIUS. Yes.

Mr. HELLER. For those who don't know, it is a demo program that will allow up to 10 States to develop State-based nonprofit public-private partnerships that provide access to comprehensive health care services to the uninsured at a reduced fee. And this demonstration model, which is an extremely successful program that started in my State in Nevada, it is called Access to Healthcare Network, or AHN. Mrs. Rice has been in my office numerous times, done a great job. Worked in northern Nevada, moved it down to southern Nevada. And I know she has met with your staff also, trying to help everybody understand how this demonstration program works. It is my understanding, though, that this demo is not funded. And there is no sign that the HHS will act on it any time soon. Is that reasonable or is that—can you respond to that?

Secretary SEBELIUS. Well, Congressman, there are numerous provisions of the Affordable Care Act which were authorized but not funded. And we look forward to working with Congress about those critical programs.

Mr. HELLER. AHN, the Access to Healthcare Network, is a medical discount plan. And it has provided quality, affordable medical care to 10,000 uninsured Nevadans. It is a shared responsibility model. The entire community, hospitals, providers, clinics, the insurance industry, employers, and even the banking industry have put aside what differences they may have to help the uninsured through this process. So I am just concerned as here is a program that works. We are insuring 10,000 Nevadans that are very, very difficult to insure. But one individual with her efforts, and obviously her clinic and the people that she has hired, has put together this program to get 10,000 of these people that would otherwise not be insured and put them in a program. So I guess I am concerned. I am concerned that—actually, what I want you to do is become more familiar with the model, because I think it does work. And I think that to be able to provide affordable, quality medical care to a population that otherwise would be very, very difficult to insure—in fact, I think after this post-health care reform there is still going to exist out there without health care—is something we

ought to take a good look at and try to determine and figure out how we can fund a program that works as smoothly and as well as this does.

Secretary SEBELIUS. Well, it sounds like a model we definitely should take a look at. In fact, I think I have met with—as you describe it, I have met with the Nevada folks. It just didn't, the title didn't capture. But I think there certainly are opportunities going forward, and I look forward to working with you to figure out how we could do that.

Mr. HELLER. If I could provide your office additional information.

Secretary SEBELIUS. Great.

Chairman CAMP. Thank you very much, Madam Secretary. Thank you for your testimony. Thank you very much for extending the time so that all Members could have an opportunity to ask a question. And if any Members have further questions, if they submit them by letter, if you would be kind enough to respond in writing, we would sure appreciate it.

Secretary SEBELIUS. I would be happy to.

Chairman CAMP. I do just want to make a quick announcement that the afternoon hearing with Budget Director Jack Lew has been moved to 2:30 because of votes that will start on the House floor about 1 o'clock. A notice has been sent to all the offices.

Again thank you very much, Secretary Sebelius.

Secretary SEBELIUS. Thank you, Mr. Chairman.

Chairman CAMP. This meeting is adjourned.

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

[Questions for the Record follow:]

W&M Full Committee Hearing on the President's Fiscal Year 2012 Budget Proposal with U.S. Department of Health and Human Services Secretary Kathleen Sebelius

February 16, 2011

Secretary of Health and Human Services Kathleen Sebelius

Question from Rep. Pat Tiberi:

Madame Secretary, in your testimony you mentioned that the Budget zeroes out and eliminates subsidies to Children's Hospital Graduate Medical Education (CHGME).

Many of us are committed to the equitable treatment through the CHGME program of the children's hospitals that fall outside of eligibility for the Medicare GME program.

I'm concerned about the Administration's commitment to sustainable training of the nation's pediatric workforce. CHGME provides essential support for the future primary care workforce for our Nation's children. Children's hospitals train 40% of all pediatricians, 60% of which are in general pediatrics (primary care). Graduate medical education is a long-term commitment on the part of teaching hospitals.

What will the Administration do to ensure that physicians who care for children are afforded the same level of training as adult physicians?

Thank you for your prompt response to this request.

Question for Secretary Kathleen Sebelius from Representative Xavier Becerra

As you know, in July 2010, the Centers for Medicare & Medicaid Services (CMS) and Office of the National Coordinator for HIT (ONC) promulgated regulations implementing the first of three stages of the Medicare/Medicaid Electronic Health Record (EHR) Incentive Program, or "meaningful use," which was established by the American Recovery and Reinvestment Act of 2009. The CMS and ONC rulemakings to implement the second stage of the program will begin later this year with the second stage starting in 2013. The "meaningful use" incentives will turn into Medicare physician payment reductions for noncompliance by eligible professionals beginning in 2015 and beyond.

Many physician specialists are concerned with the implementation of EHR Incentive Program because some of the requirements seem to be more appropriate to determine meaningful use of EHR by primary care physicians than physician specialties such as radiology, pathology and anesthesiology who use different technologies and have different data needs. In the regulations for the second stage, is HHS planning to develop a "meaningful use" standard that takes into consideration the unique practice characteristics of radiologists and other eligible specialists?

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