

OBAMACARE IMPLEMENTATION AND THE  
DEPARTMENT OF HEALTH AND HUMAN  
SERVICES FY16 BUDGET REQUEST

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HEARING  
BEFORE THE  
COMMITTEE ON WAYS AND MEANS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JUNE 10, 2015

**Serial No. 114-FC05**

Printed for the use of the Committee on Ways and Means



U.S. GOVERNMENT PUBLISHING OFFICE

22-184

WASHINGTON : 2017

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**WEDNESDAY, JUNE 10, 2015**

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. Paul Ryan [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

# ADVISORY

## FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE  
Wednesday, June 3, 2015  
No. FC-05

CONTACT: (202) 225-3625

### **Chairman Ryan Announces Hearing on Obamacare Implementation and the Department of Health and Human Services FY16 Budget Request**

Chairman of the House Committee on Ways and Means Paul Ryan (R-WI) today announced that the Committee will hold a hearing on Obamacare Implementation and the Department of Health and Human Services FY16 Budget Request. **The hearing will take place Wednesday, June 10, 2015, in Room 1100 of the Longworth House Office Building, beginning at 10:00 a.m.**

Oral testimony at this hearing will be from the invited witness only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

#### **DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:**

Please Note: Any person(s) and/or organization(s) wishing to submit written comments 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 make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the on-line 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, June 24, 2015.** For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

#### **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 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 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 submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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

**Note:** All Committee advisories and news releases are available online at <http://www.waysandmeans.house.gov/>.

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Chairman RYAN. The Committee will come to order. We know that the Secretary is on a tight timeline today with a hard deadline at noon. That is why the Ranking Member and I just discussed that we will limit Members' questions to 4 minutes so as to accommodate as many Members as possible in the questioning. But first let me start off by thanking our witness, Secretary Burwell.

I understand that you have to get going, so we are going to move this as quickly as we can. We were supposed to have this hearing earlier in the year, but events overtook us. So here we are today. I understand that the majority of your remarks are going to be about the budget. That is all well and good. But it shouldn't surprise you, Secretary Burwell, that we are a little more interested in talking about ObamaCare, especially given the President's remarks this week.

I hope he gives you a medal for this job, because defending this healthcare law is no easy task. I think any objective observer would say that this law is on the fritz, by the law's own standards. The whole point of ObamaCare was to make health care more affordable. But premiums aren't going down, they are going up, way up all over the country. Insurers are proposing double-digit premium increases. In Maryland it is close to 30 percent; Tennessee, 36 percent; South Dakota, 42 percent.

Tax season was like a bad dream before. Now it is a total nightmare. People could never afford these plans on their own, so the law gave subsidies to some people. Well, now two-thirds of the people who got them had to pay the IRS back, on average over \$700. That is not the kind of money that people just have laying around.

And for all of this hassle, for all of this, what are we getting for it? The argument was that if people had insurance they would go to the doctor instead of the emergency room. But now even more people are going to the emergency room.

So whatever the Supreme Court decides later this month, I think the lesson is absolutely clear: ObamaCare is just flat busted. It just doesn't work. And no fix can change that fact. We are not talking about a ding or a dent or a fender-bender or a flat tire. The whole law is a lemon. Its very linchpin, its central principle, is government control. That means higher prices, fewer choices, and lower quality.

So the answer isn't just to tighten a few screws and everything will be fine. The answer isn't just to tweak it here and tweak it there and we will all be okay. The answer is to repeal and replace this law with patient-centered reforms.

And the truth is, I don't have to convince this Administration that the law is broken. I know that you know it is broken, because

you keep trying to fix it. For several years now, HHS has delayed parts of the law, and sometimes, in some cases, they have rewritten it on the fly.

We know the most egregious example, the subsidies. The law says that people who buy plans on State exchanges can get subsidies. It doesn't say anything about Federal exchanges. And yet, HHS has sent millions of subsidies out the door, putting millions of people at risk.

More and more it seems the Administration isn't so much implementing the law as they are improvising it. We have already seen the evidence of the Administration using one account to pay for multiple programs—programs that Congress never funded. That is one of the main reasons that we are holding this hearing today. It is Congress that wields the power of the purse. And more and more the Administration is acting like a purse snatcher.

So again, my kudos to you, Secretary Burwell, on a very difficult assignment. But the American people, they deserve better. They deserve a healthcare system that puts the patient first. They deserve lower prices. They deserve more choices. They deserve higher quality. And the Committee is going to do all it can to make those things happen.

And with that, I would like to yield to the Ranking Member.

Mr. LEVIN. Welcome.

You know, I am glad we are having this hearing. And obviously the Republicans want to focus on ACA, and I think that is a good idea, because what is busted is not ACA, but your attacks on it, endless attacks, never coming up with a single comprehensive alternative in all these years.

So you sit as armchair critics while millions of people have insurance who never had it before. Millions of kids have insurance who would not otherwise have had it. People who have preexisting conditions no longer are canceled or can't even get insurance. The doughnut hole is gone. Millions of people in lower income categories are now insured through Medicare, millions and millions and millions. Cost containment is beginning to work. It is beginning to work. The increase in costs, that rate is going down.

And so you are livid because it is getting better. That is why you are livid. And I am not surprised at your fervor. We will be glad to take it on. We will be glad to take it on.

And I think you just need to understand what this experiment is all about. It was combining increased access to Medicare, to Medicaid, with an increased reliance on the private insurance sector. That is really what this is all about, an experiment.

And you talk about government control? More and more people are getting insurance through the private sector. And the States that are denying their citizens further coverage under Medicaid are essentially telling people: Well, get lost when it comes to health coverage. Get lost.

And you have a governor, Mr. Chairman, who is running around this country talking about the evils of health care, when millions of people are benefiting from what happened.

So you decided to turn this from budget to ACA. Welcome. Welcome. Your frustration is millions and millions and millions of people are benefiting, have health care when they did not before.

So, Madam Secretary, I think they have thrown down the gauntlet. I don't feel sorry for you. I think you love this job and you like being the person who is administering this experiment in greater health coverage after 70, 80 years of nothing being done in this town or throughout this country. So I happily welcome you because I think you are a very happy warrior.

I yield back.

Chairman RYAN. I would like to recognize the happy warrior now for your opening statement. The floor is yours, Secretary Burwell.

**STATEMENT OF THE HONORABLE SYLVIA BURWELL,  
SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN  
SERVICES**

Secretary BURWELL. Thank you. Chairman Ryan, Ranking Member Levin, and Members of the Committee, thank you for the opportunity to discuss the President's budget for the Department of Health and Human Services.

I believe firmly that we all share common interests and therefore we have a number of opportunities to find common ground. And we saw the power of common ground in the recent bipartisan SGR fix, and I appreciate all of your efforts to get that work done.

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

The budget before you makes critical investments in health care, science, innovation, and human services. It maintains our responsible stewardship of the taxpayer's dollar. It strengthens our work, together with Congress, to prepare our Nation for key challenges both at home and abroad.

For HHS, the budget proposes \$83.8 billion in discretionary budget authority. This is a \$4.8 billion increase, which will allow our Department to deliver impact today and lay a strong foundation for tomorrow. It is fiscally responsible, which in tandem with accompanying legislative proposals would save taxpayers a net \$250 billion over 10 years. In addition, it is projected to continue slowing the growth of Medicare by securing \$423 billion in savings as we build a better, smarter, healthier delivery system.

In terms of providing all Americans with access to quality, affordable health care, it builds upon our historic progress in reducing the number of uninsured and improving coverage for families who already had insurance. A recent example of this progress is the 10.2 million Americans who are currently enrolled in health insurance through the marketplaces in 2015.

The budget covers newly eligible adults in 28 States, plus D.C., with expanded Medicaid, and an improved access to health care for Native Americans. To support communities throughout the country, the budget makes critical investments in health centers and our Nation's health workforce, particularly in high-need areas. To advance our common interests in building a smarter, better,

healthier delivery system, it supports improvements to the way care is delivered, providers are paid, and information is used.

To advance our shared vision for leading the world in science and innovation, the budget increases funding for NIH by \$1 billion to advance biomedical and behavioral research, among other priorities. It invests \$215 million for the Precision Medicine Initiative, which will focus on developing treatments, diagnostics, and prevention strategies tailored to the individual genetic characteristics of individual patients.

To further our common interests in providing Americans with the building blocks of healthy and productive lives, this budget outlines an ambitious plan to make affordable, quality childcare available for working families. To keep Americans healthy, the budget strengthens our public health infrastructure with \$975 million for domestic and international preparedness, including critical funds to implement the Global Health Security Agenda. It also invests in behavioral health services, including more than \$99 million in new funding to combat prescription opioid and heroin abuse, dependence, and overdose.

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

We are also addressing our Medicare appeals backlog with a coordinated approach. We are pleased that the Senate Finance Committee last week passed bipartisan legislation, and we look forward to working with this Committee on it. I also want to assure you I am personally committed to responding promptly and thoroughly to the concerns of Members of the Committee.

I want to close by taking a moment to say how proud I am of the HHS employees, from their work combating Ebola, to assisting unaccompanied children at the border, the commitment that they show day to day, day in and day out, as they work to help their fellow Americans have those building blocks of healthy and productive lives.

I look forward to working closely with you to advance our common interests on behalf of the American people. Thank you.

[The prepared statement of Secretary Burwell follows:]

Statement by  
**Sylvia M. Burwell**  
Secretary  
U.S. Department of Health and Human Services  
on  
**The President's Fiscal Year 2016 Budget**  
before  
**Committee on Ways and Means**  
**United States House of Representatives**

**June 10, 2015**

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

I want to begin by thanking members of this Committee and your colleagues in the House of Representatives and Senate for the bipartisan, bicameral efforts you undertook in passing the Medicare Access and CHIP Reauthorization Act of 2015. As you know, this Act establishes a long-term policy solution to fix Medicare's flawed Sustainable Growth Rate (SGR) formula, replacing a broken system with one that offers predictability and advances value-based payments that reward quality and efficiency. The legislation also includes similar policies that were proposed in the President's Budget, such as requiring that Social Security numbers be removed from Medicare identification cards, increasing income-related premiums for Medicare beneficiaries, and reforming payments to post acute providers. These policies, along with other changes in the legislation, will help protect the integrity of Medicare and contribute to slowing healthcare cost growth.

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

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

In part due to the ACA, households, businesses, and the Federal Government are now seeing substantial savings. Today, health care cost growth is at exceptionally low levels, and premiums for employer sponsored health insurance are about \$1,800 lower per family on average than they would have been had trends over the decade that preceded the ACA continued. Across the board, the Department has continued its commitment to the responsible stewardship of taxpayer dollars through investments in critical management priorities. We have strengthened our ability to combat fraud and abuse and advance program integrity, further driving savings for the taxpayer while enhancing the efficiency and effectiveness of our programs.



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

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

The Department's Budget request recognizes our continued commitment to balancing priorities within a constrained budget environment through legislative proposals that, taken together, would save the American people a net estimated \$249.9 billion in HHS programs over 10 years. The Budget builds on savings and reforms in the ACA with additional measures to strengthen Medicare and Medicaid, and to continue the historic slow-down in health care cost growth. Medicare proposals in our Budget, for example, more closely align payments with the costs of providing care, encourage health care providers to deliver better care and better outcomes for their patients, improve access to care, and create incentives for beneficiaries to seek high value services.

**Providing all Americans with Access to Quality, Affordable Health Care**

The President's FY 2016 Budget request builds on progress made to date by focusing on access, affordability, and quality – goals that we share with Congress and hope to work on together, in partnership, moving forward. The Budget also continues to make investments in Federal public health and safety net programs to help individuals without coverage get the medical services they need, while strengthening local economies.

*Expanding Options for Consumers through the Health Insurance Marketplaces.* The ACA is making quality, affordable health coverage available to millions of Americans who would otherwise be uninsured. As of March 2015, about 10.2 million consumers had “effectuated” coverage, which means those individuals paid for Marketplace coverage and had an active policy. At the same time, consumers are seeing more choice and competition. There are over 25 percent more issuers participating in the Marketplace in 2015 compared to 2014. Not only that, in 2015, nearly 8 in 10 Federal Marketplace customers had coverage options for \$100 or less per month after applicable tax credits.

*Partnering with States to Expand Medicaid for Low-Income Adults.* The ACA provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the Federal poverty level through 2016, and covers no less than 90 percent of costs thereafter. This increased Federal support has enabled 28 states and the District of Columbia to expand Medicaid coverage to more low-income adults. In January, Indiana joined us to bring much needed access to health care coverage to uninsured low-income residents. Across the country, as

of March 2015, over 12.2 million additional individuals are now enrolled in Medicaid and CHIP compared to the summer of 2013. As Secretary, I am personally committed to working with Governors across all 50 states to expand Medicaid in ways that work for their states, while protecting the integrity of the program and those it serves.

***Improving Access to Health Care for American Indians and Alaska Natives (AI/AN).***

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

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

To continue encouraging provider participation in Medicaid, the Budget invests \$6.3 billion to extend the enhanced Medicaid reimbursement rate for primary care services, and makes strategic investments to encourage primary care by expanding eligibility to obstetricians, gynecologists, and non-physician practitioners. A January 2015 study by University of Pennsylvania and Urban Institute researchers found that the availability of primary care appointments for Medicaid enrollees grew by nearly 8 percentage points between 2012 and 2014, when the program was fully implemented.

***Investing in Health Centers.*** Health centers are essential sites where America's most vulnerable populations can access the health care they need. This is true for over 284,000 individuals in Wisconsin and over 558,000 individuals in Michigan. Health centers are also key in reducing the use of costlier care through emergency departments and hospitals. The Budget provides the resources to serve approximately 28.6 million patients in FY 2016, including an estimated 10.6 million rural Americans at more than 9,000 sites in medically underserved communities throughout the country. The Budget also provides the resources to open 75 new health center sites in areas of the country where they currently do not exist, including 30 projected new sites in rural areas.

**Delivering Better Care and Spending our Health Care Dollars Wisely**

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

***Improving the Way Care is Delivered.*** The Administration is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients – with an emphasis on prevention and wellness. HHS believes that incentivizing the provision of preventive and primary care services will improve the health and wellbeing of patients and slow cost growth over the long run through avoided hospitalizations and additional office visits. The Administration’s efforts around patient safety and quality have made a difference – reducing hospital readmissions in Medicare by nearly eight percent, translating into 150,000 fewer readmissions between January 2012 and December 2013 and reducing hospital-acquired conditions by 17 percent from 2010 to 2013, saving 50,000 lives and decreasing health care spending by \$12 billion according to preliminary estimates.

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

***Improving the Way Information is Distributed.*** The Administration is working to create transparency of cost and quality information and to bring electronic health information to the

point of care – enabling patients and providers to make the right decisions at the right time to improve health and care. The Centers for Medicare & Medicaid Services (CMS) is making major strides to expand and improve its provider compare websites, which empower consumers with information to make more informed health care decisions, encourage providers to strive for higher levels of quality, and drive overall health system improvement. To improve communication and enhance care coordination for patients, the FY 2016 Budget also includes a substantial investment (\$92 million) in efforts supporting the adoption, interoperability, and meaningful use of electronic health records.

#### **Leading the World in Science and Innovation**

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

***Advancing Precision Medicine.*** The FY 2016 Budget includes \$215 million for the Precision Medicine Initiative, a new cross-Department effort focused on developing treatments, diagnostics, and prevention strategies tailored to the genetic characteristics of individual patients. This effort includes \$200 million for NIH to launch a national research cohort of a million or more Americans who volunteer to share their information, including genetic, clinical and other data to improve research, as well as to invest in expanding current cancer genomics research, and

initiating new studies on how a tumor's DNA can inform prognosis and treatment choices. The Department will also modernize the regulatory framework to aid the development and use of molecular diagnostics, and develop technology and define standards to enable the exchange of data, while ensuring that appropriate privacy protections are in place. With the support of Congress, this funding would allow the Department to scale up the initial successes we have seen to date and bring us closer to curing the chronic and terminal diseases that impact millions of Americans across the country.

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

#### **Ensuring the Building Blocks for Success at Every Stage of Life**

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

*Investing in Early Learning.* High-quality early learning opportunities both promote children's healthy development and support parents who are balancing work and family obligations.

Across the United States, many American families face real difficulties finding and affording quality child care and early education. In 2013, parents on average paid more than \$10,000 per year for full-time care for an infant at a child care center –and in most States, child care costs more than the average cost of a year's in-state tuition and fees at a public 4-year college. The Budget outlines an ambitious plan to make affordable, quality child care available to every low-income and middle-class working family with young children; to build the supply of high-quality early learning opportunities through the Head Start and Early Head Start programs; and to invest in voluntary, evidence-based home visiting programs that have been shown to leave long-lasting, positive impacts on parenting skills, children's development, and school readiness. These investments complement the Department of Education proposal to provide high-quality preschool to all four-year-olds from low- and moderate-income families and expand programs for middle-class children as well.

The President's child care proposal builds on the reforms passed by Congress in the bipartisan reauthorization of the Child Care and Development Block Grant enacted last fall. The proposal makes a landmark investment of an additional \$82 billion over 10 years in the Child Care and Development Fund (CCDF), which by 2025 would expand access to more than 1 million additional children under age four, reaching a total of more than 2.6 million children overall in the program. At the same time, the proposal provides resources to help states raise the bar on



quality, and design programs that better serve families facing unique challenges in finding quality care, such as those in rural areas or working non-traditional hours.

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

The Budget also proposes \$15 billion over ten years to extend and expand access to voluntary evidence-based home visiting programs building on research showing that home visits by a nurse, social worker, or other professional during pregnancy and in the early years of life can significantly reduce child abuse and neglect, improve parenting, and promote child development and school readiness. More than 115,500 parents and children were served through home visiting programs in FY 2014, in addition to approximately 2,800 American Indian and Alaska Native parents and children served through tribal home visiting programs.

Research by the President’s Council of Economic Advisers indicates that investments in high-quality early education generate economic returns of over \$8 for every \$1 spent. Not only that, studies show high-quality early learning programs result in better outcomes for children across the board – with children more likely to do well in school, find good jobs and greater earnings, and have fewer interactions with the criminal justice system. These programs also strengthen

parents' abilities to go to work, advance their career, and increase their earnings. That is why the Administration has outlined a series of measures, including tax cuts for working families, to advance our focus on improving the quality of early care and education, while also dramatically expanding access to these important and cost-effective early learning services.

***Supporting Older Adults.*** The number of older Americans age 65 and older with significant level of disability – defined as needing assistance with 3 or more activities of daily living – that are at greatest risk of nursing home admission, is projected to increase by more than 20 percent by the year 2020. With 2015 marking the year of the White House Conference on Aging, the Department's Budget request includes \$1.7 billion for Aging Services within the Administration for Community Living for investments that address the needs of older Americans, many of whom require some level of assistance to continue living independently or semi-independently within their communities. The Budget also includes common-sense reforms that help to protect older Americans from identity theft, while supporting increased funding to support family caregivers and to expand home and community-based services and supports.

***Improving Child Welfare.*** The Department's Budget also proposes several improvements to child welfare programs that serve children who have been abused and neglected or are at risk of maltreatment. The Budget includes a proposal that has generated bipartisan interest that would provide \$750 million over five years for an innovative collaboration between the Administration for Children and Families (ACF) and CMS that would assist states to provide evidence-based interventions to youth in the foster care system to reduce the over-prescription of psychotropic medications. There is an urgent need for action: ACF data show that 18 percent of the

approximately 400,000 children in foster care were taking one or more psychotropic medications at the time they were surveyed. It also requests \$587 million over ten years in additional funding for prevention and post-permanency services for children in foster care, most of which must be evidence-based or evidence-informed. It includes savings of \$69 million over ten years to promote family-based foster care for children with behavioral and mental health needs, as an alternative to congregate care, and provides increased oversight of congregate care when such placements are determined to be necessary.

#### **Keeping Americans Healthy**

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

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

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

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

***Addressing Prescription Drug and Opioid Misuse and Abuse.*** The misuse and abuse of prescription drugs impacts the lives of millions of Americans across the country, and costs the American economy tens of billions of dollars in lost productivity and increased health care and criminal justice expenses. In 2009, total drug overdoses overtook every other cause of injury death in the United States, outnumbering fatalities from car crashes for the first time. In 2012 alone, 259 million opioid prescriptions were written – enough for every American adult to have a bottle. As part of a new, aggressive, multi-pronged initiative, the Budget includes more than \$99 million in new funding this year in targeted efforts to reduce the prevalence and impact of opioid

use disorders. The Budget also includes improvements in Medicare and Medicaid, including a proposal to require states to track high prescribers and utilizers of prescription drugs in Medicaid, which would save \$710 million over 10 years and bolster other efforts to reduce abuse of prescription drugs.

***Improving Access to Mental Health Services.*** Mental and medical condition comorbidity results in decreased length and quality of life, and increased functional impairment and cost. People with serious mental illnesses have been shown to die earlier than other Americans and also face important barriers to obtaining medical care. The Budget includes an increase of \$35 million, a total of \$151 million for the President's Now is the Time initiative to focus on prevention and treatment of mental health conditions among students and young adults. Aiming to reach 750,000 young people per year and training thousands of additional behavioral health professionals and paraprofessionals, this investment represents a substantial step toward reducing barriers for individuals seeking care. The additional funds will be used to increase workforce capacity across the nation by expanding an existing partnership between SAMHSA and HRSA that addresses the number of licensed behavioral health professionals available and by creating a Peer Professionals program to provide training for individuals who have experienced their own behavioral health issues to help reach those in need of treatment. In addition, this increase will raise awareness about mental health and substance use disorders and increase Americans' willingness to seek help through a social media campaign and other outreach efforts. The Budget also supports ongoing research at the National Institutes of Mental Health to prevent the first episode of serious mental illness and change the trajectory of these disorders and continues support for evidence-based treatment of serious mental illness at an early stage through a 5

percent set-aside within the SAMHSA Community Mental Health Services Block Grant. Finally, the Budget proposes the elimination of Medicare's 190-day lifetime limit on inpatient psychiatric facility services, removing one of the last obstacles to behavioral health parity in the Medicare benefit.

### **Leaving the Department Stronger**

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

***Strengthening Program Integrity.*** The FY 2016 Budget continues to build on progress made by the Administration to eliminate excess payments and fraud. The Budget includes new investments in program integrity totaling \$201 million in FY 2016 and \$4.6 billion over ten years. This includes, for example, the continued funding of comprehensive efforts to combat health care fraud, waste, and abuse through prevention activities, improper payment reductions, provider education, audits and investigations, and enforcement through the full Health Care Fraud and Abuse Control (HCFAC) discretionary cap adjustment. The FY 2016 Budget again requests the full discretionary cap adjustment be provided. This investment builds on important gains over the course of the past several years: from 2009 to 2014, programs supported by HCFAC have returned over \$22.5 billion in health care fraud related payments. Together, the Department's proposed program integrity investments will yield \$22 billion in gross savings for

Medicare and Medicaid over 10 years.

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

***Protecting Unaccompanied Children.*** HHS is responsible for ensuring that unaccompanied children who are apprehended by immigration authorities are provided shelter while their immigration cases are adjudicated. In the summer of 2014, the Administration responded to significant increase in the number of apprehended children with an aggressive coordinated federal response focused on providing humanitarian care for the children as well as on stronger deterrence, enforcement, foreign cooperation, and border security. The number of unaccompanied children placed in ACF's custody thus far in FY 2015 is below the FY 2014

level for the comparable period, and HHS, DHS, and the other agencies with responsibilities for unaccompanied children expect arrival levels to remain stable. To ensure that ACF can care for all children referred from DHS in FY 2016, and to promote the responsible stewardship of taxpayer dollars, the Budget includes level base funding from FY 2015 of \$948 million and creates a contingency fund that would only trigger additional resources if the FY 2016 caseload exceeds levels that could be supported with existing program funds.

***Improving Federal Spending Transparency.*** A key Congressional priority is implementation of the Digital Accountability and Transparency Act of 2014 (DATA Act) which seeks to improve the transparency of Federal spending. HHS plays a critical, government-wide role in its implementation promoting transparency, facilitating better decision making, and improving operational efficiency. The HHS Budget request includes \$10 million to begin implementing new data standards, assessing impacts, facilitating long term policies, processes, and systems, and establishing the Section 5 grants pilot in coordination with OMB.

### **Conclusion**

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





Chairman RYAN. Thank you.

Let me first start off by saying where we agree with the Administration we work with the Administration. This week's action on trade is a perfect example. But on this healthcare law we could not be more opposed to what the Administration is doing. We really think this is doing a great harm to the healthcare system and to the people we all represent.

So let me start by just addressing the big elephant in the room. Any day now the Supreme Court, as you well know, because your name is Burwell in *King v. Burwell*, is about to rule, and if the Court rules against the Administration then millions of people will be stuck with a government-designed health insurance that they cannot afford.

So, I mean, the big question is, then what? What about the people who are going to lose their subsidies and possibly their coverage? Is the President going to dictate to us how to fix this flawed law or is the President, is the Administration going to be willing to work with us to give families greater freedom in choosing the health care that works best for them?

Secretary BURWELL. With regard to the question of the courts, I think you know we believe that we are implementing the law as it was written, as the statute is written, as it was intended, as CBO has scored it for all these years, as recent articles have reflected, that those who were part of writing the law indicate that it should be. The idea that citizens in the State of New York should receive Federal subsidies that taxpayers contribute to and citizens in the State of Texas should not is not what we think the law intended—

Chairman RYAN. I understand your opinion on what the Court ought to do, but it stands to reason that there is a pretty decent chance that they may not go your way. So the question then is, then what?

Secretary BURWELL. So if the Court does decide and if the Court would decide for the plaintiffs, and the idea that the Court would say that subsidies in the Federal marketplace are not eligible, those States that are part of the Federal marketplace, that those citizens can't have those subsidies, if the Court makes that decision we are going to do everything we can, and we are working to make sure we are ready to communicate, to work with States, and do everything we can. But the critical decisions, if the Court says that we do not have the authority to give subsidies, the critical decisions will sit with the Congress and States and Governors to determine if those subsidies are available.

Chairman RYAN. So here is the question I am trying to get at. Is the President going to stand up and wave, I have a one-page bill, I have a one-sentence fix, take it my way or the highway, is that going to be the Administration's position? Or is the Administration going to be willing to work with Congress to find a way to give people more healthcare freedom? That is the question I am trying to get at.

Secretary BURWELL. With regard to the question of healthcare freedom, I think it is important to reflect, the marketplace is a market. It uses private insurers. People that sign up in the marketplace are not on, so they have many choices. As a matter of fact,

in the marketplace this year there were 25 percent more plans. That is more choice. That is more competition. That is why 8 in 10——

Chairman RYAN. Let me ask it this way, because I want to be kind to everybody's time. Let me ask it this way. If the plaintiffs prevail, if the King side wins, and then the exchanges are deemed unconstitutional, not legal in the Federal-exchange States, and the individual mandate is effectively struck down for those taxpayers in those States, is the President going to say reinstate the individual mandate? I have to tell you; it is not real popular. And we here, at least on this side of the aisle, aren't eager to reinstate the individual mandate. We would like to free people from some of these mandates.

I would say that the Administration has kind of been a little two-sided on this particular issue, mandates, where you have delayed the employer mandate twice. That goes away as well.

So is the Administration going to take the position Congress must just reinstate this thing in all these 37 States, reinstate the individual mandate, reinstate the employer mandate, my way or the highway, or is the President going to be willing and flexible to work with Congress to fix this mess and negotiate with Congress? That is what I am trying to get at.

Secretary BURWELL. So I think it is actually very important, though, with regard to the decision before the Court, the decision before the Court is who receives subsidies and whether or not those subsidies can be given in States that have a Federal marketplace versus a State marketplace.

Chairman RYAN. Yes, we understand that.

Secretary BURWELL. That is the decision, and that is the only decision before the Court right now.

Chairman RYAN. Okay, so should——

Secretary BURWELL. And with regard to what happens if that decision occurs——

Chairman RYAN. Yes.

Secretary BURWELL [continuing]. Three things occur. The first thing that occurs is, for the people——

Chairman RYAN. Secretary Burwell, we know what will occur. We all know this. The question is, what will the Administration do? Will they stand up with one piece of paper and say, "My way or the highway," or will they work with Congress to address the situation?

Secretary BURWELL. The problem that occurs if the Court decides against us is that they have made a decision that the subsidy isn't available.

Chairman RYAN. You are not going to answer the question, are you?

Secretary BURWELL. No, the answer is, the problem that gets created is subsidies aren't available. They aren't available for millions of Americans. They lose their insurance. It drives up costs in the individual market. To solve that problem the critical decisions are going to sit with the Congress or States.

Chairman RYAN. Okay. Right. So for a bill to become a law, it goes through the House, the Senate, then the person at the other end of Pennsylvania Avenue, the President, signs that bill into law.

Is the President going to come out and say, "Only my way or the highway," one-sentence, one-page fix, or is that President of the United States going to be thinking less about digging in and defending his law as exactly written, or is he going to be willing to actually deal with the issue, which is affordable health care for millions of people who are losing their health insurance? Is he going to work with Congress to address this situation or is he going to put concrete around his ankles and say, "It is my law or nothing?" That is the question I am trying to get at.

Secretary BURWELL. So the President and we have said, the Administration has said all along, with regard to improvements, and we believe that there are improvements that can be made, we look at three things and a fourth underlying: Affordability, access, quality, and the issue of how it affects the deficit and our economy. We will look at anything and have that conversation.

Chairman RYAN. Okay.

Secretary BURWELL. With regard to the specifics that you raised, I do think it is important, the issue of the individual mandate. That is related to a very fundamental part of the system, which is preexisting conditions. And it is our experience, at least in my conversations across the country, that most Americans believe that you shouldn't be kept out of insurance or banned. If I have a child that has a condition, that is born with a particular condition, that I shouldn't spend my time worrying that that child will never get insurance once they go off mine.

Chairman RYAN. You are kind of going off topic. I am going to cut you off there. We both know that there are ways of dealing with those problems without having to impose an individual mandate.

Let me leave it there, in the interest of everybody's time.

Mr. Levin.

Mr. LEVIN. Well, I am not surprised at the tone, but I really think it is so counterproductive. Chairman, you talk about two-sidedness. The two sides, when you say you worry about the millions who will lose their insurance, when it is your allies who brought the suit that would deprive them of insurance. You talk about concrete, having feet in concrete? That is exactly where you have been in terms of ACA. Your feet have been in concrete while you have brought up bill after bill to try to destroy ACA. And when you say will the President be my way or the highway, that is precisely what has been your approach to ACA. Precisely. You have never sat down with us to say, how could we make some changes? Instead, you have been out to destroy ACA. And you say, where is the President's plan, when the President believes the Court will and should uphold the law. All you have done is issue op-eds.

Chairman RYAN. And bills.

Mr. LEVIN. And bills, contrary, contradictory bills. So you don't have any plan. Like you haven't had a plan for 60 years. So you can keep going after the Secretary and she will keep trying to spell out.

I will ask you, and I finish, how many people have been receiving subsidies, Madam Secretary?

Secretary BURWELL. Some 7.3 million people have received subsidies that are in the marketplace right now.

Mr. LEVIN. So when you shed tears about 7.3 million, remember—or about the law—it is 7.3 million.

What has been the average subsidy?

Secretary BURWELL. Two hundred and seventy-two dollars per month is the average subsidy in terms of those that are in the marketplace that are subsidized. That is the 7.3 million. So 10.2 million people are currently in the marketplace overall. About 85 percent of those receive subsidies. The average subsidy is \$272 per month, which is what results in the affordability.

Mr. LEVIN. And just quickly tell us, how many people have received additional care through expansion of Medicaid?

Secretary BURWELL. The question of the total number, because there are people in terms of the expansion itself, about 10 million people are the estimates in terms of those States that have expanded.

Mr. LEVIN. So add those two together and we are talking about individuals with families, and the Republicans come here and castigate you and this President. The shoe should really be on the other foot.

I yield back.

Chairman RYAN. Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. I hardly know how to follow that.

I guess I am supposed to thank you for being here. But I have to tell you, I am not in agreement with much of what you are saying. And let me just ask you, we are trying to get the health care back in shape, and it sounds to me like you want to go your way and not try to work with us. And let me just ask you if there are any proposals that HHS supports that will reduce costs for consumers without setting price controls or imposing other restrictions that will reduce access to care?

Secretary BURWELL. Yes, there are a number of things that are part of our budget and that we are currently implementing that are reducing costs. We know that since the passage of the Act, the trajectory of Medicare—

Mr. JOHNSON. But it looks to me like everything is going up.

Secretary BURWELL. Well, Medicare spending, if we look at what it was projected to be in terms of the previous 10 years up to 2008 to where it has been since 2009 through 2014, we saved \$300 billion. With regard to per capita healthcare costs in the country, in 2011, 2012, and 2013 the cost growth is the lowest that it has been in 40 years. So that is taxpayer savings. That is also savings for providers.

Mr. JOHNSON. Well, the insurance rates are going up, not down, and everybody is paying more for it.

Secretary BURWELL. So insurance rates before the Affordable Care Act were going up often in the individual market well above double-digit numbers. And so what we have seen since the implementation is, while those rates are still continuing to go up, they are going up at a much lower rate.

Mr. JOHNSON. Okay. Let me just change subjects for a second and ask you about an effort that my colleague, Lloyd Doggett, and I have been after for a number of years, and that is ending the use of Social Security numbers on Medicare cards. As you know, that

finally became law earlier this year as part of the Medicare Access and CHIP Reauthorization Act. So let me ask you, is HHS already implementing that, and how fast do you think you will be able to issue cards without Social Security numbers on them?

Secretary BURWELL. First, let me say thank you. Having put this in the budget when I first arrived at OMB, I thought, as I told you in our call, it would take years. So thank you for your leadership and effort on this. We were pleased and I personally was very excited.

So right now we are putting together the work plan to do that. We haven't established the exact timetable, but as soon as it was passed, the next day, we asked the team for the work plans. We want to do it as quickly as possible in ways that will serve the consumer. As you know, there are a lot of Medicare consumers. We want to make sure that we are not disrupting them or their services, but we very quickly want to do it because, like you, we believe this is an important part of privacy and security.

Mr. JOHNSON. Well, I thank Lloyd Doggett for helping me with that. But how easy do you think you can make it for seniors to get a new card?

Secretary BURWELL. I think that is the part, in terms of understanding the timing, because we want it to be easy for seniors and we want to make sure they understand. One of the things we don't want to do by making this improvement is create confusion. So figuring out the way that we can enter in the new people coming in very quickly with their cards, but we want to carefully plan for those with the existing cards, because we don't want to have a confusing situation. So that is what we are working to do, and we look forward to staying in touch with you and your office about how we do that.

Mr. JOHNSON. Thank you, ma'am.

Thank you Mr. Chairman.

Chairman RYAN. Thank you.

Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman. And I want to thank my colleague, Mr. Johnson, for not drinking all of that Kool-Aid that you had in the back against ObamaCare, and bringing forward something constructive that the people outside would know that we are trying to provide health care is very healthy.

Chairman RYAN. Try the Kool-Aid.

Mr. RANGEL. I can't try that Kool-Aid, because I was a former altar boy, and I went to school and learned all the religions. And I just thought that the right thing for Americans to do was to believe that health care was a part of the pursuit of happiness. It doesn't even seem like a political thing if a kid is sick and someone says that you can't have health care. It should pain us as human beings if a person goes to a doctor and finds out that the child has an illness but he can't get insurance. Maybe we can find a Good Samaritan on the side of the road. And we know that most people, middle class people, have insurance, but that poverty sometimes restricts people from getting this.

It just seems to me that instead of tearing down a system where you know in your hearts people are getting health care, that you would say, "I don't like the way you have done it, Mr. President.

I don't like the way you Democrats have done it. Let us help you to do it better." But to take some sense of pride that the Supreme Court will just strike down the opportunity for people to get just basic health care to me is not just mean-spirited——

Chairman RYAN. Will the gentleman yield?

Mr. RANGEL. I don't think so, Mr. Chairman, because you are on a roll now, and I don't want to have you become a nice guy at this point in time, because I am glad that you have rehearsed the attack that you intend to do. And I don't care who the Secretary is, if you are on the side of giving assistance to people that can now go see a doctor, that can now prevent going into intensive care because they have had preventive care, that can now get insurance, that they couldn't have insurance, from a political point of view, I wouldn't want to be in your shoes explaining it.

Of course, those that are already covered, it is no problem there. I have mine, Jack. You get the best that you can. But I don't care what religion you believe in and even if you don't believe in any, it seems like compassion should override partisanship. And if we don't like what is before us, we should work hard to repair and to fix it and to improve it.

And so, you know, I am 85 years old. If I have to decide what moral side I am going to be raising issues on, I can't find a better one than this. And it goes without saying, if you are crippled, if you are blind, if you are disabled, if you want help, and if money and insurance is what is keeping you from getting it, you cannot give a better political home run ball to the American people to decide a basic question, which side are you on?

And so I am glad that politically my party would never put me in this position. The only position I would rather be in is where you are sitting, Madam Secretary, to be able to see that you are on the right side of the issue. You can see that people don't really want to discuss the millions of people that are being helped and we are not talking about. We are talking about life and death in the true sense of the word. And if someone had a conscience that when a doctor said, "I wish you had seen me earlier," and they said, "I wish I could have, but I didn't have insurance to do it, Doctor," or how many cases we have in intensive care saying, this woman, this man would never have had to be here if it was detected earlier and we have a mechanism for all of this.

Chairman RYAN. The time of the gentleman has expired.

Mr. RANGEL. Well, thank you, Mr. Chairman. I will turn back the balance of my time.

Chairman RYAN. Okay, that is good.

Mr. RANGEL. There was another minute there, but you cut that off.

Chairman RYAN. We are doing 4 minutes so that we can get to Members of the other dais here. I would just ask Members, if you have a question, ask it earlier on so that the Secretary has a chance to respond.

The gentleman from Texas is recognized.

Mr. BRADY. Thank you, Mr. Chairman.

And, Madam Secretary, health care is about patients, not politics. So I was really pleased to hear you answer Mr. Ryan that if the Court rules against the IRS in this case the Administration will

do everything we can. Can you give us some guidance here? Will the President sign legislation other than merely extending the subsidies to the Federal exchange?

Secretary BURWELL. With regard to the question of legislation and the Affordable Care Act, that has been a question and a comment. And where we have been is when there is repeal of fundamental elements——

Mr. BRADY. But on going forward, I appreciate looking backward, but going forward, if the Court rules for the plaintiffs, will the President sign legislation other than extending subsidies to the Federal exchange?

Secretary BURWELL. So the President has and I think will continue to sign legislation that we believe improves affordability, quality, access, and takes care of the deficit issues of the country.

Mr. BRADY. So the answer is, and thank you for saying what I hear you say, the President will sign legislation other than simply extending the subsidies to the Federal exchange. Are you saying that is correct?

Secretary BURWELL. The SGR bill that we just recently signed includes very important provisions that actually extend the Affordable Care Act's effort to do delivery system reforms.

Mr. BRADY. But as you know, that is not on the Supreme Court case. Specific to that, asking your guidance, the President will sign legislation——

Secretary BURWELL. Specific to the Supreme Court case——

Mr. BRADY [continuing]. Other than merely extending subsidies?

Secretary BURWELL. Specific to the Supreme Court case, if the question is the Supreme Court case, I want to return to what the Supreme Court case is saying.

Mr. BRADY. No, we are looking for your guidance in a bipartisan way. So your answer is, yes, the President will sign legislation other than extending the subsidies to the Federal exchange.

Secretary BURWELL. With regard to the question of the Supreme Court case, that is an issue about subsidy. That is all that is about.

Mr. BRADY. And your guidance to us would be——

Secretary BURWELL. If your question is, are we willing to consider things that would improve or enhance affordability, quality, and access, we are open to those things.

Mr. BRADY. So yes.

Secretary BURWELL. With regard to the Supreme Court case, though, I think it is very important for me to be clear. That is about one item. That is about one item.

Mr. BRADY. The subsidy. I am very well aware.

Secretary BURWELL. And that is the subsidy.

Mr. BRADY. I just want to make sure, again, as we look to work together to put patients ahead of politics, you are saying, yes, the President would definitely sign legislation other than extending the subsidies to the Federal exchange. The answer is clearly yes.

Secretary BURWELL. I want to distinguish between the question of how one resolves the problem that gets created. That doesn't have anything to do with any other parts of the Affordable Care Act.

Mr. BRADY. But no, no, no. This is such an easy question. It can be, yes, the President will sign other legislation, or, no, he will sign only that legislation.

Secretary BURWELL. Congressman, I think it is very hard for me to answer a question about hypothetical legislation.

Mr. BRADY. No, it is actually not hypothetical. As we know, the Court is going to be ruling. Not hypothetical. If they rule for the plaintiffs, guiding us, you are saying the President would sign other legislation, he will not, as Mr. Ryan said, he will not say, "My way or the highway."

Secretary BURWELL. With regard to fixing, improving the Affordable Care Act, these are two different issues. The subsidy issue—

Mr. BRADY. No, no, Madam Secretary, I don't mean to interrupt. I am really seeking your guidance. So the answer, though, to finalize it, is yes.

Secretary BURWELL. My answer, Congressman, is we will review any legislation we get that has to do with the Affordable Care Act based on four things.

Mr. BRADY. But I am asking about signing. So the answer is no?

Secretary BURWELL. With regard to legislation that we sign, we will look at any piece of legislation and we will judge it by four things: Access—

Mr. BRADY. So would the President sign legislation to extend those subsidies temporarily while Republicans and Democrats and the President work toward a long-term solution?

Secretary BURWELL. With regard to the subsidies, as I have said, the critical decision is with Congress. If the Congress writes legislation that makes sure that those subsidies are available, that is something that would fix the issue.

Mr. BRADY. The answer is yes. Yes, he would sign legislation other than extending it, correct?

Chairman RYAN. Time.

Secretary BURWELL. Congressman, I apologize, but when you say "other," I want to make sure—

Chairman RYAN. The time of the gentleman has expired.

Mr. McDermott.

Mr. MCDERMOTT. Mr. Chairman, thank you.

Ms. Burwell, it is really nice out in Seattle. I am not sure you made the right choice coming back here to work.

Secretary BURWELL. I am in the wrong Washington, is that what you are telling me?

Mr. MCDERMOTT. I listen to this, and we are all talking about if the President does this and whatever. But let's talk a specific, because I think that we haven't heard a specific come out of the Republicans since the bill was passed. They have never put anything on the table.

Now we have a bill, 1016, put in by Senator Johnson from Wisconsin, and it is his solution if the bill fails. And as I read it quickly, it repeals the individual mandate, it repeals the employer mandate, and it says that the States can continue the funding down, and the standard of benefits that people get are not the national standards, but whatever the State of Mississippi or Alabama



or Georgia or Texas or one of these States that has not had an exchange, whatever they set as a benefit.

We know it will be lower, because it already is. They won't cover people in Medicaid. So they clearly don't care about the level of health care.

But explain to me how you would respond to 1016.

Mr. PRICE. Will the gentleman yield? Will the gentleman yield?

Mr. MCDERMOTT. No, I am not going to yield. I am going to let her explain.

Mr. PRICE. Will you take back the disparagement of the citizens of the State of Georgia?

Mr. MCDERMOTT. She has the right to explain what the President would think of a particular piece of legislation that has been put forward as a serious thing by a Senator in the U.S. Senate.

Secretary BURWELL. So with regard to the Johnson piece of legislation, that piece of legislation, from our perspective, is repeal, because it gets rid of preexisting conditions, it stops the funding for preventative services, it undoes that people up to 26 would be covered, and it actually takes away subsidies from all over time.

And so with regard to that particular piece of legislation, that is a bill that, from our perspective, is repealing. And we have spoken to the issue of something that repeals the Affordable Care Act is something that the President will not sign.

Mr. MCDERMOTT. So in answer to Mr. Brady's question, will the President sign a bill that we pass, if we pass this bill, will the President sign that?

Secretary BURWELL. As I have said, this bill, in its current form, is repeal, and the President has said that he will not sign something that repeals the Act.

Mr. MCDERMOTT. Is there any place that you see where there is a proposal on the table by any Member of the House or Senate that looks at this point as though it deals with protecting the ACA in general and fixes the one specific problem?

Secretary BURWELL. We have not seen anything.

Mr. MCDERMOTT. And you have looked at all the legislation and read all of the press releases and everything else?

Secretary BURWELL. At this point we have not seen something that addresses the specific issue of the question. Although I think there is also the issue, I think we are all very focused on the loss scenario. At some point I think it actually is important to focus on the win as well in terms of how we all go forward if there is a win.

Mr. MCDERMOTT. Tell us about the costs of health care. We hear the Chairman say the President promised that there would be a reduction in premiums. Now, would you explain why that is a little bit misleading in that certainly everything is going up in the society, but they are not going up as much as was predicted. I would like you to talk about that.

Secretary BURWELL. That is correct. And as we have seen, the premium increases that occurred in the individual market and even in the employer-based market, we are seeing smaller increases in those premiums than we saw before. And so while there are increases, the increases that we were historically seeing that were driving costs for individuals, for employers, and in terms of Medi-

care and the costs to the government, that is what we have seen shrink and slow.

Chairman RYAN. Thank you.

Mr. Tiberi.

Mr. TIBERI. Thank you, Mr. Chairman.

Thank you, Secretary Burwell.

The recent SGR repeal and Medicare reform bill that passed a couple months ago included a bipartisan bill that I sponsored to require binding bids from suppliers participating in the durable medical equipment and supplies competitive bidding program. The provision, supported by my Democrat colleagues, removes bad actors from the program, something I don't have to, I know, go over with you, and ensures that seniors get quality medical equipment.

In a compromise with the Administration, the law requires that CMS implement the provision not earlier than January 1, 2017, but not later than January 1, 2019. I think that 2019 is a very generous timeline to implement the bill and would hope, with your leadership, that we could move it closer to the January 1, 2017 timeline.

Because at the end of the day, as you know, again, there is bipartisan support for this concept. My good friend Bill Pascrell is all over this issue as well. We think that this will ultimately help separate the good from the bad and ultimately help our seniors. So your leadership would be critically important to moving that closer to the beginning than the end.

Secretary BURWELL. So it is related to Mr. Johnson's question too. As soon as the bill passed, which was such a very important bill—I don't think I need to articulate to this Committee all the important things we have worked to put together so that we are specific and we do try to meet and beat deadlines. We have been able to do that on some bipartisan legislation in behavioral health that was supported both in the House and the Senate in terms of beating deadlines we were given, and where we can, we are going to try to. Thank you for your support in helping to do that. If we need further support and help I will come and ask.

Mr. TIBERI. Thank you.

Secretary BURWELL. But it is something that is a priority.

Mr. TIBERI. Thank you.

The other issues, Madam Secretary, are intellectual property rights, incentivizing the creation of innovative new medicines that improve people's lives and supporting good U.S. jobs. We are talking about trade this week.

I want to ask you specifically about India. Over the past couple of years, India's intellectual property climate has unfortunately deteriorated pretty significantly and the U.S. IP-intensive industries have suffered, including pharmaceuticals, and they have expressed significant issues with respect to the Indian market.

Most notably, courts in India have issued compulsory license, as well as denied or revoked several patents for popular medicines held by U.S. companies, citing an Indian law that many believe diverges from India's international legal and international trade commitments.

Have the compulsory license and denial, revocation of patents on medicines been part of any of HHS discussions with its Indian

counterparts? And I know this is kind of a question that might have come out of left field based upon what you prepared today, but would you agree it would be ill-advised for any U.S. Government employee to undermine the policy of the United States to promote strong international property rights in foreign markets? And if you aren't prepared to answer that, would you mind looking into it and getting back to us as we have this trade debate this week?

Secretary BURWELL. Yes, I am happy to get back to you. The USTR would probably lead in any of those conversations that were in that space. So I think what I will do is coordinate with the USTR so that we get back to you together.

Mr. TIBERI. That would be great.

Secretary BURWELL. Because I think you probably know those conversations—

Mr. TIBERI. Yep.

Secretary BURWELL [continuing]. With the governments are being led by the USTR. We give our policy and programmatic input to them and they lead.

Mr. TIBERI. Great.

Secretary BURWELL. So we will make sure that one of the two, either HHS or the USTR, gets back to you.

Mr. TIBERI. Thanks so much. I appreciate your leadership.

I yield back.

Secretary BURWELL. Thank you.

Chairman RYAN. Thank you.

Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman.

Madam Secretary, the opioid addiction issue is pronounced now across my congressional district, and there are all sorts of stories now that indicate a nationwide trend. And I am curious about the response of your Department, the agencies that you oversee, and I would also like to ask specifically about prescription drug misuse.

Secretary BURWELL. Yes.

Mr. NEAL. I would like to know about the evidence that you are coming across on that basis.

Secretary BURWELL. So with regard to the issue that you have raised, thank you for raising it. In our budget there are 99 million additional dollars to implement an evidence-based strategy on the problem.

Let's just quickly touch on the problem. When we think about the problem, as you articulated, in your district, across the country, opioid and overdose deaths have exceeded the number of deaths from car accidents or any other accidental death. In the year 2012, there were 259 million prescriptions for opioids. That is more than one for every adult in the country.

Mr. NEAL. Would you say that again? How many prescriptions?

Secretary BURWELL. There were over 250 million prescriptions in 2012 for opioids. That is how many prescriptions there were. That is more than the number of adults in our country. So that was one prescription for every adult in the country in terms of where we are in the magnitude of the problem.

Let's go to the solution. We have worked and worked with States and worked with the Congress. There are a number of bills up on

the Hill right now. There are three basic areas on which we need to focus.

One is prescribing. A big part of the problem, as you can see from that number, is prescribing. What we need to do there is we need to provide new prescribing guidelines for pain and pain medication that will help the problem. But also, in the prescribing States, States need to do what are called prescription drug monitoring plans. They are almost in all 50 States and they are the means by which a physician has the opportunity to look up and see that a controlled substance was already given to you, and control it that way. It works the same way with pharmacists. So prescribing is number one.

Number two is the use of naloxone, which is a very important drug that actually stops death when there is an overdose, and making sure that first responders have access. That is a very important part of that picture. Nick Kristof even had a piece out about it this week.

Number three is the issue of medicated assisted treatment combined with behavioral issues and making sure that we do treatment for those who are addicted.

So those are the three things. The \$99 million additional funding in our budget cuts across CDC and SAMHSA as we do this. We are doing this in conjunction with States. I have been in Massachusetts with your Governor, doing a joint event with your Governor. This is a bipartisan, bicameral, and statewide issue, whether it is Governors or both sides of the legislative body and both sides of the aisle. And certainly your colleague from Kentucky is leading in this effort in the House.

So that is our plan. That is what we are trying to do.

Mr. NEAL. And it is noted that in some places in New England heroin is selling for \$3.50 a bag on the streets of some of our old industrial cities. And I have House bill 1821 that I would invite Members to take a hard look at. Senator Markey has a companion bill in the Senate.

What specific actions should Congress be taking along these lines to assist you in noting, as you have, that there are now more deaths from overdose than from automobiles?

Secretary BURWELL. So on the heroin point, we know that the second two elements, the nonprescribing elements of the strategy, we will work on.

With regard to the places where we believe we need help from Congress to implement that strategy, one is in the area of buprenorphine, which is another drug that helps in this, and the question of prescribing. So we believe that that is an important place. The second place is in making sure people are trained with the guidelines.

Chairman RYAN. Thank you.

Dr. Boustany.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Welcome, Secretary Burwell.

Last fall the Administration proposed a child support enforcement rule, and former Chairman Dave Camp, along with Senator Hatch, sent a letter expressing concern about this. And the issues that were raised were that the Administration in this area was

usurping the authority of Congress to write law and was, in effect, writing law.

And this has been a repetitive theme. I think Chairman Ryan raised this issue with regard to certain issues relating to ObamaCare. But we have seen this with immigration, with ObamaCare, other areas of the law, TANF waivers. So why, especially in this area where this Committee in a bipartisan way has been willing to work with the Administration on these child support policies, why does the Administration choose to trample on the Constitution and Article I powers in an area where we want to work together? I just don't get it.

I mean, I understand there is always tension where we disagree. I get it. And that is a fight that we are seeing being played out in the courts. But why in an instance where we do have willingness to work and cooperate on this important issue area?

Secretary BURWELL. We would look forward to the opportunity to work in this space. In terms of that particular rule, there were some very important things that I know you are familiar with, the fact that some of these things were done in the 1990s. So people have to do paper applications with regard to child support. And so a lot of the rule was about things like improving the ability to use technology and other things, and improvements and simplifications to the rule.

If there are specific policy areas that are of concern, we are listening to those comments that have come in. I think you know we have not finalized the rule. And we would welcome the opportunity to work on the issues and the substantive areas.

Some of the things that have been mentioned in the release that happened yesterday are in areas where the States have advised us—in the State of Texas—in terms of we are following what the States have asked us to do in terms of things like using money for people to do job training, which is an issue that is important in a number of the States.

Mr. BOUSTANY. Well, Chairman Ryan and I introduced legislation yesterday dealing with this in order to protect our constitutional right to write law. I know there is companion legislation in the Senate by Senator Hatch and Senator Cornyn. But we want to put the Administration on notice that this body, the legislative branch, writes law and that the executive branch executes. And we are getting tired of it, especially in an area where we have some agreement. Just be put on notice that we are going to continue to assert our constitutional prerogative.

On a different issue, the employer mandate has not been implemented. There are a lot of complications with it. We know how complicated it is. We have heard testimony in the past on this. And I know it does not apply to small businesses, those with 50 or fewer full-time equivalents. But those individuals would still be subject to the individual mandate.

Why has the Administration been reluctant to assist these kinds of small businesses? I questioned Secretary Lew when he was before this Committee earlier this year with regard to health reimbursement accounts, and there was a move, I think, for a 6-month reprieve on really onerous penalties for small businesses, but 6 months. I just don't get it.

I have legislation that would actually make it more effective for small businesses to use these health reimbursement accounts, which are completely legal under ACA, but yet for some reason your agency and the Administration have decided to close the door on these. I don't get it. Shouldn't we be helping small businesses and their employees at a troubled time?

Secretary BURWELL. We agree with you and want to try to do more. In the budget right now, the budget proposal that is before the Congress right now for fiscal year 2016, we actually have proposed expanding the tax credit. It is available for those up to 25 employees. We want to move it up to 50, to expand the access to tax credits that they can get. It sounds like similar kinds of ideas in terms of getting folks the access they need to the help they need—

Mr. BOUSTANY. Well, health reimbursement accounts are very effective, and it is a simple solution.

Chairman RYAN. The time of the gentleman has expired.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Chairman RYAN. Mr. Doggett, are you ready?

Mr. DOGGETT. Thank you, Mr. Chairman.

Thank you, Secretary Burwell, for being here.

It seems to me that the focus of this hearing and the focus of all of our work should be on how we can make this healthcare system work better and deliver services and insure more families instead of speculating about some Court decision.

As you know, Madam Secretary, I have a number of concerns about the way this law has been implemented, particularly in Texas. I am concerned about the fact that two out of three of our Texans who are market eligible for these marketplaces are not yet enrolled.

And I think there are things that your office can do for more effective implementation. I would encourage you strongly to do the same kind of cost-benefit analysis that you did at OMB, and that is to look at these contractors and see if they are delivering on their services. As you know, I have a number of queries to you about those. I would hope to focus on how we can make it better and how we can make the implementation better.

But when I hear you accused of being a purse snatcher, it does get my attention. You know, the easiest thing for this Court to do, and I think the right thing, is to not ignore the other 900 pages of the law and focus solely on four words. And if it is necessary to have a legislative fix, deleting four words solves the entire problem and allows this law to work the way the Congress intended for it to work.

There are many other ways to address this problem, and in fact, apparently, some States are beginning to look at the possibility that the best way to fix the law, should the Court render the wrong decision, is to simply create their own exchange.

It is also extremely impressive to me that of all the proposals that have come in here at the last minute of Republicans to deal with the possibility of an adverse Court decision, how many of those proposals attempt to include as much of the hated Obama-Care as possible—preserving the right of young people up to age

26 to participate in their family's health insurance program, attempting to maintain exchanges and so on.

If today we are asking you about how to make improvements to reach more people in our laws, that would be a reasonable thing, instead of the polemics that are going on here. Indeed, I think it is probably historic. I could not find another circumstance in which Members of the House and Senate ask a court to deny thousands, indeed, millions of people across the country an opportunity to get a Federal tax credit, to say please deny—in Texas, our two Senators—please deny our constituents \$206 million every month in Federal tax relief, but let them keep paying taxes to finance the same kind of tax credits for people in California.

Or someone from Wisconsin—since Chairman Ryan joined the same brief in the Court—who says, please have my constituents continue to pay taxes to fund tax credits in Connecticut, but deny thousands of people tax credits in Wisconsin.

It is an unusual situation, to say the least, that that kind of approach would be taken.

I believe we need to look for improvements in the law, to strengthen the law, but that the idea of denying relief to people who are receiving it right now is to take away from them Federal tax assistance and to take away from them the opportunity to get the insurance that is working for their family.

To say that it is a lemon to provide families the relief with insurance for preexisting conditions that they never had before, something that is lifesaving in many cases, is truly a misstatement about the work of this legislation. Thank you very much.

Chairman RYAN. Thank you. The time for the gentleman has expired. Mr. Roskam is recognized.

Mr. ROSKAM. Thank you, Mr. Chairman. Secretary, thanks for your time today. There are two issues that I would like to use our couple of minutes together on. They are related. It is the discussion around cost-sharing reduction payments and then also the basic health program. So just to set the table, the cost-sharing reduction payments, the issue is whether the Administration has the authority to spend out of an account that hasn't been appropriated.

As you know, Chairman Ryan and Chairman Upton wrote to you and Secretary Lew on February 3. Your response back at a staff level, look, I mean, it was sort of predictable. It restates the obvious in terms of a number of truisms about the Affordable Care Act. And then it says go talk to the lawyers at the Department of Justice because there is pending litigation. A little bit of a cute response in my view. But it is your play. Now, where there is no litigation pending and the issue is exactly the same is on the issue of basic health programs. So it wouldn't be satisfactory to say you have to check with Justice. Because they are not involved in any litigation because there is no litigation between us at this point in time.

So here is my question. The law is really clear that you can't spend money that hasn't been appropriated. There is no ambiguity about that. The Constitution is clear. The GAO states this. Many, many, different entities say that money cannot be spent absent an appropriation. And, yet, there are a number of States that are an-

nouncing that, you know, Minnesota was a State that says they are going to be implementing the program.

New York has announced that they will operate the basic health program starting in January of 2016. New York has estimated that they will receive \$2.5 billion, B, billion. How is this possible since the money has never been appropriated? In other words, what extra-constitutional authority are you invoking that allows you to spend money that has not been appropriated?

Secretary BURWELL. With regard to the issue of 1311 and where that is, I think 1311 is about States that want to choose and try to do things in ways that seek flexibility. And that is what we try to do is work with States when they do that.

With regard to the authority, both for the cost-sharing and the issue of 1311, in the budget appendix, pages 1046 and 1047, is the place where we believe these authorities lie.

Mr. ROSKAM. But there has been no appropriation, you will acknowledge that, won't you?

Secretary BURWELL. With regard to the authorities there, what we believe is the authorities for the APTC are the authorities because that is what the money—

Mr. ROSKAM. But you are conflating two concepts. You are conflating authorization, which I am not arguing with, and appropriation. There has been authorization. But there has been no appropriation. So how do you appropriate money that hasn't been appropriated?

Secretary BURWELL. But programs that are tax credits aren't a part of our discretionary budget every year. In terms of discretionary programs, I mean, the Earned Income Tax Credit, other tax programs and tax credits are not a part of the discretionary process.

Mr. ROSKAM. So just to follow up, would you be willing to come in and give a briefing to me and also to Chairman Tim Murphy, who chairs the Oversight Subcommittee at Energy and Commerce, to clear up these things when we have more time together?

Secretary BURWELL. Congressman, we would look forward to the opportunity to try to clear this up and have the right people come and discuss these issues.

Mr. ROSKAM. Thanks very much. I have just one other quick point. You mentioned in your opening statement that there was \$22 billion in fraud savings, which is okay, not great. The problem is, and Mr. Lewis and I found this out together, along with all the Members of our Subcommittee, Medicare, by Medicare's own admission, is wasting \$1 billion a week, every single week in fraudulent and erroneous payments.

So \$22 billion over the decade is okay. But it is like turning it off halfway through the year and then letting 9.5 years go by without doing anything. So I think we really need to up the game. I yield back.

Chairman RYAN. Thank you. Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. Thank you for having the hearing. And thanks for helping to subsidize my California constituents and their health care. I appreciate that.

Madam Secretary, thank you very much for coming out. I just want to say that I hear a lot from my constituents as well about



the ACA. I hear from people who are pleased that the preexisting conditions is no longer an issue for them, that their 26-year-old can stay on their policy, that they have access to quality preventive care, which I know for a fact will save us all money in the long run. But I also hear them say that they recognize there are problems with the ACA. And they want us to work together to fix those problems.

I don't know how it could be a lot different than in other parts of the country. My experience has been that folks want access to quality affordable health care. And we do have a responsibility to figure out how to make that happen. And I appreciate your effort in that regard.

So I am all for fixing, making tweaks, making adjustments. Congresswoman Black and I are going to introduce legislation today, as a matter of fact, that falls into that category of making a tweak, making a fix. And we are going to introduce a bill that would ease the reporting requirements for employers offering coverage for their employees. And it would require that the exchanges use the most recent tax data to ensure that individuals and families will not have a large tax bill at the end of the year.

As I am sure you know, Covered California in my home State of California, requires that the most recent tax data be used. And it has worked well. It has been beneficial. I am just wondering if you have any thoughts on requiring the more recent tax data to determine eligibility for subsidies, especially for auto renewals, and making that apply to all the exchanges?

Secretary BURWELL. I think it is in our interest. And what we want to seek to do is get the most up-to-date information that we can possibly have which is why we encourage people to come in and update throughout the year. And we continue to do that.

With regard to the specifics of this piece, I think we would have to look at the legislation. I am not sure if it sits with Treasury or with us. But we would work together to understand. Because I think what we want is actually to have the most up-to-date information. And that information for some people is an evolving and changing piece of information. For those who are self-employed, their incomes change throughout the year. And we do have means by which they can come in and update it. And we try to encourage them to do that.

So, the most up-to-date information that we can implement is something that we do support. And so with regard to the specifics of the legislation, we would like to have the opportunity to look at it and understand between us and Treasury where we could be.

Mr. THOMPSON. Thank you. I also had some questions regarding the RACs and the appeal process that I understand from your staff we are going to work together outside of the Committee hearing to deal with. So I appreciate that commitment. I am assuming it is shared by you.

Secretary BURWELL. Yes, it is. And I would also use this just as an opportunity again to mention the piece of bipartisan legislation that Senate Finance just passed this past week on this issue, in terms of the strategic approach to help us get to a place where we can reduce that backlog of appeals. There are administrative things we can do. But we do need some statutory help. And Sen-

ator Hatch and Mr. Wyden have led an effort on that side. We are hopeful we can work with all of you too.

Mr. THOMPSON. Great. And then Mr. Boustany had some questions about the HRAs. And we are working together on that legislation. I hope that we can have the help of your agency in making sure that this is the best legislation possible.

Chairman RYAN. Thank you.

Secretary BURWELL. We will work with you.

Mr. THOMPSON. Thank you. I yield back.

Chairman RYAN. Dr. Price is recognized.

Mr. PRICE. Thank you, Mr. Chair. Madam Secretary, with respect, many of us here and many across the land sincerely believe that the principles that you outlined that all of us hold dear, accessibility, and affordability, and quality are all being harmed by the current path that we are on.

And I want to highlight some of the problems in the system that are, I believe, we believe, harming patients and in many cases destroying the ability of those working as hard as they can to care for those patients. One of them is the Electronic Health Record and Meaningful Use.

CMS is now dictating to physicians what must be documented and how it must be documented, without regard to what is truly important and necessary for taking care of patients. It is wasting money. It is wasting time. It is wasting resources. And, sadly, it is wasting the expertise of physicians, leading to further disgust on the part of physicians, many leaving practice. In fact, I know two individuals who said this was the last straw and they quit, at an age where they could be able to practice for years and years.

There are positive solutions if we allow for flexibility and respect to those providing the care. ICD-10 is another example of CMS making it more difficult for physicians to care for patients. In some cases, in small and rural practices, as we have discussed, it will drive physicians out of business. So access is destroyed for those patients in those areas.

The United States inappropriately combines and confuses clinical data, that is what is happening medically with a patient, with billing data, under the guise of wanting more information and saying that everybody else in the world is doing it. Well, the fact is that the United States will be the only country to use all 87,000 codes, the only country to use it in an outpatient setting, the only country to use it in a billing process, and the only country to put the cost on the shoulders of the physicians and those providing the care. This happens on October 1. If past is prologue, sadly, it holds real potential to be a significant disaster, further harming doctors and patients. I urge, I urge CMS to delay any penalty for coding errors for at least 2 years. It is only reasonable given the magnitude of the change coming.

Durable medical equipment and a caring provider is oftentimes the only thing that stands between a patient's quality of life and hospitalization or illness, exacerbation, or even death in the instance of the provision of oxygen. Yet, CMS has put in place a system of what they call competitive bidding, what you call competitive bidding. It doesn't work. It is harming patients. And it is driving folks who have been wonderfully providing care and service

in communities all across this Nation out of business, further harming those patients. I urge, I plead with CMS to allow, at least allow a pilot demonstration to show there is a much better way to save money and also provide services to patients.

Sadly, Madam Secretary, the President continues to shamelessly condemn and attack those standing up for patient-centered health care. As recently as yesterday, he ignored reality and cynically mocked those striving for positive solutions. We know that he has a pen and a phone. What he doesn't seem to have is the knowledge or the humility or the concern or the desire to work together on behalf of those struggling to provide care and those receiving the care.

Madam Secretary, I urge you, I urge you and your team to join with us in an open-minded way to end the oppression of meaningful use, to provide for flexibility with ICD-10 so that more practices aren't destroyed, to allow for a pilot program to demonstrate that competitive bidding is hurting patients and that there is a much better way, and to give physicians the freedom to care for patients.

If you are sincere in your desire for accessibility and affordability and quality, that would lead to your action working with us. And I look forward to that and hope that we will be able to move in a positive direction. Mr. Chairman, I yield back.

Chairman RYAN. Thank you. Mr. Larson.

Mr. LARSON. Thank you, Mr. Chairman. And thank you, Madam Secretary, thank you for your service. Hailing from the great State of Connecticut, we are so proud of the advances of the Affordable Care Act. And it is great to have a Governor that is hands on in terms of its implementation and all the progress that we know that has been made and will continue to be made under this Act.

Mr. Chairman, I would like to submit for the record a 28-page report entitled "The Language of Healthcare 2009," by Frank Luntz. Mr. Chairman, is there an objection?

Chairman RYAN. No objection.

[The submission of The Honorable John Larson follows:]

## THE LANGUAGE OF HEALTHCARE 2009

### THE 10 RULES FOR STOPPING THE “WASHINGTON TAKEOVER” OF HEALTHCARE

- (1) **Humanize your approach.** Abandon and exile ALL references to the “healthcare system.” From now on, healthcare is about *people*. Before you speak, think of the three components of tone that matter most: *Individualize. Personalize. Humanize.*
- (2) **Acknowledge the “crisis” or suffer the consequences.** If you say there is no healthcare crisis, you give your listener permission to ignore everything *else* you say. It is a credibility killer for most Americans. A better approach is to define the crisis in your terms. “*If you’re one of the millions who can’t afford healthcare, it is a crisis.*” Better yet, “*If some bureaucrat puts himself between you and your doctor, denying you exactly what you need, that’s a crisis.*” And the best: “*If you have to wait weeks for tests and months for treatment, that’s a healthcare crisis.*”
- (3) **“Time” is the government healthcare killer.** As Mick Jagger once sang, “*Time is on Your Side.*” Nothing else turns people against the government takeover of healthcare than the realistic expectation that it will result in delayed and potentially even denied treatment, procedures and/or medications. “*Waiting to buy a car or even a house won’t kill you. But waiting for the healthcare you need – could. Delayed care is denied care.*”
- (4) **The arguments against the Democrats’ healthcare plan must center around “politicians,” “bureaucrats,” and “Washington” ... not the free market, tax incentives, or competition.** Stop talking economic theory and start personalizing the impact of a government takeover of healthcare. They don’t want to hear that you’re opposed to government healthcare because it’s too expensive (any help from the government to lower costs will be embraced) or because it’s anti-competitive (they don’t know about or care about current limits to competition). But they are deathly afraid that a government takeover will lower their quality of care – so they are extremely receptive to the anti-Washington approach. It’s not an *economic* issue. It’s a *bureaucratic* issue.
- (5) **The healthcare denial horror stories from Canada & Co. do resonate, but you have to humanize them.** You’ll notice we recommend the phrase “*government takeover*” rather than “*government run*” or “*government controlled*” It’s because too many politician say “*we don’t want a government run healthcare system like Canada or Great Britain*” without explaining those consequences. There is a better approach. “*In countries with government run healthcare, politicians make YOUR healthcare decisions. THEY decide if you’ll get the procedure you need, or if you are disqualified because the treatment is too expensive or because you are too old. We can’t have that in America.*”

- (6) **Healthcare quality = “getting the treatment you need, when you need it.”** That is how Americans define quality, and so should you. Once again, focus on the importance of timeliness, but then add to it the specter of “*denial*.” Nothing will anger Americans more than the chance that they will be *denied* the healthcare they need for whatever reason. This is also important because it is an attribute of a government healthcare system that the Democrats CANNOT offer. So say it. *“The plan put forward by the Democrats will deny people treatments they need and make them wait to get the treatments they are allowed to receive.”*
- (7) **“One-size-does-NOT-fit-all.”** The idea that a “committee of Washington bureaucrats” will establish the standard of care for all Americans and decide who gets what treatment based on how much it costs is anathema to Americans. Your approach? Call for the “*protection of the personalized doctor-patient relationship.*” It allows you to fight to protect and improve something good rather than only fighting to prevent something bad.
- (8) **WASTE, FRAUD, and ABUSE are your best targets for how to bring down costs.** Make no mistake: the high cost of healthcare is still public enemy number one on this issue – and why so many Americans (including Republicans and conservatives) think the Democrats can handle healthcare better than the GOP. You can’t blame it on the lack of a private market; in case you missed it, capitalism isn’t exactly in vogue these days. But you *can* and should blame it on the *waste, fraud, and abuse* that is rampant in anything and everything the government controls.
- (9) **Americans will expect the government to look out for those who truly can’t afford healthcare.** Here is the perfect sentence for addressing cost and the limited role for government that wins you allies rather than enemies: *“A balanced, common sense approach that provides assistance to those who truly need it and keeps healthcare patient-centered rather than government-centered for everyone.”*
- (10) **It’s not enough to just say what you’re against. You have to tell them what you’re for.** It’s okay (and even necessary) for your campaign to center around why this healthcare plan is bad for America. But if you offer no vision for what’s *better* for America, you’ll be relegated to insignificance at best and labeled obstructionist at worst. What Americans are looking for in healthcare that your “*solution*” will provide is, in a word, more: *“more access to more treatments and more doctors...with less interference from insurance companies and Washington politicians and special interests.”*

**You simply MUST be vocally and passionately on the side of reform.** The status quo is no longer acceptable. If the dynamic becomes “*President Obama is on the side of reform and Republicans are against it,*” then the battle is lost and every word in this document is useless. Republicans must be for the *right kind* of reform that *protects the quality of healthcare for all Americans*. And you must establish your support of reform early in your presentation.

## THE BIG PICTURE: AMERICA'S HEALTHCARE CLIMATE

This document is based on polling results and Instant Response dial sessions conducted in April 2009. It captures not just what Americans want to see but exactly what they want to hear. The Words That Work boxes that follow are already being used by a few Congressional and Senatorial Republicans. From today forward, they should be used by everyone.

But don't expect to reach everyone. More than one quarter of the population will back significant government involvement in healthcare and a third support "universal" care. The primary message of this document is to focus on the persuadables and generate support among wayward Republicans and conservatives. Here's how.

- (1) **Acknowledge the crisis or risk the consequences.** Fully 70% of Americans consider our healthcare system to be either in a state of crisis or seriously troubled and requires significant reform. While it is true that the "crisis" response has dropped significantly in the past 15 years, the percentage of Americans who think the system needs significant reform has soared. So you say there is no healthcare crisis, you are telling those 70 percent that you are ignorant of their fears and concerns.

*How would you define the state of the healthcare system in America today?*

It is in crisis and needs a total overhaul.	12.0%
It is seriously troubled and needs significant revisions.	57.5%
It is adequate but still needs tweaks.	15.1%
It is a good system and only needs minor changes.	13.3%
It is one of the best systems in the world and doesn't need to be changed.	2.1%

The best approach is to empathize with the fear, anxiety and financial pain people are clearly feeling right now. So instead of dismissing their concerns, acknowledge them – up front – and then pivot to your solution. Some conservatives will undoubtedly find this distasteful. But failure to connect on a personal level at the beginning will lead to communication failure at the end.

#### WORDS THAT WORK

If you can't get the treatment you need, when you need it, there is a crisis.

If you are denied the ability to choose the doctor or hospital that's best for you, then it is a crisis.

If you can't afford the coverage you need for you and your family, then you have a crisis.

We need to stop looking at it from a global perspective and restore the humanity to healthcare. We need to focus more on people and less on the system.

This is the single best approach to the crisis language because it *individualizes* and *personalizes* healthcare – and shows empathy for anyone and everyone struggling right now. This plays into more favorable Republican territory by protecting individual care while downplays the need for a comprehensive national healthcare plan.

- (2) **You simply MUST be on the side of “the right reform.”** The status quo is no longer acceptable. The overwhelming majority of Americans believe significant reform is needed – and they see Republicans (and the insurance companies) as the roadblock. If the dynamic becomes “*President Obama and Congressional Democrats are on the side of reform and Republicans are against it.*” -- which is exactly what Obama has already started to promote -- the public will side with the Democrats and you will lose both the communication and the policy.

#### WORDS THAT DON'T WORK

We don't need a complete overhaul of our health sector. We need to support what works and change what doesn't.

The language above from a conservative website doesn't work for two reasons:

- 1) **It starts out with a negative.** Unfortunately, that's how most conservatives begin the healthcare discussion, and then they're surprised when only the most ardent followers agree with them. Start by telling them what you are for, not what you are against.
- 2) **It talks about the system, not about the individual.** Healthcare is *personal*, and so your opening statement should be personal.

Republicans must be for the *right kind* of reform that promotes “*protection*” of what Americans want and demand most:

**WORDS THAT WORK A LOT BETTER**

**We need to carefully address America’s healthcare challenges. Let’s find immediate, measurable ways to make it more accessible and affordable without jeopardizing quality, individual choice, or personalized care. And let’s protect the doctor-patient relationship**

Be sensitive to the anti-Washington bias ingrained in *both* parties. President Obama has already begun to employ an “*us vs. them*” context to the debate – hinting that those who *oppose* his reforms *support* the “*special interests*.” You need to be very careful to be seen as challenging the “Washington special interests” rather than defending them.

**OBAMA WORDS THAT WORK**

Now, I know people are skeptical about whether Washington can bring about this change. Our inability to reform health care in the past is just one example of how special interests have had their way, and the public interest has fallen by the wayside. And I know people are afraid we’ll draw the same old lines in the sand and give in to the same entrenched interests and arrive back at the same stalemate that we’ve been stuck in for decades.  
– President Obama

- (3) **It’s not enough to just say what you’re against. You have to tell them what you’re for.** Overt attacks against the Democratic proposals will fail if they aren’t balanced with your solutions. It’s okay (and even necessary) for your communication effort to center around why the Democratic-supported “*government takeover of healthcare*” is bad for America. But if you offer no vision for what’s *better* for America, you’ll be relegated to insignificance at best and labeled obstructionist at worst.

Later in this document I offer the best language to talk about the proper role of government, but it is important to note in this opening section that Republicans who simply run against Washington-run healthcare will lose the healthcare debate. It may be accurate, and it may be ideologically sound, but a campaign against government healthcare has left the GOP at least 20 points behind on the issue – perhaps more. There is a far better approach. Here is the perfect passage for articulating the Republican agenda of opposing the Democratic plan while remaining positive about your principles:



#### WORDS THAT WORK

Whether you call it a crisis, a problem, or a challenge is less important than tackling the real challenges to expand healthcare availability, lower costs, and ensure quality of care.

As our first priority, we need to preserve what works in America, protect the sacred doctor-patient relationship, and allow people to choose the personal care that suits their individual needs.

We should be cautious of proposed government fixes that increase taxpayer costs and shrink personal choices. And we should avoid government intrusion that decreases quality and increases bureaucracy.

We need targeted reform with measurable results that improves patient care – not a politicized, special interest-driven radical restructuring.

In the five sentences above, you have redefined the issue, personalized it, told people what you support, articulated what you're against, and offered a vision of healthcare reform that everyone – including most Democrats – can eagerly embrace.

- (4) **It's about \$\$\$: cost and profit.** Your solution HAS to address the financial component of healthcare. It's on people's minds and so it must be in your approach.

*Which of the following is the American healthcare system's single biggest problem?*

Too profit-driven	59.9%
Too bureaucratic	38.5%
Too inaccessible	20.5%
Too complicated	19.3%
Too restrictive	12.6%
Too confusing	12.4%
Too limited	10.5%
Too unsafe/intimidating/unpredictable/insensitive	Less than 10 %

- (5) **The availability and bureaucracy of healthcare causes significant frustration.** A quick scan of the polling data below shows that there is no love lost for insurance companies – primarily because of their perceived profitability, a lack of accessibility, their lack of accountability, and an excess of bureaucracy. In fact, notice how many of the top complaints involve health insurance in some way.

We suggest ratcheting up the rhetoric against insurance companies to almost the same degree as you do against Washington bureaucracy. Call the Democratic plan a “*bailout for the insurance industry*” – both because it *is*, and because it will build lasting credibility by going after the two things the American people hate most: Washington bureaucracy and insurer greed.

*Which of the following is the greatest short-coming of America's healthcare system?*

Not having health insurance	49.8%
Dealing with the insurance companies	43.0%
The lack of focus on preventative medicine	39.6%
That healthcare is not yet universal	34.5%
Inflexibility of healthcare plans	30.9%
Insurance companies' refusal to cover preexisting conditions	30.9%
Too many frivolous lawsuits	30.4%
Too much gov't regulation/intervention	11.3%
Not enough gov't regulation/oversight	5.9%
Poor quality of care	5.8%

Very few Americans are complaining about “*not enough general practitioners*,” “*not enough specialists*,” or “*too unsafe*.” In fact, only 6% say “*poor quality of care*” is one of their three top concerns. The lesson is this: people do believe that American healthcare TODAY offers good quality and the doctors we need. *Use this to your advantage.* Raise the prospect of what happens when – with all the *other* problems we have in healthcare and with everything we *already* know about government – we follow the Democratic proposal and jeopardize our quality of care and access to good doctors by putting politicians in charge of *your* healthcare.

- (6) **Your political opponents are the Democrats in Congress and the bureaucrats in Washington, not President Obama.** Every time we test language that criticized the President by name, the response was negative – even among Republicans. Americans want solutions, not politics. Here is a better approach:

**WORDS THAT WORK**

Now is not the time to play politics with healthcare. Now is the time for everyone to work together to achieve what matters most: more affordable, more accessible, more individualized and personalized healthcare.

Therefore, we ask the President to commit to the principle that the government that can't even run a company should not be running healthcare.

We ask him to commit to the principle that doctors and patients should be making healthcare decisions, not some Washington bureaucracy.

And we ask him to commit to patient-centered, not government-centered healthcare. In turn, we commit to working with him on his stated goals of increasing efficiency and lowering healthcare costs for all.

If you make this debate about Republicans vs. Obama, you lose. But if you make it about Americans vs. politicians, you win. When asked directly what would be the best reason to oppose what President Obama is trying to do regarding healthcare, Americans gave us two clear winners:

- 1) *"It could lead to the government setting standards of care, instead of doctors who really know what's best."*
- 2) *"It could lead to the government rationing care, making people stand in line and denying treatment like they do in other countries with national healthcare."*

And if you find that you must challenge the president, we suggest the following.

*"President Obama wants to put the Washington bureaucrats in charge of healthcare. I want to put the medical professionals in charge, and I want patients as an equal partner."*

## A BALANCED APPROACH: “AFFORDABILITY, QUALITY, & ACCESS”

### OVERVIEW

Cost remains king of the healthcare crisis. Americans of all political stripes and demographic backgrounds will agree that their number one complaint about healthcare today is how much they have to pay for it and how profit-driven it has become.

*However, if you ask a certain question a certain way, you change the game entirely:*

### THE QUESTION YOU MUST ASK EVERY HEALTHCARE TOWN HALL FORUM

*Would you rather...*

*“Pay the costs you pay today for the quality of care you currently receive,”*

-- OR --

*“Pay less for your care, but potentially have to wait weeks for tests and months for treatments you need.”*

Their Answer:

### OVERWHELMINGLY KEEP THE CURRENT ARRANGEMENT

Put slightly differently, here are the results from our national survey:

*And if the federal government were to offer a healthcare plan that was 20 percent less expensive than what you probably pay now and gives you many but not all the benefits and choices you have now, would you be more likely to sign up for the cheaper government plan or pay for the more expensive private plan?*

More expensive private plan	63.0%
Cheaper government plan	37.0%

Note: Even the most liberal Obama voters narrowly preferred the private plan by 51%-49%. As you move across the spectrum, preference for the more expensive private plan grows exponentially: 54%-46% for moderate Obama voters, 71%-29% for moderate McCain voters, and 86%-14% for conservative McCain voters.

Americans will prioritize cost over quality right up until the moment they realize that it's *their* quality that they are sacrificing. So put it these terms, because this is exactly the choice that the healthcare legislation is putting before Americans today. Here's the best way to do it:

**WORDS THAT WORK:**

**THE PERFECT PLATFORM FOR HEALTHCARE REFORM**

"As a matter of principle, Republicans are firmly committed to providing genuine access to affordable, quality healthcare for every American. The time has come to create a balanced, common sense approach that will guarantee that Americans can receive the care they deserve and protect the sacred doctor-patient relationship. We will oppose any politician-run system that denies you the treatments you need, when you need them.

**TALKING ABOUT AFFORDABILITY**

When it comes to healthcare costs, the biggest cost concern among all cost components is the threat of catastrophic expenses. "*The potential costs I would be responsible for in a catastrophic situation*" is the first or second biggest fear among two-thirds of Americans, followed by "*the monthly premiums that I have to pay*" at just over 55%. Co-pays, deductibles, out-of-network costs, and even prescription medications barely register.

- (7) WASTE, FRAUD, ABUSE & MISMANAGEMENT are your best targets for bringing down costs. Make no mistake: the high cost of healthcare is still public enemy number one – and the hardest for Republicans to attack. Republicans are currently blaming the lack of real competition, but in case you missed it, capitalism isn't exactly in vogue these days. Moreover, fixing the problem utilizing the tax code sounds disingenuous to some, dangerous to others, and ineffective to almost everyone. But the combination of *waste, fraud, and mismanagement* along with the consequences of the ongoing *lawsuit abuse* is both credible and accurate.

**WORDS THAT WORK**

As a matter of principle, every American should have access to affordable, quality healthcare. How? By ending all the waste, fraud, abuse, and mismanagement in the system -- and by eliminating all the unnecessary tests and procedures that are being imposed on patients by doctors practicing defensive medicine rather than preventative medicine.

We need to keep healthcare patient-centered rather than government-centered. With a greater focus on preventing waste, fraud, abuse and mismanagement, and by promoting greater access to information, prevention, and wellness for all Americans – we can do it.

- (8) **Shift the healthcare focus to “preventative treatments” and “early detection.” Tell people that the single best way to reduce healthcare costs is to promote “wellness.”**  
Wellness emerged from our research as one of the four most important core values for American healthcare. Apply the principle to lower costs and you have a solid answer for cost-conscious Americans.

#### WORDS THAT WORK

We have a system that rewards insurance companies for insuring people who are not sick and are not going to get sick, and then we penalize companies that insure people who are sick. Five diseases account for 75% of all healthcare dollars in this country – five preventable diseases. Prevention is the key for us if we want to control healthcare costs.  
– Senator Tom Coburn

#### WORDS THAT WORK

The earlier we detect, the more options we have. The better we educate, the better prevention works. And consequently, the less expensive healthcare is for the American family.

– Senator Richard Burr

#### **TALKING ABOUT QUALITY**

- (9) **Healthcare quality = “getting the treatment you need, when you need it.”** That is how Americans define quality, and so should you. The key opportunity here is that **this commitment goes beyond what the Democrats can offer.** Their plan will deny people treatments they need and make them wait to get the treatments they can actually receive. This is more than just rationing. To most Americans, rationing suggests limits or shortages – for others. But personalizing it – **“delaying your tests and denying your treatment”** -- is the concept most likely to change the most minds in your favor.

- (10) **"One-size-does-NOT-fit-all."** The idea that a "committee of Washington bureaucrats" will establish a single standard of care for all Americans and decide who gets what treatment based on how much it costs is an anathema to Americans. There are a number of ways to attack this:

- Demand the *"protection of the personal doctor-patient relationship."*
- Compare the personalized relationship with their doctor to the distant, cold, calculations of a federal medical panel.
- Utilize examples of medical breakthroughs that would be undermined or jeopardized.

#### WORDS THAT WORK

The problem with federal standardization is that one size doesn't fit all.

It's true that research can tell us what usually works best, and doctors use that research all the time. They rely on *The New England Journal of Medicine* and other studies to develop a set of best practices.

But they also know that healthcare is very personal, so doctors combine that knowledge with the essential freedom to tailor care to the individual. This has led to some exciting advances, like in genomics research, which allows doctors to prescribe medications that are designed to suit your individual body.

So one size definitely does not fit all, and we should never allow a federal panel of bureaucrats to erase these great gains in personalized care.

– Senator Jon Kyl

**FEDERAL BUREAUCRATS, WASHINGTON  
LOBBYISTS & OUT-OF-TOUCH POLITICIANS:  
REFORM AMERICA DOESN'T WANT**

*"No Washington bureaucrat or healthcare lobbyist should stand between your family and your doctor. The Democrats want to put Washington politicians in charge of YOUR healthcare. We can and must do better. Say no to a Washington takeover of healthcare and say yes to personalized patient-centered care."*

**The best anti-Democrat message**

Americans of all political stripes agree on this: the government does a poor job regulating healthcare today. Even if they disagree on *why* it does a poor job, they all share a distrust of mixing Washington with their healthcare. Consider:

*How effective is the government at regulating healthcare in the U.S.?*

Extremely Effective	0.6%
Very Effective	3.1%
Somewhat Effective	21.6%
Somewhat Ineffective	19.3%
Very Ineffective	32.4%
Extremely Ineffective	20.5%

Surprisingly, there was little difference between Democrats and Republicans; people from both parties skewed heavily towards the "ineffective" answers. This sets the context for the entire message campaign that follows.

- (11) **The arguments against the Democrats' healthcare plan must center around politicians, bureaucrats, and Washington... not the free market, tax incentives, or competition.** Simply, healthcare is too personal and vital to Americans to put a price tag on it. They don't want to hear that you're opposed to government healthcare because it's too expensive or anti-competitive. But they are deathly afraid that government will lower their quality of care – so they are extremely receptive to the anti-Washington approach.



Allow me to shout, for I fear conservatives will continue to make this mistake if someone doesn't stand up and shout out:

**Healthcare is NOT an *economic* issue. It's a *personal* issue.**

Let me be as clear and definitive as I can about this assertion. Every message by every Republican speaker that delved into an economic argument about healthcare was poorly received. Every polling question that asked about the economic (private sector, free market, competition, etc.) component of healthcare failed. Consider the following:

*Which healthcare system would you most like to see  
America adopt in the coming years?*

Patient-centered Healthcare	61.8%
Free Market Healthcare	20.3%
Private Healthcare	9.3%

If you're still not convinced, consider the following:

*Who or what would you say is most to blame  
for the high cost of healthcare today?*

Waste, fraud & abuse	47.5%
Insurance companies	42.5%
Mal-practice lawsuits	31.5%
Pharmaceutical companies	26.3%
Lack of regulation & oversight	13.8%
Lack of private competition	6.5%

Nobody is asking for "*private healthcare*" or "*free market healthcare*." There is no demand for more "*competition*." Those are economic terms. They want patient-centered healthcare – healthcare that's individualized, personalized and humanized. So if you want to demonstrate to Americans that you understand and empathize, stop bringing in economic terminology into a debate about healthcare.

- (12) **What Americans do care about: “denial” of care.** It is essential that “deny” and “denial” enter the conservative lexicon immediately because it is at the core of what scares Americans most about a government takeover of healthcare. Then add to it the source of that denial and you have the perfect anti-government, anti-Washington and anti-Democratic message:

*What would you be most concerned about  
if the government were to further regulate healthcare?*

Being denied a procedure or medication because a Washington bureaucrat says no	33.1%
Quality of care going down	24.6%
Putting special interests’ needs before the public’s needs	23.4%
Getting in the way of the doctor-patient relationship	22.3%
A longer list of regulations will lead to longer lines and longer waits for care	20.8%

Note: ALL of the more abstract or economic arguments like “inhibiting research into new cures” “forcing doctors to study regulations instead of medicine,” or “increasing the national debt” failed to make the list above. Why? Because they aren’t *personal*.

#### WORDS THAT **DO NOT** WORK

There’s another thing that Americans should be concerned about if we are going to have government run healthcare: 75% of all the innovations in healthcare in the world come out of this country.

There’s a reason for that. It’s because even though we don’t have a good market, the market we still have generates entrepreneurship, invention, advancement, and excellence in terms of new ideas and new cures and new treatments in healthcare. That will go away under government run healthcare, and with it tons of jobs.

- (13) Maximize your attacks on the Democratic plan by choosing the BEST words. For instance, calling it the “Democratic plan” isn’t your best bet; doing so makes it political in the *wrong* way. It makes the issue Republicans vs. Democrats – which doesn’t favor you. The issue needs to be Americans vs. Washington. So here are the words to use:

- “This plan puts politicians in charge of your healthcare” is even better than “bureaucrats.” Bureaucrats are scary – but at least they are professionals. But politicians? They bring *all* the wrong things to something as vital as healthcare. Both words do damage to the Democratic plan, but “politicians” does the most.
- “Washington” beats “Government.” Washington has all the problems of every other level of government, and more.
- “Washington Takeover” beats “Washington Control.” Takeovers are like coups – they both lead to dictators and a loss of freedom. What Americans fear most is that *Washington politicians will dictate what kind of care they can receive.*

- (14) Americans believe and fear that if the Washington gets involved in their healthcare, quality of care will greatly diminish. Most agree that if the government runs healthcare, it will take longer to get the care they need – if they can even get it at all. The point here is to remind people *why* they should oppose the Washington-centric, politician-based healthcare system by personalizing the harm:

*“YOUR quality of care will go down if THEY in Washington make YOUR healthcare decisions for you.”*

#### WORDS THAT WORK

This plan may sound good rhetorically, but at the end of the day, we are moving very swiftly towards a Washington-engineered, bureaucratic controlled, healthcare system. And we all know that when the government gets in the middle of anything, the quality can quickly diminish.

– Eric Cantor

Note that in this case, saying healthcare *system* is actually okay – because you are using the word as a weapon to describe what the Democrats are trying to do.

- (15) **ISSUE: Federal Standardization. Oppose this policy idea by attacking bureaucrats in the name of protecting the doctor-patient relationship.** Polling reveals two attacks that work best against the creation of a federal panel that would determine a standardized approach to medical care.

- *"It would have federal bureaucrats determining healthcare standards rather than the doctors who are actually providing the care."*
- *"It will take the power away from patients and doctors to choose what treatment the patient receives and give it to the politicians in Washington."*

#### WORDS THAT WORK

Science and research should be used to enhance and improve healthcare quality, not limit a patient's choices or options. We should encourage doctors and healthcare professionals to share best practices and learn from each other's experiences, but we need to recognize that every patient is different and every illness needs an individualized, personalized approach. Statistical analysis can help, but healthcare requires a human approach, timely decisions, and the right of patients to try an innovative approach if everything else has failed.

A federal panel that looks at healthcare from a national perspective will not be flexible enough to react to individual patient needs. The ultimate power to decide the best treatment needs to remain with the patient and the doctor.

There are specific words here that are particularly effective:

- *"Every patient is different"* because it's a truism we already believe. Similarly, *"a human approach"* puts the humanity back into healthcare.
- *"Healthcare by committee"* because it suggests an impersonal approach to important decisions;
- *"Inefficiency"* because it suggests more waste, fraud and mismanagement.
- *"Letting doctors make the decisions"* because we believe they are the most qualified, capable, and have our best interests at heart.

The following Words That Work box puts it all together:

**WORDS THAT WORK**

Federal standardization is healthcare by committee – and we don't need the inefficiencies of government committees making healthcare decisions.

Doctors are our true experts. The best system is where a patient and a doctor make the decisions about care. Doctors have to go through a pretty rigorous plan to get "Dr." next to their name, and the overwhelming majority of them are great doctors.

We don't need some committee rationing care and telling people what they can and can't have. We need to give patients the best choices of health plans and doctors and let them make their own decisions.

– Senator Jim DeMint

- (16) The cure rate differentials between the United States and countries with government-run healthcare is a powerful weapons. You need to assemble a list of the five most staggering facts that show better cure rates in the United States than our neighbors in Canada and our cousins in Great Britain. Focus on the kinds of diseases that touch the most people in the most personal ways, like cancer and heart disease. The facts *must* be accurate – because our research indicates that this kind of information really will move people. It personalizes the harm of government-run healthcare in a powerful way.

**WORDS THAT WORK**

Why is it that we have a 50% higher cure rate in cancers that anybody else in the world? And why is it if you get breast cancer in America, you are into your treatment within three weeks and in the rest of the world it's four months or six months or nine months?

– Senator Tom Coburn

## PERSONALIZE, HUMANIZE, AND EMPHASIZE THE DOCTOR-PATIENT RELATIONSHIP

### OVERVIEW

Notice how the highest priorities below are highly personalized – and none is more important than the personal doctor-patient relationship. It's not about healthcare in general. It's about MY doctor and MY choice – without any interference.

Which TWO concepts or phrases do you AGREE with the MOST?

Decisions about my healthcare should be between me and my doctor and no one else	58.3%
I should have the right to choose the healthcare that's right for me	52.5%
Healthcare dollars should follow me, the patient, not lobbyists and special interests.	41.8%
Everybody is different. My healthcare should reflect those differences.	26.5%
The right to spend my own healthcare dollars must be protected and preserved.	11.8%
My healthcare belongs to me.	9.3%

There's a message in all this: humanize your approach. Abandon and ALL references to the "healthcare system." This entire issue is about *people*. Individualize. Personalize. Humanize. Talk about *health* and *care* as distinct qualities, values, and objectives ... rather than a massive system. Americans think about their care as a highly personal issue. So should you. It's not about the *public healthcare system*. It's about personal health.

- (17) STOP talking about "consumers" and START talking about "human beings." The term consumer reeks of the economic arguments about competition, free markets, and private insurance companies – none of which gets you anywhere with persuadables. Talking about "*patients*"... or better still "*human beings*" ... casts the whole discussion in the humanized approach we strongly advocate. In fact, this is exactly what Americans *want* to be called:

Which of the following best describes the way in which you WANT to think of yourself when you use the health care system?

A Human Being	32.5%
A Patient	26.8%
A Person	14.5%
A Customer	8.8%
A Consumer	7.0%
The Boss	6.5%
A Client	4.0%

- (18) Call for a creation of a “patient-centered” approach to healthcare. What the Democrats offer is a “Washington-run healthcare system”. What you advocate is a patient centered approach. The rhetorical value of emphasizing this difference is immense.
- (19) Always place protecting the doctor-patient relationship an essential priority for any healthcare initiative. Your three most powerful phrases are:
- “No Washington politician or bureaucrat should stand between you and your doctor.”
  - “Decisions about you and your healthcare should be between you and your doctor and no one else.”
  - “Let your doctor decide.”

#### WORDS THAT WORK

Government should not stand between the patient and the physician. The government should not be able to tell you how much care you can get. Nobody in the government should tell you that you can't get a medication that's going to help prolong your life or a treatment that's going to make it easier for you. Imagine needing a new hip that will make it easier to get around, but just because you're over 75, the government denies you that surgery. We can't allow that to happen in America.

– Senator Jon Kyl

## WORDS THAT WORK

The axiom in medical schools all across this country is “if you will listen to the patient, they will tell you what is wrong with them.” We’ve had a shift in our country, as physicians have tried to keep up with the declining reimbursements: they can’t listen as well. The practice guidelines they have to follow totally disregard the *art* of medicine.

I can give you example after example of people who I’ve diagnosed with diseases that don’t fit in the guidelines. In these situations, diagnosing through the *art* of medicine has saved their life. And the guidelines would have never captured what was needed to save their life.

Under this approach we ignore 40% of the physician’s capability to actually make a difference in somebody else’s life because we force them to practice cookie cutter medicine that a bureaucrat in Washington decides on. -- Senator Tom Coburn

- (20) Personalizing the issue isn’t just about the individual. It’s even *more* about their *children and their families*. For the parents we talked to, the idea of waiting in line for the treatment they need -- or being flat-out denied that treatment -- was deeply worrying. But the idea that their *children* might not get life saving treatment in time? Unacceptable. And yet this is exactly what can happen under the Democrats’ proposed plan. Children will not be immune from waiting lines and rationing -- and parents need to be aware of this fact.

Most parents said they could tolerate waiting and enduring for certain treatments for themselves. They acknowledge that they often put off going to the doctor for their own treatments because of cost or a lack of time, but they don’t hesitate to take their children in right away. The urgency to get *the care you need when you need it* is significantly heightened when it becomes *the care your CHILD needs when he or she needs it*.

Similar feelings apply to *elderly parents* who in many ways are equally vulnerable as children. Appealing to the *family* of persuadable middle age voters must be a key part of your approach.



- (21) A perfect way to articulate this parental concern is to talk about your desire to protect your own family. It takes the discussion out of the political realm and puts it where it belongs – with the people most impacted by the policy. Below is more than just good language – it's perfect.

#### WORDS THAT WORK

Other than my freedom, the most important thing in the world to me is my family's health. And I think that's true with most people. I am going to fight as hard as I can for a system that enables me to take care of my family as best I can.

I don't want somebody telling me that I can't have good healthcare for my family. I don't want a government bureaucrat telling me that I can't have some medication or procedure that's going to prolong my life or my mother's life. And I fear that the kind of rationing that's involved in the planning that's being done right now is going to prevent me, or at least my children, from having the same kind of high quality healthcare that I've had.

– Senator Jon Kyl

## RATIONING

*"We should be very skeptical of government control of healthcare. With government run healthcare, federal bureaucrats make coverage decisions. They decide what you get for what you're charged. They also decide when you can't have certain coverage because it's too expensive or because you are disqualified based on criteria like age.*

*Other countries with government healthcare can and do deny treatment for hip replacement or knee replacement based on age. We must never get to the point in our country where some bureaucrat in Washington is telling us what we can or can't have for ourselves or our families."*

-- Senator Jon Kyl (the perfect anti-rationing language)

"Rationing" is one of the rare examples when the word itself is a less powerful concept than the meaning. Put simply, while Americans would oppose the concept (and reality) of healthcare rationing, it is the impact of rationing – the long waits for tests, the denial of care, the thousands of people fleeing to America to get the care they can't get in their own countries – this is what truly frightens the public more than the word rationing itself.

- (23) The healthcare horror stories from Canada & Co. do resonate, but you have to humanize them. It's not enough to say "we don't want a government run healthcare system like Canada or Great Britain." That assertion itself doesn't pack much of a punch. Instead, you have to attach the human element to it:

-- "With government run healthcare, politicians and bureaucrats make your healthcare decisions for you."

-- They decide if you are eligible or disqualified because a treatment is too expensive or you are too old. Imagine being turned down – and no way to appeal.

- (24) The word "rationing" does induce the negative response you want, but what you really want audiences to focus on is the "consequences of rationing." As you can see, "rationing" tests very well against the other healthcare buzzwords that frighten Americans:

*Which TWO concepts or phrases would FRIGHTEN you the most?*

Healthcare Rationing	43.9%
One-size-fits-all Healthcare	36.3%
Healthcare by Lobbyist	34.9%
Socialized Medicine	26.4%
Politicized Healthcare	25.6%
Nationalized Healthcare	17.4%
Hilary-Care	10.1%

However, when asked which of eight different consequences would “scare people more” about the future of American healthcare, “rationing came in 7<sup>th</sup> at just 14%. In first place by far was “the government will decide what treatment I can or can’t have” at 43%. Yup, that’s rationing – only by a better name.

A better approach than simply saying “*rationing*” is to personalize just what that means. The three best lines? See below.

**WORDS THAT WORK:  
THE BEST WAYS TO PERSONALIZE “RATIONING”**

**Top Ranked Answers:**

*That the government will decide what treatment I can or can’t have.*

*That it will be government-run, bureaucratic-controlled, and special interested driven.*

*That healthcare will become a “one-size-fits-all” system that takes my options and choices away.*

- (25) *“Delayed care is denied care.”* While this comes towards the end of the analysis, it may well be the single most important language finding in our work to date. Of the roughly 30 distinct messages we tested, nothing turns people against what the Democrats are trying to do more immediately and intensely than the specter of having to wait for tests and treatment thanks to a government takeover of healthcare by nameless, faceless bureaucrats. The polling data is conclusive:

*Which consequence of government involvement in healthcare would anger you more?*

Waiting weeks or even months to get the procedure or treatment you need	44.4%
The rationing of healthcare which limits your choices and options	26.3%
That America's seniors may be denied some treatments based on their age	19.1%
Interference in the private doctor-patient relationship	10.3%

The choice that *personalized* the harm the *most* is the one that *won*. And as people emphasize in dial sessions, delayed care is denied care – a genuine life and death decision. In fact, when asked which was a higher priority – spending less on healthcare or being treated in a timely fashion – timely treatment beat cost almost unanimously. Add to it the inability to appeal the government decision and you have the single strongest argument against the Democratic proposal.

**WORDS THAT WORK: PUTTING IT ALL TOGETHER**

As a matter of principle, America should strive to offer the most people the best quality, most timely healthcare in the world. What does that mean?

First, Americans should not have to wait weeks for the tests they need or months for treatment.

Second, no one should be denied the healthcare they need because of government limits, restrictions, or rationing.

Third, no government bureaucrat should interfere in the doctor-patient relationship.

And forth, we have the right to know all the information about our condition and our treatment options.

As we prepare for much needed healthcare reform, let's learn from the mistakes of Canada and Europe and not repeat them.

**THE HEALTHCARE GLOSSARY:  
WORDS THAT WORK & WHAT NOT TO SAY**

NEVER SAY	INSTEAD SAY
<p><u>Most important healthcare values.</u></p> <p>Hopeful (1.0%) Less stress (2.5%) Personal Security (5.1%) Security (6.5%) Valued (6.8%)</p>	<p><u>Most important healthcare values.</u></p> <p>Informed (23.4%) Peace of Mind (21.6%) Wellness (21.0%) In Control (20.6%) Hassle-free (15.8%)</p>
<p><u>The state of healthcare in America is...</u></p> <p>Healthcare in America a good system but still needs tweaks (15.1%)</p> <p>Healthcare in America is one of the best systems in the world and doesn't need to be changed (2.1%)</p>	<p><u>The state of healthcare in America is...</u></p> <p>Healthcare in America is seriously troubled and needs significant reform (57.5%)</p>
<p><u>Healthcare is...</u></p> <p>Too Unsafe (1.5%) Too Intimidating (1.8%) Too Unpredictable (6.8%)</p>	<p><u>Healthcare is...</u></p> <p>Too Profit-driven (59.9%) Too Bureaucratic (38.5%)</p>
<p><u>When it comes to healthcare, people should treated like...</u></p> <p>A Client (4.0%) A Consumer (7.0%) A Customer (8.8%)</p>	<p><u>When it comes to healthcare, people should treated like...</u></p> <p>A Human Being (32.5%) A Patient (26.8%)</p>
<p><u>Which of the following scares you the most?</u></p> <p>It will become unfriendly to patients like Canada and Great Britain (9%)</p> <p>Healthcare rationing (14.4%)</p>	<p><u>Which of the following scares you the most?</u></p> <p>The gov't will decide what treatment I can or can't have. (42.8%)</p> <p>It will be gov't run, bureaucratic-controlled and special interest driven (38.8%)</p>

NEVER SAY	INSTEAD SAY
<p><u>Whom do you blame for the cost of healthcare?</u></p> <p>Hospitals (4.0%) Doctors (5.0%) Lack of private competition (6.5%)</p>	<p><u>Whom do you blame for the cost of healthcare?</u></p> <p>Waste, fraud &amp; abuse (47.5%) Insurance companies (42.5%) Lawsuit abuse (31.5%)</p>
<p><u>What concerns you most about gov't regulation?</u></p> <p>It will get in the way of research &amp; development for new and advanced treatment options (7.1%)</p> <p>It will increase generational debt that our children will have to pay (8.4%)</p> <p>Doctors will have to be more concerned about learning and practicing regulations than they are about learning and practicing medicine (9.3%)</p>	<p><u>What concerns you most about gov't regulation?</u></p> <p>We will be denied a procedure or medication because a Washington bureaucrat says no (33.1%)</p> <p>The quality of care will go down (24.6%)</p> <p>It will put special interests' needs before the public's needs (23.4%)</p> <p>It will get in the way of the doctor-patient relationship and decision-making (22.3%)</p>
<p><u>What would anger you more?</u></p> <p>That America's seniors may be denied some treatments based on their age (19.1%)</p>	<p><u>What would anger you more?</u></p> <p>Waiting weeks or even months to get the procedure or treatment you need (44.4%)</p> <p>The rationing of healthcare which limits your choices and options (26.3%)</p>
<p><u>The most important part of access is...</u></p> <p>Access to non-traditional therapies, such as acupuncture, chiropractic care, etc. (9.0%)</p> <p>Access to full and complete information about your healthcare choices and options (10.4%)</p> <p>The ability to buy as much or as little coverage as you want for your own needs (10.8%)</p>	<p><u>The most important part of access is...</u></p> <p>The ability to see the doctor of your choice when you want (40.8%)</p> <p>Complete access to healthcare and medical specialists (38.9%)</p> <p>Access to the most advanced medical technology, procedures and medications (32.9%)</p>

NEVER SAY	INSTEAD SAY
<p><u>Which healthcare system do you want most?</u></p> <p>Private healthcare (9.3%) Free market healthcare (20.3%)</p>	<p><u>Which healthcare system do you want most?</u></p> <p>Patient-centered healthcare (61.8%)</p>
<p><u>Which healthcare policy do you want the most?</u></p> <p>My healthcare belongs to me (9.3%) The right to spend my own money for my own healthcare must be protected/preserved (11.8%)</p>	<p><u>Which healthcare policy do you want the most?</u></p> <p>Decisions about my healthcare should be between me and my doctor and no one else (58.3%) I should have the right to choose the healthcare that's right for me. (52.5%)</p>
<p><u>Which healthcare statement do you agree with?</u></p> <p>Government-run healthcare will be too impersonal, too bureaucratic and too uncaring (11.3%) It's my life. I want complete control over my healthcare. (13.3%)</p>	<p><u>Which healthcare statement do you agree with?</u></p> <p>Freedom and flexibility matter most. The freedom to choose the doctor, hospital and plan that's best for me, and the flexibility to change my mind and change my plan. (46.8%) Everybody is different. Healthcare should have the flexibility to fix my health problems. (30.8%)</p>
<p><u>Which healthcare "right" matters most?</u></p> <p>The right to take your healthcare coverage with you when you change jobs or move. (6.5%) The right to know what your policy does and does not cover in plain language. (11.1%)</p>	<p><u>Which healthcare "right" matters most?</u></p> <p>The right to choose the doctor, hospital and policy that fits your individual needs, not a set of government mandates. (43.5%)</p>
<p><u>Which is the best reason to oppose Obama?</u></p> <p>It will cause America to lose its position as the world leader in developing cures for diseases. (5.1%) It will put private healthcare providers out of business so that everybody will eventually be in a lower quality gov't program. (15.5%)</p>	<p><u>Which is the best reason to oppose Obama?</u></p> <p>It will lead to the gov't setting standards instead of the doctor who really knows best. (38.9%) It will lead to the gov't rationing care, making people stand in line and denying people treatment like they do elsewhere. (33.1%) There is no good reason (30.9%)</p>

Mr. LARSON. No objection. And I think that, I have a great deal of respect for Mr. Luntz as well. He and Stan Greenberg, another pollster and someone who spends an awful lot of time on the science of language, in looking at, in detail, what people should say around subject matter areas, have studied this debate. Now, this is particularly of interest to me because it passed, you know, this was recommended in 2009. And, basically, Mr. Luntz describes the 10 rules for stopping the Washington takeover of health care. And it is informative even to this debate today.

For example, one of the things he says, that arguments against the Democratic healthcare plan must center around politicians, bureaucrats, and Washington, not free markets, tax incentives, or competition, is interesting. So we will hear a lot on that. It also goes on to underscore, you simply must be vocal and passionate on the side of the reform. The status quo is no longer acceptable. If the dynamic becomes President Obama is on the side of reform and Republicans are against it, then the battle is lost and every word of this 30-page document is useless.

He goes on to say this, and this is the whole point, it is not enough just to say what you are against. You have to tell them what you are for. It is okay and even necessary for your campaign to center around why this healthcare plan is bad for America. But if you offer no vision for what is better for America, then you will be relegated to insignificance at best and labeled obstructionist at worst. What Americans are looking for in health care is what your solution is, what it will provide. The words of more access, more treatments, and more doctors are sure winners. I agree with Mr. Luntz there. And that is what this subject should be about, for us providing more access.

Madam Secretary, may I ask you, are you aware of any Republican legislative proposals that reduce the number of uninsured in this country by more than 60 million and make sure that we continue to provide all the benefits of addressing preexisting conditions, keeping your children on the plan, and making sure we focus on prevention?

Secretary BURWELL. I have not seen a proposal that does that.

Mr. LARSON. I thank you, Madam Secretary. And with that, submitting this full report for the record, I think it is worth everybody's reading. And we ought to get back to what this Committee should be doing. And that is to put Americans first and put Americans on the road to having the best access, more access, more accessibility, and more availability to health care. Thank you.

Chairman RYAN. Thank you. Time for the gentleman has expired. We are now going to enter into the two-to-one phase, two on our side, one on the Democrats side, to keep it equal. Mr. Buchanan.

Mr. BUCHANAN. Thank you, Mr. Chairman. And thank you, Madam Secretary. I appreciate you taking the time this week to give us a call, give me a call and make time for a chance to visit. My biggest concern, you made four points. At the top of the list, I was Chairman of the Florida Chamber. We had 137,000 businesses we represented. Most of them were 50 employees or less. So we have a lot of small businesses. But the biggest issue, and it is before the ACA, it goes back 15 years, is affordability. And there



was an expectation or hope that we could bend the curve on affordability. There is no question people who get the subsidies, they benefit. There are over a million in Florida. But there are many just above that line, the poverty line that don't get the subsidies.

And I want to talk on two bases first. Small business, their cost of trying to provide health care has gone up 20 to 30 percent in the last 3 or 4 years. I just talked to another person the other day who has 130 employees, and it went up 30 percent. But throughout Florida, throughout our region, we are not seeing any reduction or anything in terms of affordability from that standpoint. And many times, last week we had a town hall meeting, we had one woman, or a couple weeks ago, we had one woman who said it cost \$2,000 a month to get health care. She can get it for less. But then she has to pay some kind of a \$10,000 penalty in terms of her health care if she has a claim. What is your thought on the affordability, where we are at as it relates to people who don't get subsidies?

Secretary BURWELL. When we think about the affordability, I think we think that some progress has been made. And as you appropriately reflect, what we were seeing before is we were seeing rising deductibles and we were seeing growth. And we have seen a slowdown in the premiums. The things that we have seen slow down, is we have seen a slowdown in premium growth across a number of categories. We have also seen Medicare savings that I mentioned earlier, over \$300 billion in terms of where we are in our Medicare pricing.

The other thing that is indicative is that we have seen the per capita healthcare costs grow. As a Nation, because we have so many people retiring and coming into Medicare, the overall costs of health care are probably going to go up because we have more elderly. So we do focus deeply on that per capita—

Mr. BUCHANAN. Well let me just mention, because we are short on time, we are not seeing the discounts, per se. I would love to have you come to Florida and talk to a lot of small businesspeople. We are not seeing those. We are not seeing any kind of discounts. Most of it is 20 to 30 percent increases. In the last couple of years, they were hopeful but they are not seeing it. And then, unfortunately, a lot of the costs get pushed to the employee.

Secretary BURWELL. That is right.

Mr. BUCHANAN. And so, many of the employees that were maybe picking up a couple hundred bucks a month, now they are paying \$500 to \$600 out of their pocket. If they don't get a subsidy, many of them are being gutted. We like to talk up here a lot about the middle class. But this is, a lot of this is putting the middle class at risk in terms of healthcare costs. And what is your thoughts on that?

Secretary BURWELL. I think this is why one of the things we need to focus on now deeply is delivery system reform. And that is the idea of better, smarter, healthier. And by that, it is both about quality and I think we have to be careful when we talk about this topic because people hear it and we need to make sure we preserve quality and improve quality. Why in our country do we have some of the lowest levels of quality offerings for health care? It is about improving quality and affordability.

And right now, one of the things that we did, in January we committed that the Federal Government, that Medicare payments, 30 percent of them by 2016, 50 percent by 2018 will be based on value instead of volume as a part of working on this overall issue. Because we want to hear what you are hearing and that is important to us. And so that is a part of why we think this is so important.

Mr. BUCHANAN. Let me close with the idea, because I have a few seconds, I hope we can focus more on affordability, all of us. Because it is bankrupting a lot of people that don't get subsidies. That is the reality in Florida for small business and individuals. So the focus needs to be on affordability, finding a way to bend the curve on healthcare costs. Thank you, Madam Secretary.

Secretary BURWELL. We look forward to the opportunity to actually work with you on some of these delivery system reform issues.

Chairman RYAN. Thank you. Mr. Smith.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman. And thank you, Madam Secretary, for being here today. There is limited time and a lot to cover here. As you know, as we spoke earlier about the consumer operated and oriented plan programs which were the alternative to the public option, I would argue, perhaps, these are somewhat quasi-public options, intended to be low-cost, government-subsidized healthcare plans. And to date, I believe HHS has awarded \$2 billion in Federal loans to establish the plans.

One plan, as you know, CoOpportunity, which served over 100,000 people in Nebraska and Iowa, was seized by the State of Iowa and has since been liquidated. Folks who were on the plan have been left confused and frustrated and, again, looking for other plans. And I sent a letter on January 23 asking specific questions. I did receive a response on May 21. I would like to request unanimous consent to submit both of these letters for the record.

Chairman RYAN. Without objection.

[The submission of The Honorable Adrian Smith follows:]

ADRIAN SMITH  
THIRD DISTRICT, NEBRASKA  
<http://adriansmith.house.gov>

COMMITTEE ON WAYS AND MEANS  
SUBCOMMITTEE ON TRADE  
SUBCOMMITTEE ON HEALTH

**Congress of the United States**  
**House of Representatives**  
**Washington, DC 20515**

January 23, 2015

The Honorable Sylvia Burwell  
Secretary  
Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Dear Secretary Burwell:

I am writing in regards to CoOpportunity Health, one of twenty-three Consumer Operated and Oriented Plan Programs (CO-OP) created through the Affordable Care Act (ACA). As you know this ACA created program has awarded \$2 billion in federal loans to establish health insurance plans. Democrats included CO-OPs in the ACA as an alternative to the "public option."

One main concern raised about these CO-OPs from their inception was their financial solvency. Initial start-up funding for the CO-OPs came from low interest government loans with 5 years provided to repay. The government also provided solvency loans with fifteen year repayment periods. CoOpportunity Health, which services beneficiaries in Iowa and Nebraska, received approximately \$146 million in federal loans.

On December 23, 2014, the Iowa Insurance Commissioner submitted a petition for an Order of Rehabilitation of CoOpportunity Health. The company was taken over by the state and now faces liquidation. Approximately 120,000 of CoOpportunity Health's customers, who are mostly in Nebraska, have been strongly encouraged to switch carriers by February 15, 2015 or risk not having coverage until the next open enrollment period.

I am extremely concerned about this situation for Nebraskans needing health coverage and for the taxpayers who have seen millions of dollars lost and millions more at risk. Because of this situation, I respectfully request a response to the following questions:

1. Will the open enrollment period be extended for CoOpportunity customers who have been encouraged to shop for an alternative carrier?
2. If a CoOpportunity customer has not enrolled with another carrier by February 15, 2015 and the company is liquidated, what options will they have to obtain insurance?

416 VALLEY VIEW DRIVE  
SUITE 600  
SCOTTSBLUFF, NE 68961  
(308) 633-6333  
FAX: (308) 633-6336

2241 RAYBURN HOB  
WASHINGTON, DC 20515  
(202) 225-6435  
FAX: (202) 225-0207

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1811 WEST SECOND STREET  
SUITE 275  
GRAND PRAIRIE, NE 68803  
(308) 384-3900  
FAX: (308) 384-3902

3. Should CoOpportunity be liquidated, will they be required to pay back any of their federal loans? If so, how?
4. Is the failure of CoOpportunity in part due to CO-OPs having to set artificially low premiums to attract customers, risking insolvency with higher than expected enrollment numbers or claims?
5. How much funding was requested for assistance by CO-OPs in 2014? How much was available?
6. Are any other CO-OPs currently at risk of failure? Which ones, and what are you doing to monitor their financial stability and limit the risk to tax payers?

I recently learned a second CO-OP, Community Health Alliance, located in Tennessee has also suspended enrollment. This is an extremely unfortunate situation and I fear one more example of how the ACA is failing. Americans were promised they could keep the insurance they had and liked, now we are seeing they cannot even keep the insurance this law created. Because open enrollment is coming to an end, I respectfully request a response by February 2, 2015.

I appreciate your attention to this matter and look forward to working with you to ensure people have access to affordable health care.

Sincerely,

  
Adrian Smith  
Member of Congress

AMS/mb



THE SECRETARY OF HEALTH AND HUMAN SERVICES  
WASHINGTON, D.C. 20201

MAY 21 2015

The Honorable Adrian Smith  
U.S. House of Representatives  
Washington, DC 20515

Dear Representative Smith:

Thank you for your letter regarding your concerns about the financial solvency of CoOpportunity Health, and Consumer Operated and Oriented Plan Programs (CO-OPs) more generally.

Our first priority is to make sure that existing CoOpportunity consumers remain covered and receive the health care they need. Our first step was to help CoOpportunity enrollees understand that they must switch to another qualified health plan offered through the Marketplace to continue to receive advance premium tax credits (APTC) and cost-sharing reductions (CSRs) to help pay for their health coverage. We conducted extensive outreach to encourage enrollees of CoOpportunity to select a new plan during the open enrollment period for the 2015 plan year. Additionally, the Centers for Medicare & Medicaid Services (CMS) worked with Iowa and Nebraska Departments of Insurance (DOI) to set up a special enrollment period that ran through April 29, 2015, and allowed CoOpportunity enrollees to select any non-grandfathered individual health plan offered in Iowa or Nebraska, including those outside of the Marketplace. Throughout this special enrollment period, we conducted targeted outreach to CoOpportunity enrollees to make them aware of their options. Additionally, through the authority granted under the Affordable Care Act, CMS worked with the Marketplace plans to keep premiums affordable for Iowans and Nebraskans.

The vast majority of the CoOpportunity enrollees have selected a qualified health plan offered through the Marketplace, which allowed them to continue to receive APTC and CSRs if they were eligible. However, a small number remain enrolled in CoOpportunity with no coverage end date; their individual claims up to an aggregate of \$500,000 will be paid by the state's guaranty fund.

Concerning CO-OPs more generally, section 1322 of the Affordable Care Act established the CO-OP program to foster the creation of non-profit health insurance issuers to increase consumer choice, promote competition, and improve quality in the health insurance market. To this end, section 1322 of the Affordable Care Act provided start-up and solvency loan funding to eligible entities to help establish and maintain these new plans. Since any start-up enters a market with the inherent risks of building a business from the ground up, the funding provided by the law was intended to provide needed support while these non-profit insurance companies became stable entities.

Implementation of the CO-OP program has been a collaborative effort among CMS, state DOIs, and the new CO-OP plans. As you know, states are the primary regulator of health insurance issuers and market rules. State DOIs also oversee the financial stability of issuers and protect consumers in those markets. CMS's role is to monitor CO-OPs for compliance with their loan agreements and program policies.

Due to a number of substantial Congressional rescissions to the initial funding level for the CO-OP program, CMS did not have sufficient funds to make full awards to all CO-OPs that requested additional funds. To support the new CO-OPs, while operating within the limits of reduced funding, the availability of additional loan funding was announced through guidance issued on April 30, 2014. Awards resulting from those applications were made on September 26, 2014. Additional loan funding was announced through guidance issued on August 22, 2014, and awarded on December 15, 2014.

The applications included actuarially certified analysis and financial projections, which necessarily incorporated data regarding current and projected levels of enrollment. On September 26, 2014, CMS granted CoOpportunity Health an additional \$32,700,000 based on a request of \$32,700,000. This amount was included among the five loan requests granted by CMS, totaling \$267,895,000 in additional loan funding to existing CO-OPs to support solvency and to expand coverage into additional states. The awards included:

- The Maine Community Health Options CO-OP received \$67,630,000;
- Common Ground Healthcare Cooperative in Wisconsin received \$28,450,000;
- CoOpportunity Health in Iowa and Nebraska received \$32,700,000;
- Health Republic Insurance in New York received \$90,688,000; and
- HealthyCT in Connecticut received \$48,427,000.

Pursuant to the August 22, 2014 funding announcement, CMS received a request from CoOpportunity Health for an additional \$55,000,000 in federal loan funding. While the total funding requests received in response to the August 22, 2014 announcement exceeded the amount of funding available to make loan awards, CMS was able to award \$65,000,000 to Kentucky Health Cooperative and \$22,667,899 to Common Ground Healthcare Cooperative in Wisconsin.

CMS therefore considered a number of additional factors in making loan awards, including: the reasonableness and viability of the business plan, contingency plans, market impact, and CMS's evaluation of the CO-OP experience and performance to date.

When using these criteria to review CoOpportunity's request leading up to the December award announcement, based on the financial analyses discussed above, CMS and the external review panel concluded that the capitalization needs of CoOpportunity Health were well in excess of additional funds available, and decided not to fund this request.

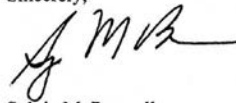
The Honorable Adrian Smith  
Page 3

With respect to your question regarding Community Health Alliance of Tennessee, this CO-OP achieved its enrollment target for 2015 much earlier during open enrollment than it anticipated, and therefore requested that its state regulator permit the CO-OP to suspend writing new business in accordance with the financial capacity exception to the federal guaranteed availability requirements. Consumers who have already purchased Community Health Alliance plans for the 2015 plan year remain enrolled and will continue to receive coverage. CMS is working closely with state officials and the CO-OP on a plan to resume new enrollment for the 2016 open enrollment period later this year.

CMS is committed to safeguarding the interests of CO-OP beneficiaries and taxpayers in our management of the CO-OP program. CMS has worked with the Nebraska and Iowa Departments of Insurance and the CO-OP to assist with the smoothest possible transition for the current members of CoOpportunity. CMS continues to conduct oversight of CO-OPs in their operational phase. CO-OPs are required to provide monthly data on enrollment, quarterly financial statements, including cash flow data, and semi-annual reporting. CMS evaluates the data to assess performance and compliance. CO-OPs also undergo site visits by CMS and submit to regular external audits. While the day-to-day oversight of insurance companies, and review and approval of their products and rates is performed by state regulators, CMS will continue to monitor each CO-OP's progress. CMS communicates weekly or more frequently with all CO-OPs regarding performance and challenges, and engages in regular communications with state regulators.

Again, thank you for your interest in this matter. I hope that you find this information helpful, and I look forward to working with you to provide accessible, affordable, and high quality health insurance options to all Americans.

Sincerely,



Sylvia M. Burwell

Mr. SMITH OF NEBRASKA. Thank you. Now, quickly some questions. CoOpportunity received approximately \$146 million in Federal loans. Will any of those dollars be paid back to the Federal Government?

Secretary BURWELL. With regard to that, that is a question I will follow up on.

Mr. SMITH OF NEBRASKA. Okay. I appreciate that.

My understanding is Iowa and Nebraska were told they could not suspend enrollment within CoOpportunity and have it remain a qualified health plan. Yet, Tennessee was later allowed to do so. Do you know why that policy changed?

Secretary BURWELL. So, per our conversation, I actually did follow up with CMS. And we didn't have the record of that request in any way coming in. So I would love for our team to be able to follow up and understand if there was miscommunication. Because, based on your comment, it was something that was concerning to me when you mentioned it. And I went and followed up. So if we can work with your staff to understand what your staff understands happened, that would be helpful.

Mr. SMITH OF NEBRASKA. Okay. Recent reports claim only one co-op didn't have an operating loss in 2014. Is that accurate?

Secretary BURWELL. I would have to go co-op by co-op.

Mr. SMITH OF NEBRASKA. Okay. Are there any concerns about possible liquidation of any of the other plans in the near future or not so distant future?

Secretary BURWELL. With regard to the co-ops, because they are all new businesses, they are start-ups, like the small businesses that we were just talking about before, you know, we are going to have failures in terms of the co-op system. That was a part of what was set up in terms of the original \$5 billion that the Congress gave, but then through sequester and other means went to \$1 billion.

So I think that there will be co-ops that will have challenges and issues. I think we are working closely with the States and State insurance departments to make sure that we get in front of them and do the kinds of things that we attempted to do in the CoOpportunity situation, which was make sure as much as possible and where it was appropriate we would engage in supporting communication, offering a special enrollment period, and working with the State insurers to use our and any authorities we had to make sure that those consumers were taken care of.

Mr. SMITH OF NEBRASKA. Okay. Will any of the consumers who lost coverage from the failed co-op be penalized by the individual mandate?

Secretary BURWELL. I do not know how many are not still in the system. But I will check and will follow up on that. My understanding is no, but I want to confirm that before—

Mr. SMITH OF NEBRASKA. In that vein, I have introduced H.R. 954, which would exempt anyone who has lost health insurance from the failed co-ops from the individual mandate. Could the Administration support that approach and that piece of legislation?

Secretary BURWELL. What I would love to do is have the opportunity to see if that is something that has already happened or not and then review the bill.



Mr. SMITH OF NEBRASKA. Okay. Now, in the bigger picture of obviously large sums of money being offered to these consumer-operated and oriented programs, what is the likelihood of those dollars being paid back?

Secretary BURWELL. With regard to the loans that have gone out?

Mr. SMITH OF NEBRASKA. Correct.

Secretary BURWELL. I think with regard to a number of the co-ops, that will happen in terms of the successful co-ops and those that are gaining traction and working. As I said, there may be some that are not. And we will get back to you on that specific question.

Mr. SMITH OF NEBRASKA. It seems to me also that the various States relevant to this issue might have a different approach for paying the claims that were submitted by—how on top of this are we? Because it is, in Nebraska, there is a fall back and, yet, it hurts more people. I apologize. My time has expired.

Secretary BURWELL. State insurance law, as you know, is a big part of how that gets determined. But we try to work with and support the States with different options.

Chairman RYAN. The time for the gentleman has expired. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman. Madam Secretary, I appreciate your reluctance to deal with hypothetical legislation that hasn't yet been written to deal with a legal decision that hasn't yet been rendered. I think that is prudent. But if this occurrence takes place by the Court, it seems to me that it would not be rocket science, as some of my colleagues have mentioned, to make relatively minor changes, to conform statutes to the intent and text of the bill and move forward. I think the Committee could take one weekend and fix it and move on.

I would like to shift gears slightly. We have had an ongoing series of conversations, it has been 6 years since a provision I authored was approved unanimously by this Committee, not just by part of it, unanimously by this Committee, dealing with end-of-life care. That provision, despite a kerfuffle and certain rhetorical flourishes, remained in the legislation. Unfortunately, it fell victim to the reconciliation process. And 6 years later, we are still trying to achieve those objectives.

Although the world has moved on, in a best-selling book by Atul Gawande, Bill Frist, and Billy Graham, all agree that this is necessary. You recently received a letter from 65 notable national organizations calling on you to have Medicare reimbursement for advanced care planning. As you know, the AMA did the coding. It is all teed up, ready to go. We thought the Administration was going to be there. And, yet, it lingers.

Published, peer-reviewed research shows that advance care planning leads to better care, better patient and family outcomes, fewer unwanted hospitalizations. The list, as you personally know, is compelling for this service. Is the Administration prepared to finally move forward and authorize it?

Secretary BURWELL. With regard to this, as I think you just mentioned, the AMA has given us the guidance and the coding. And we are in the process of reviewing that. As we indicated in a

recent rulemaking, indicated in our preamble, that is something that we are working on and reviewing the current coding.

Mr. BLUMENAUER. So it has been 6 years since Congress embraced it. The Committee approved it unanimously. We have had the research clear, the IOM dying in America. I am trying to understand what it is that is so hard to figure out whether or not this is part of the legacy of the Obama Administration, which has done some good things with health care. This seems to be a really terrific thing that is really simple, that would make a huge difference in people's lives. Private insurance is moving. What is it that is hanging this up? Why can't we just get to yes?

Secretary BURWELL. Congressman, as we have said and in our conversations and our team's conversations with you, this is an issue we are going to continue to work on. Because we want to make sure if we move that we do make the progress that we would intend to make.

Mr. BLUMENAUER. Well, I find it mystifying that the rest of the world is aligned. This is one of the few things that this Committee agreed to unanimously and that we see the difference it makes in human lives. And the Administration continues to study. And I really hope that this could be part of the legacy and that it is part of the 2016 reimbursement.

I find it frustrating beyond my ability to express. I am happy to walk, I have walked the plank for this Administration on things before. And this is really troubling.

Chairman RYAN. Thank you. Time for the gentleman has expired. Ms. Jenkins.

Ms. JENKINS. Thank you, Mr. Chairman. And thank you, Madam Secretary, for being here today. I want to echo the comments of Chairman Ryan and others on the Committee regarding the Supreme Court's decision later this month on the constitutionality of this President's healthcare law. Many Kansans are poised to lose their subsidies, which is the only thing that makes their insurance somewhat affordable. Many of my constituents will be facing increases over 30 percent next year, which, in addition to the loss of their subsidies, will make their insurance unaffordable.

And I am extremely frustrated because I had an exchange with your predecessor, Secretary Sebelius, 3 years ago on February 28, 2012, when she was a witness here before the Committee. And on that day, I expressed my concern that I did not see anything in the President's healthcare law that would allow Federal subsidies to flow through non-State-based exchanges. And I told her the Administration didn't have the authority to allow these subsidies to flow through federally-facilitated exchanges, even though the IRS at the time was telling Congress that the distinction didn't matter. Because in the law, there is no mention of the term federally-facilitated exchanges.

Even though Secretary Sebelius promised me that HHS would give me a detailed answer in writing defending her interpretation of the law, she never did. And, obviously, this issue didn't go away. And now the Supreme Court will finally weigh in on it. And I am equally concerned when you suggest that the decision before the Supreme Court is just about the subsidies. Because it isn't. We have research here from the American Action Forum which talks

about all of the positive outcomes from a decision by the Supreme Court against the Administration. Over 11 million individuals freed from the individual mandate, over 260,000 businesses freed from the employer mandate, hundreds of thousands of new jobs, 1.2 million workers added to the labor force.

With limited time, what I would like to do is turn my attention to a different topic. I have introduced legislation the past 3 years, along with my colleague, Representative Kind from Wisconsin, to repeal a provision in the healthcare law that allows folks to go to their doctor to get a note in order to purchase over-the-counter medicines with their HSAs or FSAs. And this presents patients with a maze of government redtape that they must navigate in order to purchase over-the-counter medicines, whose use saves the healthcare system money.

Additionally, it presents physicians with the bizarre scenario of unnecessarily seeing patients in order to prescribe over-the-counter pain relievers or allergy medicines. This provision makes care less affordable, more confusing, clogs doctors' offices, and makes patients less likely to use over-the-counter medicines. So, Madam Secretary, I was just wondering if you think that this is good policy and if you would support us in repealing this provision?

Secretary BURWELL. As I have articulated, one of the things we are focused on is this idea of how we can improve quality and move toward affordability. The specific piece of legislation, I am sorry, I am not familiar with, I am not familiar in terms of the issue that I think you are trying to resolve. And so this is one I would want to understand. I also do want to return to where you began.

Ms. JENKINS. Okay. But, in theory, would you support this if we could convince the Chairman to mark up the bill and move it over to the Senate? We have done that once. It has already passed with bipartisan support out of this Committee and out of the House once before.

Secretary BURWELL. Congresswoman, I would want to look at the substance of the issue before I could comment specifically on that. It is not one, I am sorry, I am familiar with.

Ms. JENKINS. Okay. All right. Thank you, I yield back.

Chairman RYAN. Thank you so much. Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman. Madam Secretary, thanks for being here. In the limited amount of time, I want to address a couple of things. In Minnesota, unlike many States, we had a pretty low uninsured rate prior to the President's healthcare law kicking into effect. You know, we had a high-risk pool for people who had preexisting conditions. It has been in existence since 1976. And it certainly wasn't perfect but it worked pretty well. That high-risk pool was closed to make way for the new State exchange program that was set up.

And now a lot of the headlines, similar to what we have heard from some of our colleagues and concerns about premiums rising, headlines over the last few weeks in Minnesota that have appeared in some of our papers, show the experience under the new exchange and the President's healthcare law has been affecting their pocketbooks, right? And so it got here, you know, eight Minnesota healthcare plans propose premium hikes from 11 to 74 percent.

We have another story here, Blue Cross and Blue Shield of Minnesota, which is the largest insurer in the individual market, which you mentioned earlier about the individual market, having the marketplace work, they announced proposed average increases of 54 percent. So certainly this is a pocketbook issue for families, for individuals, for small businesses alike. And that is why I really do hope, regardless of the court decision and how that goes, that we will be able to work with the Administration on addressing some of these affordability costs. Because I think when you are talking about premiums, this goes to the heart of affordability, as opposed to talking about, you know, per capita healthcare costs being lowered in Medicare and other areas like that.

So just some commentary there, that I hope that cooperation will be coming forward. Because we need that. We need that on a host of issues if we are going to solve some of the challenges rather than just digging in and just protecting every provision of the law as it is intact right now. And I will just mention this. You know, my interest with medical devices and medical technology, which we talked about last week, is very important in my State. And America has been a leader in developing these technologies and cures. And innovation happens at a really rapid pace. But often the regulatory process does not keep pace. And I don't think it is acceptable that American-made technology is available to citizens in other countries and it is not available to our patients here at home.

And the number one concern that I hear now from patient groups, from doctors, from investors in new med-tech companies, from manufacturers isn't the FDA. The biggest hurdle they now face is CMS and the lack of certainty surrounding coverage and coding and reimbursement. And these decisions take 2 or 3 years. And that is after the devices have already been approved. And they have already been approved. And this creates a lot of uncertainty for manufacturers and doctors that want to utilize the best available technology for their patients.

So I guess my question is, you know, what can HHS do to oversee CMS, right, which is under your authority, to make sure that we are bringing certainty to the coverage, to the coding, and to the reimbursement process for medical technology that, quite honestly, can lead to less invasive procedures and a whole host of areas of health care that can actually save money? It is definitely an impediment right now.

Secretary BURWELL. On the issue of the DME and CMS, we want to continue to work and would like to work. What we are trying to do is get that balance between making sure, we have all talked a lot about healthcare costs and growing healthcare costs, so making sure that the evidence-based decisions in terms of CMS saying they will pay for it.

FDA determines its safety. And then CMS determines if we will pay, if, you know, the benefits are such that it should be a part of a payment scheme. And we will continue to move things through quickly. But we will also continue to try to figure out the ways that we balance it. If there are places and things that people, that you have ideas about faster, that is something that we would welcome in terms of what you are hearing from the companies.

The other thing I think it is important to touch on is the premium issue. What has been in the news recently is actually a part of the ACA's effort to make sure that we have transparency and downward pressure on premiums. What has been in the news recently is any premium increase that is above 10 percent has to be reviewed. It has to be reviewed by State insurers. And so what you are seeing in the space right now in many of the articles, I am not sure of all the headlines you read, but a number of those headlines are about the fact that these are now their first submission. And last year we saw this come down because the review process works. Because there are conversations like this in public, that it creates downward pressure on those premium increases.

So it is a part of the process. And it doesn't reflect the whole base. Most insurers are saying that the majority of their people that they think will enroll next year in 2016 will have premium increases less than 10 percent. So we agree with you on the importance of that downward pressure.

Chairman RYAN. Thank you. Mr. Kind.

Mr. KIND. Thank you, Mr. Chairman. Madam Secretary, thank you for being here. Obviously, there is a lot of attention and focus on *King v. Burwell* and where that Court ultimately comes down. But in your opinion, how quickly or easily could this Congress, if it wanted to, enact legislation language to fix that overnight if it is an adverse decision from the Supreme Court?

Secretary BURWELL. I think I would hesitate to say how quickly the Congress could act.

Mr. KIND. Assuming there is a willingness.

Secretary BURWELL. But I think the question of, the issue, if it is ruled that it is about the subsidy, that that is a relatively simple solution that one can do legislatively with regard to subsidies for those that are in the Federal marketplace.

Mr. KIND. I come from a State, Wisconsin, I am very proud of, but I have never seen a greater act of fiscal malpractice by the current Governor than what has been perpetrated the last few years in his denial of the Medicaid expansion money. And his budget this year is proposing over \$300 million of cuts to our university system. But if he took the Medicaid expansion money over the next 2 years, that would bring into the State \$350 million over the next 2 years.

It just seems to be basic math. And his denial of that is not only denying people who are tough to cover to begin with, but also denying getting that money into the State where it can do some good in Wisconsin. I know you especially and HHS have been working very closely with many other Republican Governors throughout the Nation to figure out a path forward on waivers, and modifications, and other things. I would encourage you to continue those lines of communication. Because we need help in Wisconsin.

He also rejected the ability for us to form our own exchange. So we are in that box right now looking at the Supreme Court. And we could have done it the Wisconsin way and created our own health insurance exchange. He chose not to. So if we do get an adverse decision, 166,000 Wisconsinites would lose their premium tax credits. And my guess is insurance then would be rendered unaffordable to them too. So there is a lot riding on this decision.

And, hopefully, you will be able to continue to work with the States and convince them to do the right thing, especially in Wisconsin where we need help. But I also appreciate your focus, your sustained focus not only on delivery system reform, but payment reform, getting to a quality-based reimbursement system.

And I agree with my colleague, Mr. Buchanan, that more needs to be paid to cost containment. And there is some good news. You have set up the new network on quality collaboration throughout the Nation. And I hail from the land of integration, coordination, quality measurements, best practices, value-based medicine and so forth. But in your estimation, how quickly can we pivot now from fee-for-service volume to a quality-based reimbursement system?

Secretary BURWELL. When one considers that Medicare dollars are a large portion, we believe that we can move to 50 percent by 2018. The goal for 2016, being 30 percent, was where we started out. Because, obviously, I won't be here, we needed to set a goal, an achievement that would be there while we serve out. So we think that you can get to 50 percent of Medicare, at the point at which 50 percent of Medicare is based on value. And what we are trying to do is make that pass by this network. So I am meeting with the insurance, the CEOs, as well as CEOs of companies, because those are the other payers.

In New York State, Medicaid has committed to doing the same thing we are. So I think the path that we have Medicare on is close to the trajectory for the Nation in terms of moving toward more value-based——

Mr. KIND. You mentioned New York. Why do you think more States aren't taking up this challenge and converting Medicaid to that type of payment system too?

Secretary BURWELL. I think that more States are interested. And in our conversations with States, I think a number of States are not wanting to have the public commitment. And so a number of States are a part of that network.

And across all States, I can look around and have talked to Governors from a number of your States that are willing and thinking about this because they believe getting the value-based payments in Medicaid, which is a large expense for the States, is a very important thing. So I think there are more States that are interested but are not at the point of public commitment.

Mr. KIND. Thank you. Thank you, Mr. Chairman.

Chairman RYAN. Thank you. We are now going to move to 3 minutes per person in order to try to fit in as many people as possible. Mr. Marchant.

Mr. MARCHANT. Thank you, Mr. Chairman. Secretary Burwell, in the period of time in which the Affordable Care Act was being adopted, probably the most unpopular aspect of it and most debated in my district were the IPAB panels. Many names were given to those panels. And then last week, I think, I was able to cast a vote publicly that would abolish that panel. Yet, there is talk about strengthening the panel. There is talk about expanding the panel. Could you give us an explanation of what this talk is all about and what the purpose of it is?

Secretary BURWELL. With regard to the changes in our budget around IPAB, it is to strengthen and increase the Medicare sav-

ings. Because as we have all discussed, healthcare costs and the issue of healthcare costs, Medicare being a core element of that, are very important.

What we are hopeful of, and in the budget, the \$423 billion of Medicare savings that is specific in specific ways, that we can all have a discussion about, I know there are those who disagree with us about the balance we have of provider and beneficiary approaches to getting that money. But I think what we believe is that IPAB as a tool, and a tool that the Congress would still engage with, because you all would approve anything that was suggested by IPAB, Congress would have the opportunity to give it a thumbs up or a thumbs down, is an important tool to keep the pressure on all of us.

Because I think we all know, Medicare expenditure is a tough issue. It is a very tough issue for everyone in terms of, even the issues we are talking about, about payments for DME or other things, that is what drives those costs upward. And so we believe it is a tool in the toolbox. We actually, in our budget, are depending though on specific issues that the Congress could review.

And right now, IPAB would not kick in, in the President's budget it would be 2019. If you don't do any of the changes that we would do, it would be 2022. And that obviously is in another Administration.

Mr. MARCHANT. And so why has the President not named anyone to the panel?

Secretary BURWELL. With regard to the issue of panel members, it is something that we believe we should do in consultation with the Congress. And so that has been a place and I think it is because, as you were expressing, making sure if you were going to name a panel, there is appropriate congressional input.

And the other thing is at this point, now that we see the numbers, and we have made improvements in terms of the Trust Fund's viability over, you know, increased by many years, the need is not for now. And it would be in another Administration. So the question of us naming the panel now—

Mr. MARCHANT. So the President will not name a panel in his Administration?

Secretary BURWELL. At this point, with regard to where we are in the budget, we have not yet done it.

Chairman RYAN. The time of the gentleman has expired. Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman. And thank you for being here, Secretary Burwell. Mr. Chairman, I ask unanimous consent to insert this report from the Treasury Inspector for Tax Administration in the record.

Chairman RYAN. Without objection.

[The submission of The Honorable Diane Black follows:]

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**TREASURY INSPECTOR GENERAL FOR TAX ADMINISTRATION**



***Affordable Care Act: Assessment of  
Internal Revenue Service Preparation for  
Processing Premium Tax Credit Claims***

May 11, 2015

Reference Number: 2015-43-043

This report has cleared the Treasury Inspector General for Tax Administration disclosure review process and information determined to be restricted from public release has been redacted from this document.

**Redaction Legend:**

2 = Risk Circumvention of Agency Regulation or Statute

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**Phone Number / 202-622-6500**

**E-mail Address / [TIGTACommunications@tigta.treas.gov](mailto:TIGTACommunications@tigta.treas.gov)**

**Website / <http://www.treasury.gov/tigta>**





## HIGHLIGHTS

### **AFFORDABLE CARE ACT: ASSESSMENT OF INTERNAL REVENUE SERVICE PREPARATION FOR PROCESSING PREMIUM TAX CREDIT CLAIMS**

## Highlights

**Final Report issued on May 11, 2015**

Highlights of Reference Number: 2015-43-043  
to the Internal Revenue Service Director,  
Affordable Care Act Office.

#### **IMPACT ON TAXPAYERS**

The Patient Protection and Affordable Care Act created a refundable tax credit, referred to as the Premium Tax Credit (PTC), to assist individuals with the cost of their health insurance premiums. Individuals may elect to receive the PTC in advance as partial payment for their monthly premiums (referred to as the Advance Premium Tax Credit (APTC)) or receive the PTC as a lump sum credit on their annual Federal income tax return. Beginning in January 2015, individuals are required to reconcile the APTC and can claim additional PTC on their annual tax return beginning with Tax Year 2014.

#### **WHY TIGTA DID THE AUDIT**

This audit was initiated as part of TIGTA's continued coverage of the IRS's implementation of key Affordable Care Act tax provisions. The overall objective of this review was to assess the status of the IRS's preparations for verifying the accuracy of PTC claims during the 2015 Filing Season.

#### **WHAT TIGTA FOUND**

The IRS did not receive all required enrollment data from the Exchanges prior to the January 20, 2015, start of the 2015 Filing Season. For example, the Centers for Medicare and Medicaid Services indicated that it would not send approximately 1.7 million (40 percent) of the approximately 4.2 million Federal Exchange enrollment records to the IRS until mid-February. In addition, six of the 15 State Exchanges (including the District of Columbia)

had not provided enrollment data to the IRS as of January 20, 2015. The IRS indicated that data from four of the six State Exchanges would be provided in mid-February but could not provide a time frame for when the remaining two State Exchanges would provide the required enrollment data.

In response to the delays in receiving required Exchange Periodic Data submissions, the IRS developed contingency plans in an effort to improve its ability to ensure the accuracy of PTC claims. However, without the required enrollment data from the Exchanges, the IRS will be unable to ensure that all taxpayers claiming the PTC bought insurance through an Exchange as required.

In addition, TIGTA's review of the Internal Revenue Code and the Department of Health and Human Services regulations found that the guidance does not fully address repayment of the APTC received during the months in which an enrollment inconsistency is being resolved if the individual is ultimately determined to not qualify for insurance through the Exchange. Such individuals are not entitled to the PTC. Furthermore, procedures have not been established for the Exchanges to notify the IRS when an individual is determined to be ineligible subsequent to enrollment.

#### **WHAT TIGTA RECOMMENDED**

TIGTA recommended that the IRS revise computer programming business requirements to use Forms 1095-A, *Health Insurance Marketplace Statement*, in conjunction with monthly data provided by the Exchanges to verify claims for the PTC. In addition, the IRS should work with the Exchanges to establish procedures to ensure that the IRS receives notification when an individual is determined to be ineligible subsequent to enrollment.

The IRS did not agree to revise computer programming to use Forms 1095-A in conjunction with monthly data and partially agreed to work with the Exchanges to identify individuals who are found to be ineligible to use the Exchange. TIGTA's concerns with the IRS's responses to the recommendations are noted in the report.



TREASURY INSPECTOR GENERAL  
FOR TAX ADMINISTRATION

DEPARTMENT OF THE TREASURY  
WASHINGTON, D.C. 20220

May 11, 2015

**MEMORANDUM FOR DIRECTOR, AFFORDABLE CARE ACT OFFICE**

 for

**FROM:** Michael E. McKenney  
Deputy Inspector General for Audit

**SUBJECT:** Final Audit Report – Affordable Care Act: Assessment of Internal Revenue Service Preparation for Processing Premium Tax Credit Claims (Audit # 201440325)

This report presents the results of our review to assess the status of the Internal Revenue Service's preparations for verifying the accuracy of Premium Tax Credit claims during the 2015 Filing Season. The audit is included in our Fiscal Year 2015 Annual Audit Plan and addresses the major management challenge of Implementing the Affordable Care Act and Other Tax Law Changes.

Management's complete response to the draft report is included as Appendix VI.

Copies of this report are also being sent to the Internal Revenue Service managers affected by the report recommendations. If you have any questions, please contact me or Russell P. Martin, Acting Assistant Inspector General for Audit (Returns Processing and Account Services).



***Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims***

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***Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims***

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***Abbreviations***

ACA	Affordable Care Act
APTC	Advance Premium Tax Credit
CMS	Centers for Medicare and Medicaid Services
EPD	Exchange Periodic Data
FPL	Federal Poverty Line
HHS	Department of Health and Human Services
IRS	Internal Revenue Service
MEC	Minimum Essential Coverage
PTC	Premium Tax Credit
QHP	Qualified Health Plan
SLCSP	Second Lowest Cost Silver Plan



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***Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims***

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## ***Background***

The Patient Protection and Affordable Care Act (ACA)<sup>1</sup> created the Health Insurance Marketplace, also known as the Exchange. The Exchange is where individuals find information about health insurance options, purchase qualified health plans, and, if eligible, obtain help paying premiums. The ACA also created a new refundable tax credit,<sup>2</sup> the Premium Tax Credit (PTC), to assist eligible taxpayers with paying their health insurance premiums.

When enrolling in a Qualified Health Plan (QHP)<sup>3</sup> through the Exchange, eligible individuals can choose to have some or all of the PTC paid in advance to their insurance company as payment of their monthly premium (hereafter referred to as the Advance Premium Tax Credit (APTC)) or can wait to claim all of the PTC on their tax return. Individuals began using the Exchanges on October 1, 2013, to purchase health insurance for Calendar Year 2014. Figure 1 lists eligibility requirements to purchase insurance through an Exchange and to qualify for the PTC.

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<sup>1</sup> Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S. Code), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

<sup>2</sup> Refundable tax credits can be used to reduce a taxpayer's tax liability to zero. Any excess of the credit beyond the tax liability can be refunded to the taxpayer.

<sup>3</sup> A QHP is an insurance plan that is certified by the Health Insurance Exchange and provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements.



**Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims**

**Figure 1: Eligibility Requirements to Purchase Insurance  
Through an Exchange and Qualify for the PTC**

Exchange Eligibility Requirements	PTC Eligibility Requirements
<p><b>Individuals must:</b></p> <ul style="list-style-type: none"> <li>• Live in the United States.</li> <li>• Be a U.S. citizen or national or be lawfully present.</li> <li>• Not be currently incarcerated.</li> </ul>	<p><b>Individuals must:</b></p> <ul style="list-style-type: none"> <li>• Buy health insurance through the Exchange.</li> <li>• Be ineligible for insurance through an employer or government plan.</li> <li>• Be within certain income limits.<sup>4</sup></li> <li>• File a joint tax return, if married.</li> <li>• Not be claimed as a dependent on another tax return.</li> </ul>

Source: IRS.gov and Healthcare.gov.

**Health Insurance Exchange eligibility and enrollment process**

The Centers for Medicare and Medicaid Services (CMS) oversees implementation of certain ACA provisions related to the Exchanges. The CMS operates the Federal Exchange and works with States to establish State and State-partnership Exchanges, including overseeing their operations. During the Calendar Year 2014 health insurance enrollment period, 15 States (including the District of Columbia), operated their own Exchanges while the remaining 36 States partnered with the Federal Exchange. The Exchanges have sole responsibility for determining if an individual is eligible to purchase health insurance through the Exchange as well as determining the amount of the APTC they are eligible to receive. The Exchanges use a combination of Federal and State data sources to determine eligibility. The following Federal agencies provide information to the Exchanges during the enrollment and APTC eligibility process:

- The U.S. Social Security Administration verifies the applicant's Social Security Number, citizenship, wage data, and incarceration status.
- The U.S. Department of Homeland Security verifies the applicant's legal immigration status and lawful presence in the United States.

<sup>4</sup> The taxpayer's income must be at least 100 percent but not more than 400 percent of the Federal Poverty Line for the taxpayer's family size. For example, in Calendar Year 2013, this equated to \$23,550 to \$94,200 for a family of four.



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- The Internal Revenue Service (IRS) provides tax return information for applicants and their family members. For example, the Exchange will use Calendar Year 2013 tax information received from the IRS in conjunction with other income data to verify an individual's estimated Calendar Year 2015 income. The Exchange uses an individual's estimated income and family status to determine if an individual is eligible to receive an APTC.

The Exchanges can also request that the IRS provide the maximum monthly APTC an individual is entitled to receive based on his or her estimated income and family size for the upcoming tax year. However, the ACA does not require the Exchanges to use the information the IRS provides when ultimately determining the amount of the APTC an individual is entitled to receive. As a result, some Exchanges created their own APTC calculator to compute this amount.

Once the Exchange determines the amount of the APTC an individual is entitled to receive, an individual then elects the actual amount to be sent to his or her insurance provider (hereafter referred to as insurer) on a monthly basis. Individuals can elect to send all, a portion, or none of the APTC to which they are entitled. Once an individual selects his or her insurance coverage and determines the amount of the APTC to be sent to the insurer, the insurer submits the information to the CMS, which then sends a request to the U.S. Department of the Treasury Bureau of the Fiscal Service to issue monthly APTC payments to the individual's insurer. According to the IRS, almost \$11 billion in the APTCs was paid to insurers in Fiscal Year 2014.

**Reconciliation of APTC amounts received and PTC claims**

The IRS is responsible for determining the amount of the PTC a taxpayer is entitled to receive. The ACA requires all individuals for which APTC payments were made to an insurer to file a tax return to reconcile the APTC with the actual PTC they are entitled to receive based on the income and family size reported on their tax return. This reconciliation is necessary as the Exchange's computation of the APTC is based on estimates of an individual's anticipated income and family size for the upcoming calendar year. The actual amount of the PTC that taxpayers are entitled to receive is based on their actual income and family size reported on their annual tax return, which can be different from the estimates used by the Exchange to determine the allowable APTC.

Beginning in January 2015, taxpayers who purchased insurance through an Exchange are required to include Form 8962, *Premium Tax Credit (PTC)*, with their tax return to claim the PTC and reconcile any APTC payments that were made to an insurer on their behalf. Taxpayers who are entitled to more PTC than was received in advance receive the additional credit as a refund on their tax return. However, taxpayers who received more PTC in advanced payments than they were entitled to must repay the excess, subject to certain limitations, when filing their tax return. For those individuals who are assessed additional tax resulting from an overpayment, the ACA limits the amount of tax that individuals with income between 100 percent and



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400 percent of the Federal Poverty Line (FPL)<sup>5</sup> will have to repay. However, individuals whose actual income exceeds 400 percent of the FPL are not eligible to receive the PTC and are required to repay the full amount of any APTC they received. Figure 2 lists the repayment limits for individuals with household income less than 400 percent of the FPL.

**Figure 2: Limit on Repayment – Individuals Receiving Excess APTC**

Household Income Percentage of the FPL	Repayment Limit – Filing Status Single	Repayment Limit – Filing Status Other Than Single
• Less Than 200%	\$300	\$600
• 200% but Less Than 300%	\$750	\$1,500
• 300% but Less Than 400%	\$1,250	\$2,500
• 400% or More	No Limit	No Limit

Source: Treasury Regulation Section (§) 1.36B-4.

**The Exchange Periodic Data (EPD) and health insurance statements**

The ACA requires the Exchanges to provide the IRS with information regarding individuals who are enrolled by the Exchange on a monthly basis. These data are referred to as the EPD. In addition, the Exchange is also required to provide an annual summary to both the IRS and the individual detailing specific information relating to the individual's enrollment. This is referred to as Form 1095-A, *Health Insurance Marketplace Statement*. The data provided by Exchanges monthly and annually include:

- Individuals and families enrolled in a QHP through the Exchange.
- Coverage start and end dates of the QHP.
- The monthly premium amount of the QHP.
- Amount of the APTCs paid for coverage under the QHP.
- Employer-offered minimum essential coverage (MEC).

As early as 2011, the IRS began developing computer programming to use the EPD at the time tax returns with claims for the PTC are processed to primarily verify that:

- The individual purchased insurance through an Exchange.

<sup>5</sup> The FPL is a measure of income level issued annually by the Department of Health and Human Services. The FPL is used to determine eligibility for certain programs and benefits.





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- The amount of the APTC the individual received during the year is accurately reported on his or her tax return.

The ACA also requires employers and insurers to provide individuals with information related to health insurance coverage obtained outside of the Exchange. Individuals will receive a Form 1095-B, *Health Coverage*, or Form 1095-C, *Employer-Provided Health Insurance Offer and Coverage*, when they obtain insurance from a source other than an Exchange. Employers and insurers are also required to provide the Forms 1095 to the IRS. The Forms 1095 will show whether individuals were offered qualifying insurance, the individuals enrolled in health insurance coverage for the calendar year, the level of coverage, and the months for which coverage was provided. In addition, the IRS can use the Forms 1095-B and 1095-C to verify that taxpayers receiving the PTC were not eligible for insurance from their employer.

This review was performed at the IRS Headquarters in Washington, D.C., in the Affordable Care Act Office and the Affordable Care Act Program Management Office within the IRS Chief Technology Office in New Carrollton, Maryland. We also obtained information from the IRS Wage and Investment Division in Atlanta, Georgia. In addition, we obtained information from the Federal Exchange and 14 of the 15 State Exchanges.<sup>6</sup> This audit was conducted during the period of May 2014 through January 2015. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective. Detailed information on our audit objective, scope, and methodology is presented in Appendix I. Major contributors to the report are listed in Appendix II.

<sup>6</sup> See Appendix IV for a list of the Exchanges.



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***Results of Review***

***Delays in Receiving Exchange Periodic Data Increase the Risk of Not  
Detecting Erroneous Premium Tax Credit Claims at the Time Tax  
Returns Are Processed***

The IRS did not receive all required EPD submissions from the Exchanges prior to the January 20, 2015, start of the 2015 Filing Season. For example, the CMS indicated that it would not send approximately 1.7 million (40 percent) of the approximately 4.2 million Federal Exchange enrollment records to the IRS until mid-February.<sup>7</sup> In addition, six of the 15 State Exchanges had not provided enrollment data to the IRS as of January 20, 2015. The IRS indicated that data from four of the six State Exchanges would be provided in mid-February. However, the IRS has not received any indication from the remaining two State Exchanges as to when they will provide the required enrollment data. According to the IRS, it expects to continue to receive and rely on EPD submissions received after the start of the 2015 Filing Season.

Internal Revenue Code § 36B(f)(3) requires the Federal Exchange and State Exchanges to report EPD information to the IRS. Treasury Regulation § 1.36B-5, issued May 7, 2014, requires this information to be reported both monthly (by the 15th of each month) as well as annually (by January 31) to the IRS. The IRS anticipated the first EPD submission would be in June 2014 and would cover the period January 2014 through May 2014. However, the first EPD submission from an Exchange was not received until October 2014, and it contained information for only two States.

IRS management indicated that delays in the Exchanges' testing of the EPD to ensure that it conformed with CMS and IRS transmission requirements contributed to the IRS not timely receiving the required EPD. This testing helps to ensure that EPD submissions meet format and other requirements and that the Exchanges, CMS, and IRS information systems can communicate to transmit data from one system to another before the data are needed for the filing season. However, the IRS did not require the Exchanges to complete IRS testing before it would accept the EPD from the Exchanges. Regardless of whether an Exchange tested its EPD submissions with the IRS, the IRS still needs to perform checks and verifications to ensure that the data received are reliable before using it to verify PTC claims at the time tax returns are processed.

<sup>7</sup> As of January 20, 2015, the IRS had received partial data for individuals in 35 of the 36 States participating in the Federal Exchange.



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In addition, management indicated that delays in the receipt of the EPD also result from the effectuation process in which the Exchanges reconcile enrollment records with insurer policy records. This reconciliation is necessary to ensure that data for individuals who enrolled through the Exchange and paid their premiums to maintain active health care coverage were accurately reported to the IRS.

In response to the delays in receiving required EPD submissions, the IRS developed contingency plans in an effort to improve its ability to ensure the accuracy of PTC claims. These plans include a combination of at-filing (*i.e.*, when tax returns are processed) data filters and post-processing compliance activities to address those claims that cannot be verified using the EPD. However, despite efforts to mitigate the risk of issuing improper PTC payments without the EPD, the IRS will be unable to ensure that all taxpayers claiming the PTC enrolled in a QHP through an Exchange. On December 8, 2014, we alerted IRS management to our concerns regarding:

- The IRS's decision not to use Form 1095-A data as they become available, in conjunction with the EPD, to verify PTC claims at the time tax returns are processed. Original business requirements submitted to the Office of Information Technology requested that computer programming be developed to use the EPD to verify PTC claims until Form 1095-A data became available. However, in September 2014, IRS management decided to not complete the programming to use Form 1095-A data as they become available to verify PTC claims at filing and instead to rely solely on the EPD to verify PTC claims at filing.
- The IRS allowing PTC claims when it is unable to confirm insurance was purchased at an Exchange.

We recommended that the IRS:

- Revise computer programming business requirements to use Forms 1095-A as the primary third-party data to verify PTC claims at filing with the EPD used as a secondary source. For example, when a tax return is filed with a PTC claim, computer programs should match information from the tax return to the Form 1095-A data file to confirm the purchase of insurance through an Exchange. If this match does not confirm the individual purchased insurance from an Exchange, perform a secondary match to the EPD.
- Revise processes and procedures to freeze the portion of the refund attributed to the PTC when matches to both Forms 1095-A and the EPD do not confirm the individual purchased insurance through an Exchange. This process is similar to other prerefund examination and error resolution processes that the IRS uses whereby it suspends the processing of all or part of the tax return and requests additional documentation from the taxpayer. At a minimum, these processes should ensure that the taxpayer purchased insurance from an Exchange before the PTC claim is paid.



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In response, IRS management indicated that the Form 1095-A is compiled using EPD. As such, the IRS believes that using the EPD will provide the same information as taxpayers are provided on Form 1095-A that they are required to receive from an Exchange. The IRS also responded that the Form 1095-A data will be available for review once received, and the IRS will use them to review specific individual situations. For example, Forms 1095-A data will be used by compliance operations to evaluate taxpayer data sent in as a result of a compliance activity.

In addition, IRS management indicated that they will use the IRS's existing capabilities to freeze refunds to prevent erroneous refunds if the information from the EPD does not match the information on the tax return and the IRS is unable to resolve the discrepancies. While these processes should enable the IRS to verify a significant number of PTC claims to Exchange data, it should be noted that the IRS could not verify Exchange enrollment for all individuals claiming the PTC at the start of the 2015 Filing Season because of the delays in receiving these data.

We are concerned with IRS management's decision to not revise computer programming to use Form 1095-A data when verifying PTC claims. As of March 5, 2015, the IRS indicated that four of the six states for which the IRS had no EPD as of January 20, 2015, had subsequently submitted EPD and Form 1095-A data. IRS management indicated that the IRS has not been able to load the EPD submitted in January and February into its processing systems for use in verifying PTC claims. As such, the IRS still does not have Exchange enrollment data for individuals living in these four states for use in verifying PTC claims before the claims are paid. Unlike the EPD, IRS management indicated that Form 1095-A data have been made available to IRS employees for use in researching discrepancies on PTC claims. Had the IRS completed the computer programming to verify PTC claims using EPD and Form 1095-A data as planned, the IRS would be able to ensure that all individuals claiming the PTC met the primary PTC eligibility requirement to obtain a QHP through an Exchange before the claim is paid.

### **Recommendation**

**Recommendation 1:** The Director, Affordable Care Act Office, should revise computer programming business requirements to use Forms 1095-A data, in conjunction with the EPD, to verify PTC claimants enrolled in a QHP from an Exchange before tax refunds are paid.

**Management's Response:** The IRS disagreed with this recommendation. The EPD contains the same plus additional information that is not reported on Forms 1095-A, and the EPD are available earlier than the Form 1095-A data, which allows the data to be available in the return processing systems at the start of the filing season. During the processing of tax returns, the IRS uses Form 1095-A data as a secondary source in conjunction with the EPD. In addition, to mitigate any delay in receipt of the EPD, the IRS developed and implemented a strategy that included contingency plans to ensure the accuracy of PTC claims and to prevent erroneous refunds from being paid. IRS contingency plans include contacting the taxpayer to obtain additional information when the IRS cannot determine whether the taxpayer enrolled in a QHP at the Exchange.



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**Office of Audit Comment:** IRS management indicated that the EPD are available sooner than the Form 1095-A data. This is not an accurate statement. As our report details, the Federal Exchange did not provide the EPD for 1.7 million individuals, and six State Exchanges did not provide the EPD prior to the start of the 2015 Filing Season. IRS management informed us that the remaining data from the Federal Exchange and four of the six State Exchanges were not available for use in verifying tax returns until March 29, 2015, whereas the Forms 1095-A data were available to verify tax returns on February 18, 2015. In addition, while the IRS does use Form 1095-A data as a secondary source to verify PTC claims, the process is a manual process. Programming its computer system to match tax returns to Form 1095-A data when the EPD are missing or are not consistent with the tax return would improve the efficiency of the IRS's verification process and ensure that it is using its limited resources most effectively.

**Guidance Does Not Fully Address Repayment of Advance Premium  
Tax Credits Paid During an Inconsistency Period**

Our review of the Internal Revenue Code and the Department of Health and Human Services (HHS) regulations<sup>8</sup> found that the guidance does not fully address repayment of the APTC received during the months in which an enrollment inconsistency is being resolved if the individual is ultimately determined to not qualify for insurance through the Exchange. Such individuals are not entitled to the PTC. \*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\*.

During the enrollment process, the Exchanges are responsible for verifying eligibility requirements to obtain a QHP through the Exchange and receive the APTC. The ACA allows individuals 90 days to provide supporting information to the Exchange when the Exchange is unable to verify that the individual met enrollment and/or APTC requirements. Individuals whose attested information qualifies them to receive the APTC are considered conditionally eligible and can receive APTC payments during this 90-day inconsistency period. At the end of the 90-day inconsistency period, the Exchange is to make a final determination as to an individual's eligibility to use the Exchange to purchase a QHP and/or receive the APTC. \*\*2\*\*\*  
\*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\*  
\*\*2\*\*\*\*. As a result, these individuals continue to receive APTC payments until such time as the Exchange finds the individuals to be ineligible.

On December 8, 2014, we recommended that the IRS seek guidance from the IRS Office of Chief Counsel to determine whether an individual is or is not entitled to all or a portion of

<sup>8</sup> 45 C.F.R. §§155.300 – 355.



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APTC payments received during an inconsistency period when the Exchange determines that the individual is ineligible or the inconsistency was not addressed. On December 8, 2014, IRS management indicated that they would forward our concern to the IRS Office of Chief Counsel. IRS management received guidance from its Health Care Counsel which states that persons who are not lawfully present in the United States are not eligible to receive the PTC and that all APTC must be repaid. However, this guidance does not address the need for repayment of the APTC received during inconsistency periods resulting from discrepancies in other eligibility requirements.

**Recommendation**

**Recommendation 2:** The Director, Affordable Care Act Office, should work with the Exchanges to \*\*\*\*\*2\*\*\*\*\* when an individual is determined to be ineligible subsequent to enrollment.

**Management's Response:** The IRS partially agreed with this recommendation. The IRS provided instructions to the Exchanges for reporting EPD and Form 1095-A data when an individual who received the APTC is subsequently determined not to qualify for insurance through the Exchange and is therefore not entitled to the PTC. The IRS will review and update, as appropriate, current instructions for the recipients of Form 1095-A, instructions for Form 8962, Publication 974, *Premium Tax Credit (PTC)*, and IRS.gov to clarify the reconciliation requirements.

**Office of Audit Comment:** The instructions do not include a requirement for the Exchanges \*\*\*\*\*2\*\*\*\*\* who received APTC payments during an inconsistency period and the Exchange determines the individual is ineligible. \*\*\*\*\*2\*\*\*\*\*.

**Employer and Insurer Reporting Relief Increases the Risk Ineligible  
Individuals Will Erroneously Receive Premium Tax Credits**

The ACA requires the Exchanges to determine if applicants were offered health coverage by their employer. However, based on discussions with the Federal and State Exchanges, we determined that the majority of the Exchanges cannot verify most individuals' attestation that they were not offered health coverage by their employer, with the exception of those individuals who are eligible for a Government plan (such as Medicare, Medicaid, or Veterans Benefits).

Individuals are not eligible to receive the PTC if they are eligible for the MEC from an employer or government plan. Individuals are asked if their employer offered them health coverage when they apply to the Exchange to receive the APTC. The Exchanges are required to provide the applicants' response to this question along with information related to their employer to the IRS in the monthly EPD. Figure 3 shows how the Exchange application portrays this information.



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**Figure 3: Application for Health Coverage and Help Paying Costs**

2. Is anyone listed on this application offered health coverage from a job?  
Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. If yes, you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. If no, continue to Step 5.

Source: Marketplace.cms.gov.

The ACA requires employers and insurers to file paper-filed Forms 1095-B and 1095-C for insurance offered during Calendar Year 2014 with the IRS no later than February 28, 2015, and electronically filed forms no later than March 31, 2015. These forms will provide the IRS with information to identify individuals to whom employers offered health insurance and whether the insurance offered was the MEC. The IRS can use the information provided on Forms 1095-B and 1095-C to verify that individuals claiming the PTC were not eligible for coverage from an employer. However, the receipt of required insurer (Form 1095-B) and employer (Form 1095-C) information reports has been delayed.

- **Form 1095-B** is filed by the insurer to report individuals who are covered by the MEC and was originally due to individuals on or before January 31, 2015, and due to the IRS by February 28, 2015. However, on July 9, 2013, the Department of the Treasury granted insurers transition relief from the Form 1095-B filing requirement. The transition relief was intended to give insurers time to adapt their health coverage and reporting systems to comply with the ACA. Under the transition relief, the filing deadline for paper-filed Forms 1095-B was delayed from February 28, 2015, to February 29, 2016, with electronically filed Forms 1095-B delayed from March 31, 2015, to March 31, 2016.
- **Form 1095-C** is filed by employers with 50 or more employees to provide information about offers of health coverage and enrollment in health coverage for their employees. The Form 1095-C was originally due to individuals on or before January 31, 2015, and due to the IRS by February 28, 2015. The same transition relief granted to insurers was also granted to employers. Under the transition relief, the filing deadline for paper-filed Forms 1095-C was delayed from February 28, 2015, to February 29, 2016, with electronically filed Forms 1095-C delayed from March 31, 2015, to March 31, 2016.

\*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\* As we noted previously, the information provided by the Exchanges regarding an individual's eligibility for employer-sponsored coverage may not be reliable due to the Exchanges inability to verify information provided during enrollment. IRS management indicated that the IRS will match PTC claims to information provided on Forms 1095-B and 1095-C beginning with Tax Year 2015. However, because these forms will generally not be



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available until March 2016, which is after most taxpayers file their annual tax return, the match to Form 1095-B and Form 1095-C data will occur after tax return processing is completed.

**Tools Were Developed to Assist the Internal Revenue Service and  
Taxpayers in Determining the Second Lowest Cost Silver Plan  
Premium**

In order to accurately compute the PTC, the IRS and taxpayers must know the second lowest cost silver plan (SLCSP) premium cost applicable to their family size for each month of the year they receive coverage. The SLCSP refers to the level of coverage provided by a health plan. Health plans offered by the Exchange are categorized as Platinum, Gold, Silver, Bronze, or Catastrophic, depending on the share of costs the insurer covers.<sup>9</sup> The applicable SLCSP premium can change throughout the year. For example, changes in an individual's family size could affect the amount of the APTC an individual is entitled to receive in a given month. In addition, the SLCSP premium is based on the geographic location of where an individual resides. If the individual moves from one pricing location to another, the SLCSP will change and in turn affect the monthly APTC.

Exchanges should be notifying individuals at the time they enroll that they need to notify the Exchange if their circumstances change (*i.e.*, birth of a child or a change in income) throughout the year. This notification enables the Exchange to reassess an individual's eligibility to use the Exchange and adjust the amount of the APTC received, if necessary. The Exchanges are required to report the SLCSP premium to individuals and the IRS on Form 1095-A. However, if an individual does not report a change in circumstance, the amount of the SLCSP premium provided in monthly EPD data and on the Form 1095-A may not be accurate.

Form 8962 instructions caution individuals that the SLCSP premium reported on Form 1095-A may not be correct if they neglected to notify the Exchange of a change in their circumstances. Form 8962 instructions tell taxpayers to review Publication 974 for information on determining the correct premium for the applicable SLCSP. It should be noted that, as of January 26, 2015, the draft Publication 974 was not finalized and did not yet contain information that taxpayers would need to determine the correct SLCSP premium amounts.

On December 8, 2014, we notified the IRS of our concern regarding \*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\*the SLCSP premium used by the taxpayer to calculate PTC claims on the Form 8962. We also raised a concern with the burden taxpayers may experience in obtaining the correct SLCSP premium to file their PTC claim and reconcile their APTC payments. We suggested the IRS work with the Exchanges to develop a tool that taxpayers can use to determine the benchmark SLCSP premium amount needed to accurately compute the PTC for their income

<sup>9</sup> A Silver plan will provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan. This means the plan will cover about 70 percent of the costs for covered medical services.





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and family size. The IRS can also use the data made available to taxpayers by the Exchanges to verify the SLCSP premium amounts provided by taxpayers on Form 8962.

IRS management responded that the Exchanges have an option of creating a self-help tool so taxpayers can look up their SLCSP or report the applicable SLCSP by month to all enrollees on Form 1095-A. The IRS has included links on IRS.gov to the individual State Exchanges and Healthcare.gov tools that can assist taxpayers in obtaining this amount. While these tools are intended to assist individuals who were not provided their SLCSP premium amount or who did not report a change in circumstance to the Exchange, individuals can also use these tools to verify the accuracy of the SLCSP premium provided on Form 1095-A.

In our ongoing review assessing the IRS's efforts to accurately verify PTC claims during the 2015 Filing Season, we plan to further assess the IRS's ability to verify the SLCSP premium in those instances in which a taxpayer reports an SLCSP premium amount on Form 8962 that does not match EPD data or information contained on Form 1095-A.

**Additional Compliance Tools Are Needed to Prevent the Payment of  
Erroneous Premium Tax Credit Claims**

The ACA included a number of provisions that once adhered to and implemented will provide the IRS with the information it needs to effectively identify erroneous PTC claims at the time tax returns are processed. However, even though the IRS will have the data it needs to identify erroneous claims moving forward, it does not have the tools it needs to effectively prevent PTC claims from being paid. The IRS can use existing math error authority<sup>10</sup> and electronic filing reject processes to adjust PTC claims when individuals do not provide certain required information (e.g., the individual fails to attach Form 8962 when the APTC was received) or when a mathematical error on the tax return affects the accuracy of the claim.

However, the ACA did not grant the IRS the authority to systemically adjust a PTC claim when the claim is not supported by Exchange data (e.g., the Exchange data show the individual did not use the Exchange to purchase insurance). As such, the IRS must audit PTC claims that are not supported by Exchange data before it can adjust the claim. The number of PTC claims the IRS can examine is limited to available resources. The IRS Examination function plan contains 36,000 PTC audits. In addition, the IRS plans to review approximately 75,000 PTC tax returns in the Automated Questionable Credits program for Fiscal Year 2015. IRS management indicated these numbers will continually be evaluated as returns are selected for treatment and may be increased or decreased as needed.

The IRS included a legislative initiative in its budget requests for Fiscal Years 2013, 2014, and 2015 to obtain authority to disallow tax benefit claims when reliable third-party data indicate the

<sup>10</sup> Math error authority allows the IRS to systemically disallow certain taxpayer claims at the time a tax return is processed.



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claim is erroneous. This authority would enable the IRS to more effectively and efficiently identify and prevent the issuance of erroneous PTC claims before tax refunds are issued by allowing the IRS to systemically deny all PTC claims for which Exchange data show the claim is erroneous.



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**Appendix I**

***Detailed Objective, Scope, and Methodology***

The overall objective of this review was to assess the status of the IRS's preparations for verifying the accuracy of PTC claims during the 2015 Filing Season. To accomplish our objective, we:

- I. Obtained an understanding of the role of the Federal and State Exchanges<sup>1</sup> and the processes and procedures in place to ensure that individuals are eligible to use the Exchange and receive the APTC.
  - A. Obtained information from the HHS Office of Inspector General as to the role of the Federal and State Exchanges in the application processing and how the CMS will verify enrollment and eligibility.
  - B. Visited the Federal Exchange and seven State Exchanges to obtain an understanding of how the Exchanges verify enrollment and eligibility for both electronic and paper applications and the status of the Exchanges' readiness to submit monthly EPD and annual reports (Form 1095-A, *Health Insurance Marketplace Statement*) to the IRS.
  - C. Surveyed the remaining eight State Exchanges to obtain an understanding of how the Exchanges verify enrollment and eligibility for both electronic and paper applications and the status of the Exchanges' readiness to submit monthly EPD and annual reports (Forms 1095-A) to the IRS.
- II. Assessed the adequacy of the IRS's plans to obtain, validate, and use third-party data (EPD and Forms 1095-A) provided to the IRS.
  - A. Determined whether the IRS's processes ensure that all required data are included in the EPD and Forms 1095-A.
  - B. Determined whether the Exchanges will fulfill the monthly reporting requirements by submitting the EPD.
  - C. Determined whether the Exchanges are prepared to fulfill the annual reporting requirements by submitting Forms 1095-A to the IRS, identified the impact on individuals if the Exchanges are not ready to provide the Forms 1095-A, and identified any additional information taxpayers can use to claim the PTC if they do not receive a Form 1095-A.

<sup>1</sup> For the purposes of this report, the District of Columbia is included in "States" and "State Exchanges."



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- D. Determined whether the IRS adequately tested the EPD transmissions prior to the “go live” date.
- E. Identified any additional third-party data that will be available to the IRS to verify PTC claims at filing.
- III. Determined whether the IRS has adequate plans to validate the accuracy of APTC reconciliations and PTC claims at filing.
  - A. Determined whether the IRS is able to accept and accurately process returns containing PTC reporting requirements.
  - B. Determined how the IRS will confirm PTC eligibility requirements.
  - C. Obtained IRS estimates of how many taxpayers will claim the PTC during the 2015 Filing Season and staffing needs to verify tax returns with related PTC claims.
  - D. Determined how the IRS plans to identify and address potentially fraudulent requests for the PTC at filing.

**Internal controls methodology**

Internal controls relate to management’s plans, methods, and procedures used to meet their mission, goals, and objectives. Internal controls include the processes and procedures for planning, organizing, directing, and controlling program operations. They include the systems for measuring, reporting, and monitoring program performance. We determined that the following internal controls were relevant to our audit objective: the policies and procedures the Federal and State Exchanges have in place for determining if a taxpayer is eligible to use the Exchange and receive the APTC and for submitting the EPD to the IRS for processing PTC claims at filing; the IRS’s policies and procedures for developing tax forms, instructions, and publications to assist taxpayers with APTC reconciliation and PTC claims; the IRS’s policies and procedures for obtaining, validating, and using the EPD provided by the Exchanges; and the IRS’s policies and procedures for monitoring and validating the accuracy of APTC reconciliations and PTC claims at filing. We evaluated these controls by interviewing employees of Federal and State Exchanges, obtaining and reviewing the results of synthetic data testing prior to the “go live” date, interviewing IRS management, and reviewing key system documentation related to the verification and processing of APTC reconciliations and PTC claims at filing.



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**Appendix II**

***Major Contributors to This Report***

Russell P. Martin, Acting Assistant Inspector General for Audit (Returns Processing and Account Services)  
Deann L. Baiza, Director  
Sharla J. Robinson, Audit Manager  
Linna K. Hung, Lead Auditor  
Laura P. Haws, Senior Auditor  
Lance J. Welling, Senior Auditor  
Jeffrey D. Cullum, Auditor  
Nikole L. Smith, Auditor



***Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims***

**Appendix III**

***Report Distribution List***

Commissioner C  
 Office of Commissioner – Attn: Chief of Staff C  
 Deputy Commissioner for Operations Support OS  
 Deputy Commissioner for Services and Enforcement SE  
 Chief Technology Officer OS:CTO  
 Commissioner, Wage and Investment Division SE:W  
 Director, Filing and Premium Tax Credit Strategy SE:ACA  
 Director, Program Management Office SE:ACA  
 Associate Chief Information Officer, Affordable Care Act (PMO) OS:CTO:ACA  
 Director, Submission Processing, Wage and Investment Division SE:W:CAS:SP  
 Chief Counsel CC  
 National Taxpayer Advocate TA  
 Director, Office of Legislative Affairs CL:LA  
 Director, Office of Program Evaluation and Risk Analysis RAS:O  
 Office of Internal Control OS:CFO:CPIC:IC  
 Audit Liaison: Director, Affordable Care Act Office SE:ACA:ONE



**Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims**

**Appendix IV**

**Health Care Exchanges**

Thirty-six States used the Federal Exchange for eligibility and enrollment determinations during the 2014 Exchange health insurance enrollment period. Fifteen States, including the District of Columbia, operated their own Exchange. The number of States that make up the Federal Exchange and that operate their own State Exchange has changed for the 2015 enrollment period.

Federally Facilitated Exchange <sup>1</sup>			State-Based Exchanges
Alabama	Louisiana	Ohio	California
Alaska	Maine	Oklahoma	Colorado
Arizona	Michigan	Pennsylvania	Connecticut
Arkansas	Mississippi	South Carolina	District of Columbia
Delaware	Missouri	South Dakota	Hawaii
Florida	Montana	Tennessee	Kentucky
Georgia	Nebraska	Texas	Maryland
Idaho	New Hampshire	Utah	Massachusetts
Illinois	New Jersey	Virginia	Minnesota
Indiana	New Mexico	West Virginia	Nevada
Iowa	North Carolina	Wisconsin	New York
Kansas	North Dakota	Wyoming	Oregon
			Rhode Island
			Vermont
			Washington

Source: The CMS as of September 30, 2014.

<sup>1</sup> Idaho and New Mexico are in Supported State-Based Exchanges and the eligibility and enrollment process was completed by the Federally Facilitated Exchange.



**Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims**

**Appendix V**

**Overview of Exchange Periodic Data Testing Phases**

Each Exchange must complete a four-phase testing process with the IRS and the CMS before it can submit the EPD through the HHS Data Services Hub<sup>1</sup> to the IRS. An Exchange cannot advance to the next phase of testing until the results of the previous test phase are reviewed and validated. This testing helps ensure that the Exchanges' EPD are consistent with established data formats. The following table contains an overview of the testing phases the Exchanges must complete before transmitting monthly EPD to the IRS.

Testing Phase	Description
<b>Phase I</b>	State Readiness Phase – State Exchanges <sup>2</sup> test connectivity with the CMS.
<b>Phase II</b>	CMS Phase – Exchanges submit test transmissions to the HHS Data Services Hub and will receive mock responses from the Hub to ensure that the data submissions meet the required file formats and data are accurately maintained during transmissions.
	Testing Readiness Review – This review must be completed before beginning IRS testing in Phase III to ensure that the Exchange is ready to enter testing.
<b>Phase III</b>	IRS Phase – Test transmissions of various monthly report file data sets.
	Stage 1: Transmission of a single Monthly Report file generated by an Exchange with a successful response from the IRS for a single family for a single month to verify the Exchange can successfully send and receive a Monthly Report.
	Stage 2: Transmission of a Monthly Report for two coverage months to establish a baseline set of families for testing.
	Stage 3: Transmission of a Monthly Report for three coverage months including some changes in family circumstances for baseline families.
	Stage 4: Transmission of a Monthly Report for 11 coverage months with more complex changes in family circumstances for the household throughout the year.
<b>Phase IV</b>	Production Phase – Begin reporting monthly data.

Source: CMS and IRS interagency testing documents.

<sup>1</sup> The HHS maintains the Data Services Hub. The Exchanges will electronically transmit the EPD and Form 1095-A data through the Hub. No quality checks of the EPD or Form 1095-A data will be performed by the Hub.

<sup>2</sup> For the purposes of this report, the District of Columbia is included in "State Exchanges."





**Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims**

**Appendix VI**

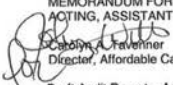
**Management's Response to the Draft Report**



DEPARTMENT OF THE TREASURY  
INTERNAL REVENUE SERVICE  
WASHINGTON, DC 20224

April 16, 2015

MEMORANDUM FOR RUSSELL P. MARTIN  
ACTING, ASSISTANT INSPECTOR GENERAL FOR AUDIT

FROM:  Douglas A. Weaver  
Director, Affordable Care Act

SUBJECT: Draft Audit Report – Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims  
(Audit 201440325)

Thank you for the opportunity to respond to the above-referenced report. We appreciate your acknowledgement of the Internal Revenue Service (IRS) efforts in administering the Premium Tax Credit (PTC) provision under Section 36B of the Internal Revenue Code. The IRS takes very seriously its role to ensure the accuracy and timely administration of the Affordable Care Act (ACA) provisions.

Section 36B was enacted as part of the Patient Protection and Affordable Care Act (PPACA) in March 2010. Beginning in 2014, the PTC helps to make health insurance more affordable for moderate-income families by providing assistance in paying for health insurance premiums. Individuals who obtain their health insurance through the Health Insurance Exchange and meet certain income requirements may be entitled to receive the PTC. Eligible individuals can elect to receive the PTC in advance as monthly payments directly to their insurance company as payment for their premium (the Advance PTC (APTC)), or wait and claim the PTC on their annual tax return. The IRS is responsible for determining the amount of PTC an individual is entitled to receive. The amount of PTC an individual is entitled to is based upon the actual income and family size reported on the annual tax return which can be different from the estimates used by the Exchange to determine allowable APTC. All individuals who elect to receive APTC must file a tax return to reconcile the advance payments.

Your review of this provision highlighted actions the IRS took to ensure accurate processing of PTC claims for tax year 2014 and acknowledged that we had contingency plans in place if Exchange Periodic Data (EPD) was not available, and we could not determine if a taxpayer had enrolled in a qualified health plan at the Exchange. The IRS not only has existing data tools and systems to address tax compliance generally, but the data from the Exchange also allows IRS to determine the taxpayer's qualification for the PTC. Prior to the start of the filing season, the IRS developed and implemented contingency plans to ensure all returns were passed through new and existing filters to detect and prevent erroneous refunds from being issued. IRS also took steps to prevent erroneous refunds when there was no evidence that a taxpayer went to the Exchange.

We are using a combination of fraud and other filters applied "at-filing" and post-processing compliance activities to address those claims that cannot be verified during the processing of the returns. In addition, the IRS is using its existing capabilities to withhold refunds and prevent erroneous refunds when the information from the EPD and Form 1095-A *Health Insurance Marketplace Statement*, does not match the information on the tax return. This gives the IRS time to correspond with the taxpayer for additional information to substantiate appropriate payments.

In addition, we appreciate your noting IRS efforts to provide taxpayers with self-assistance tools to determine their applicable Second Lowest Cost Silver Plan (SLCSP) premium amount. For example, IRS has provided links on [irs.gov](http://irs.gov) to the individual State Marketplaces and [Healthcare.gov](http://Healthcare.gov) tools. Per CMS, these tools are intended to assist individuals who were not provided their SLCSP premium amount on Form 1095-A; or who had a change in circumstances not reported to the Exchange during the coverage year.



***Affordable Care Act: Assessment of Internal Revenue Service  
Preparation for Processing Premium Tax Credit Claims***

Attached are our comments to your recommendations. If you have any questions, please contact me, or Johnny Witt, Deputy Director, Affordable Care Act Office, 202-317-3764.

Attachment

**RECOMMENDATION 1:**

The Director, Affordable Care Act Office, should revise computer programming business requirements to use Forms 1095-A in conjunction with the EPD to verify PTC claimants enrolled in a QHP from an Exchange before tax refunds are paid.

**CORRECTIVE ACTION:**

The IRS disagrees with this recommendation. The EPD contains the same plus additional information that is not reported on the Form 1095-A, and EPD is available earlier than the Form 1095-A which allows the data to be available in our return processing systems at the start of the filing season. During the processing of tax returns, the IRS uses the Form 1095-A as a secondary source in conjunction with the EPD. In addition, to mitigate any delay in receipt of EPD, the IRS developed and implemented a strategy which included contingency plans to ensure the accuracy of PTC claims and to prevent erroneous refunds from being paid. Our contingency plans include contacting the taxpayer to obtain additional information when we cannot determine whether the taxpayer enrolled in a qualified health plan at the Exchange.

**IMPLEMENTATION DATE:**

N/A

**RESPONSIBLE OFFICIAL(S):**

N/A

**RECOMMENDATION 2:**

The Director, Affordable Care Act Office, should work with the Exchanges to \*\*\*\*\*2\*\*\*\*\*  
\*\*\*\*\*2\*\*\*\*\* when an individual subsequent to enrollment is determined to be ineligible.

**CORRECTIVE ACTION:**

The IRS partially agrees with this recommendation. We provided instructions to the Exchanges for reporting EPD and Form 1095-A when an individual who received APTC is subsequently determined not to qualify for insurance through the exchange and is therefore, not entitled to the PTC. The IRS will review and update, as appropriate, current instructions for Recipient on Form 1095-A, Instructions for Form 8962, Publication 974, and irs.gov to clarify the reconciliation requirements.

**IMPLEMENTATION DATE:**

12/31/2015

**RESPONSIBLE OFFICIAL(S):**

Director, SE Affordable Care Act Office

Mrs. BLACK. The Affordable Care Act requires the exchanges to determine if applicants were offered health insurance by their employer. And if they were offered that comprehensive and affordable coverage, then those individuals are not eligible for the premium tax credit.

The Treasury Inspector General recently reported in this report, stated that neither the Federal nor the State exchanges were able to verify most individuals' attestation that they were not offered health insurance by their employer. And this is happening despite the fact that the burden and the costly reporting requirements have been placed upon our employers. What is it that HHS is doing to ensure that people who receive these credits actually legally are eligible for them?

Secretary BURWELL. So much of our, this is the APTC that you are referring to, correct?

Mrs. BLACK. That is right.

Secretary BURWELL. So with regard to that, we have a data matching process that we are doing. And it checks both immigration status, as well as income status. And that is one of the processes we are doing to make sure that people who are eligible, and we release numbers, I think you probably saw last week where over 100,000 people came off the rolls because we weren't able to verify the information.

And so that is a process, it is a process last year that took a longer period of time. And now we have improved to a 90-day period of time.

Mrs. BLACK. So let me quickly go to the other part of this which involves the IRS. Because in their application, that is the individual's application for this coverage, individuals are asked if their employer offered them health insurance. And the exchanges then are required to provide the applicant's response to this question along with the information related to the employer to the IRS in a monthly data report.

The Treasury found that neither the CMS nor many of the State exchanges were able to submit this information until well after the 2015 filing season was complete. So it appears that two of those State exchanges have still not provided that required information. This is just one example of the numerous delays from CMS when it comes to Obamacare.

So *healthcare.gov* alone took over \$1 billion to build. And yet it is apparent that these systems are still not fully functioning based on this report. So CMS undertook this mammoth project without effectively planning for the development or the oversight. And this has led to hundreds of millions of dollars, these are taxpayer dollars, that are being wasted.

So my question is, can you outline the oversight that is being conducted to ensure that the legal requirements that were set up by the law are actually met and the systems are properly developed to protect our taxpayer dollars?

Secretary BURWELL. Congresswoman, I want to check because this report, I think, as you all probably know, there have been over 50 audits of the Affordable Care Act, and I want to make sure that I am focused on the right one.

With regard to the one you are speaking about, if it is the one that I think it is, we are now in a place where the information is going from the Federal marketplace to the IRS on a monthly basis. And, you know, with all of these audits that we have received from both IGs and the GAO, we continue to work through their suggestions. And I think it is that one. But we will follow up, and if it is not the case, we are now in a monthly reporting—

Mrs. BLACK. I would really appreciate your following up. Because it is related to this report. Thank you very much.

Chairman RYAN. Thank you. Mr. Pascrell.

Mr. PASCARELL. Thanks, Mr. Chairman. And thank you, Madam Secretary. I am pleased that during your confirmation process, you expressed support for improving the safety of medical devices—a few of us have brought that up—by incorporating the FDA’s new, Unique Device Identifier, the UDI, to assist in health insurance claims. Myself and Chairman Brady have talked about this in the past.

I am asking you today, despite this widespread support, that—some in the CMS, I am putting it mildly, have resisted this important public health and patient safety effort. So we need the tools. Could you commit to work with the Committee this summer to move the policy forward?

Secretary BURWELL. I do commit. And I think we have made some progress by having FDA and CMS working together on something that will actually be more implementable. So we are working on it. And your comments and the Chairman’s comments and others are something that I recognized when I came in. And so we have been working on it, but would look forward to working with the Committee further.

Mr. PASCARELL. Thank you. Let me shift a gear a little bit here. You would think that if my colleagues on the other side cobbled together all of the time they spent trying to undermine the ACA, they would have been able to come up with an alternative to this law. They can’t find anything good to say about anything. So in this Committee alone, we have had over a dozen hearings just on issues related to the individual and employer mandate. Many Members, in good faith I am sure, brought this up today. Not to mention nearly 64 votes to repeal or undermine the ACA. Make no mistake about it. That is what this is about. And how many have we had on this elusive Republican alternative I keep hearing about? Zero.

The reality is that this Act is working. It has problems. Medicare has problems. Medicaid has problems. This is a very imperfect world, Madam Secretary. More than 10 million Americans have health coverage through the marketplaces. Eighty-five percent receive tax credits to help with the cost of coverage. So while we are waiting, I am interested in the answer to one question. Has the ACA impacted employer-sponsored insurance offering take-up rates? And does the ACA maintain the financial incentives for employers to cover and to offer coverage? That is my question.

Secretary BURWELL. This past week, we have seen a piece of work by the Urban Institute with regard to the number of employer-base. The statistics that we have, certainly CBO’s changes to its numbers, most recent changes to its ACA numbers, have to

do with the fact that they now have lowered the number of people they think will switch from the employer-based market to the marketplace.

And the Urban Institute numbers that came out this week said that there actually, on a percentage basis, has been a slight, very slight, so I would call it basically the same, no decrease, but the same. It is a slight tip up, but not numerically, I think, significant. Actual maintenance of those in the employer-based market. And so there has not been a decrease.

Mr. PASCRELL. Thank you very much, Madam Secretary. I yield back, Mr. Chairman.

Chairman RYAN. Thank you. Mr. Young.

Mr. YOUNG. Madam Secretary, thank you for being here today. The President after the G-7 summit this week said the Affordable Care Act is working. I mean, part of what is bizarre about this whole thing is we haven't had a lot of conversation about the horrors of Obamacare because none of them have come to pass. And he continued, somewhat oblivious, seemingly, to some of the things I am hearing in my own district, saying, "It hasn't had an adverse effect on people who already had health insurance."

You know, I am frustrated. And I know many Hoosiers are frustrated by some of the adverse impacts they have experienced, from diminished coverage options, to lack of accessibility in their own communities for care. A lot of people are being squeezed when they go into the exchanges with price increases on premiums. And then there are the penalties, of course, the mandate taxes that exist if they can't afford to buy health insurance.

And so I just want to humanize this a little bit for you. Because I know you are quite conversant in the statistics and the goings on of much of this healthcare law. Patsy, from my district in Jeffersonville, Indiana, her premium went up \$135 a month. She no longer has access to the family physician that has cared for her for over 25 years. Brandon, from Greenville, signed up for health care his family can't use because his family's deductibles are too high. And they make just enough that they don't qualify for assistance. Jason, from Georgetown, Indiana, had to seriously consider paying the individual mandate tax because he couldn't afford to pay the increased premiums on the exchange and didn't qualify for an exemption. Debra, from New Albany, had her monthly premium skyrocket to \$800 a month, more than her mortgage payment.

So these are just illustrative of what are larger problems in every State across the country, every congressional district. And, you know, to use the President's own words, these horror stories haven't come to pass. They are coming to pass. They are in existence right now. And I just want to know what you believe, Madam Secretary, I should tell my constituents who are trying to comply with this law? Are they merely collateral damage?

Secretary BURWELL. With regard to the examples and stories, I think they are important. And they are important to combine with the numbers in terms of what we know, that, you know, 16.4 million people in our country are no longer uninsured. And the stories, I hear those stories and respect those stories. But having traveled 22,000 miles and having been out amongst people, I heard the story from the woman in Texas who said you want to know how

to treat MS? I will tell you how to treat MS. You get sick enough to go to the emergency room, and they will treat you. And now she said I will know how.

Mr. YOUNG. So in the near term, what do we do? I am sorry for interjecting but time is short. What do we do for these Hoosiers who don't qualify for a hardship exemption?

Secretary BURWELL. I think, first of all, we need to make sure they have exhausted that remedy. And, please, we are——

Mr. YOUNG. I have made sure they have. Our office has.

Secretary BURWELL. And have worked through us. The other thing, on a number of the examples that you talked about, there is the issue of coverage to care and helping people understand how to select the right plan. The plans on the marketplace are very varied. There are many in terms of the questions of deductibility and that sort of thing.

Chairman RYAN. Thank you. Thank you. Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman. And thank you, Madam Secretary, for being here. Earlier on, you said the Administration is looking for fixes and improvements for the ACA. And I want to run through just a couple of them that I think would, it is disingenuous if you don't help make some of those fixes.

One of them deals with seasonal employees, the definition between seasonal workers and seasonal employees. I am not sure if you are aware of the conflict with that definition and some of the difficulty it is causing people in my district but also across the country.

The other is the readmission, hospital readmission program. This program was aimed at reducing unnecessary hospital readmissions called the Hospital Readmission Reduction Program. The goal of the program was really something that I would support and probably many of my colleagues support. In fact, it is estimated that nearly \$18 billion per year is wasted on avoidable readmissions of Medicare patients alone. However, the implementation of this program has been problematic, especially for those hospitals serving low-income populations.

Evidence suggests that economically disadvantaged patients, especially patients eligible for both Medicare and Medicaid, are much more likely to be readmitted within 30 days of discharge regardless of physicians' efforts to educate them on proper post-discharge care.

Do you believe the readmission program criteria can be improved by adding clear adjustments for dual eligible status as well as for other planned readmissions such as those following trauma?

Secretary BURWELL. So I agree with you on the issue of socioeconomic status and the difficulties that that can cause. We actually had a proposal and a rulemaking and a proposed rulemaking and a suggestion of how to make some of those kinds of changes. The remarks we received back were an important issue, but not the right way to go about it.

The Congress, thankfully, has also given us money to actually do this specific study of how we can work through this issue. We look forward to working with you on how we correct it because we had a proposal that others didn't. We believe it is an important issue. When I analytically understand how we can account for that but at the same time do what your beginning point was, which is we

know we have more readmissions than we should, both in terms of quality and price, I will discuss it in more detail. And so getting to that is something we would like to do. We have tried to propose it. We clearly didn't get it there.

Mr. RENACCI. Thank you. I have Ensuring Beneficiary Equity in Hospital Readmission Program, H.R. 1343, a bill that I have introduced which does have bipartisan support that I would hope the Administration would consider and support.

Also, on seasonal employees, I have STARS Act, H.R. 863, really to clarify the conflicting definitions between seasonal workers and seasonal employees, which is causing compliance problems for both employers and individuals. Interactions between seasonal, seasonality, the employer mandate and the individual mandate really create opportunities for accidental noncompliance resulting in significant tax penalties for American workers and businesses alike.

So that is another issue I would hope that we can work on. Because these are issues clarifying and fixing, as you said, fixing or improving the current law. So I thank you, and I yield back.

Chairman RYAN. The gentleman yields back. I understand that the Secretary has a hard stop. I regret the fact that not every Member will be able to ask questions of the witness at this moment. I would like to invite any Member, particularly those who did not have the opportunity, to give us—the Committee their questions in writing. We will submit them to the Secretary, to the witness, and I ask the Secretary to respond in a very timely manner to these questions from the remaining Members.

Secretary BURWELL. I would be happy to. I would be happy to and I think a number of you have my cell number, so feel free.

Chairman RYAN. With that, and to honor your time, your deadline, the hearing stands adjourned. The Committee stands adjourned.

[Whereupon, at 12:03 p.m., the Committee was adjourned.]

[Submissions for the Record follow:]

May 12, 2015

The Honorable Sylvia Mathews Burwell  
Secretary of Health and Human Services  
The Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

Dear Secretary Burwell:

The undersigned organizations would like to express our support for Medicare reimbursement of advance care planning (ACP) services and urge the Administration to start making separate payment for these codes in CY 2016.

As you may know, the American Medical Association (AMA) through the Current Procedural Terminology (CPT) Editorial Panel developed two new codes – 99497 and 99498 – that describe complex ACP. These codes were carefully considered and crafted by physician representatives of interested medical societies, as part of the AMA's CPT process. This process included the opportunity for input from caregivers and other providers.

Complex ACP involves one or more meeting(s), lasting 30 minutes or more, during which the patient's values and preferences are discussed and documented, and used to guide decisions regarding future care for serious illnesses. These consultations are voluntary on the part of the patient and the patient's preferences are paramount. The patient may choose to include his/her family, caregiver (if applicable) in the decision making process.

Published, peer-reviewed research shows that ACP leads to better care, higher patient and family satisfaction, fewer unwanted hospitalizations, and lower rates of caregiver distress, depression and lost productivity. ACP is particularly important for Medicare beneficiaries because many have multiple chronic illnesses, receive care at home from family and other caregivers, and their children and other family members are often involved in making medical decisions.

ACP has become a standard of care and consensus regarding its value is widespread. The 2014 Institute of Medicine (IOM) report "Dying in America" cited payment for ACP as one of its five key recommendations. The report states that "payers and health care delivery organizations should adopt these standards and their supporting processes, and integrate them into assessments, care plans and the reporting of health care quality." The Centers for Disease Control and Prevention (CDC) has also advocated for increased use of ACP.

Making separate payment for ACP will not only promote these services for beneficiaries, but will also allow Medicare to track how these services are being furnished and to assess their impact on the quality of life and effectiveness of care. Programs like the physician quality reporting system already ask physicians to report on whether or not they did advance care planning with patients. Payment for this service will align with these quality reporting mechanisms and promote higher quality and value in the system.



Thank you for your consideration of this request. If you would like to discuss this matter further, please contact Paul Rudolf at [paul.rudolf@aporter.com](mailto:paul.rudolf@aporter.com) or 202-942-6426.

Sincerely,

- AARP
- Alzheimer's Association
- Alzheimer's Foundation of America
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Family Physicians
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American Assisted Living Nurses Association
- American Association for Long Term Care Nursing
- American Association of Nurse Assessment Coordination
- American Cancer Society Cancer Action Network
- American College of Chest Physicians
- American College of Emergency Physicians
- American College of Osteopathic Family Physicians
- American College of Physicians
- American Federation for Aging Research
- American Geriatrics Society
- American Heart Association
- American Medical Association
- American Nurses Association
- American Osteopathic Association
- American Psychological Association
- American Psychosocial Oncology Society
- American Society for Blood and Marrow Transplantation
- American Society of Clinical Oncology
- American Thoracic Society
- Ascension Health
- Association of Directors of Geriatric Academic Programs
- Association of Oncology Social Work
- Center for Elder Care and Advanced Illness, Altarum Institute
- Center to Advance Palliative Care
- Children's National PANDA Palliative Care Program
- Coalition for Supportive Care of Kidney Patients
- Community Catalyst
- Gerontological Advanced Practice Nurses Association
- Gerontological Society of America
- Hartford Institute for Geriatric Nursing
- Health in Aging Foundation
- Hospice and Palliative Nurses Association
- LeadingAge

- LIVESTRONG Foundation
- Lung Cancer Alliance
- National Academy of Elder Law Attorneys
- National Alliance for Caregiving
- National Association for Geriatric Education
- National Association for Home Care & Hospice
- National Association of Directors of Nursing Administration in Long Term Care
- National Association of Geriatric Education Centers
- National Coalition for Hospice and Palliative Care
- National Comprehensive Cancer Network
- National Council on Aging
- National Gerontological Nurses Association
- National Hospice and Palliative Care Organization
- National Partnership for Women & Families
- Oncology Nursing Society
- Partnership for Palliative Care
- PHI (Paraprofessional Healthcare Institute)
- Providence Health & Services
- Renal Physicians Association
- Society of Hospital Medicine
- Supportive Care Coalition
- The Conversation Project
- The Pew Charitable Trusts
- Trinity Health
- Visiting Nurse Associations of America

cc: Andrew M. Slavitt, Administrator (Acting), Centers for Medicare and Medicaid Services

ACT No. 2015- 279

1 SJR79  
 2 169503-2  
 3 By Senators Melson, Hightower, McClendon, Holtzclaw,  
 4 Livingston, Glover, Williams, Scofield, Pittman, Holley,  
 5 Brewbaker, Reed, Beasley, Allen, Shelnutt, Coleman, Dial,  
 6 Waggoner, Marsh, Bussman, Orr, Chambliss, Stutts, Figures,  
 7 Whatley, Singleton, Albritton, Sanders, Dunn and Blackwell  
 8 RFD:  
 9 First Read: 21-MAY-15



SJR79

1 SJR79

2

3

4 ENROLLED, SJR79,

5

6 URGING THE UNITED STATES CONGRESS TO TAKE ALL  
7 NECESSARY MEASURES TO DELAY THE MANDATED IMPLEMENTATION OF  
8 ICD-10 AND LESSEN THE BURDEN ON ALABAMA MEDICAL PRACTICES.

8

9 WHEREAS, the Centers for Medicare and Medicaid  
10 Services (CMS) is forcing an unfunded mandate on the health  
11 care community known as the International Classification of  
12 Diseases and Related Problems, 10th Version (ICD-10) on  
13 October 1, 2015, to replace the ICD-9 System currently in use;  
14 and

15 WHEREAS, implementing ICD-10 requires physicians and  
16 their office staffs to transition to a system that makes use  
17 of 68,000 new diagnostic codes, a four-fold increase from the  
18 current ICD-9 system that hosts approximately 13,000  
19 diagnostic codes, requiring an abundance of costly and  
20 time-consuming education, software, coder training, and  
21 testing for conversion; and

22 WHEREAS, physicians, who are the actual individuals  
23 diagnosing and treating patients, widely agree that this  
24 conversion will not improve patient care and that such an  
25 overnight four-fold increase in diagnostic codes could lead to

SJR79

1 coding errors and further erode the relationships between  
2 patients and their doctors; and

3 WHEREAS, ICD-10, with its four-fold increase in  
4 diagnostic codes, could provide insurers four times as many  
5 reasons to deny necessary medical services and procedures for  
6 patients for coding errors; and

7 WHEREAS, this unfunded mandate requiring transition  
8 to ICD-10 will hit private medical practices hardest forcing a  
9 significant and unrecoverable financial investment which,  
10 depending on medical practice size, can range from \$80,000 to  
11 approximately \$2.7 million, without any assistance from the  
12 government for the mandated transition; and

13 WHEREAS, the United States is the only country  
14 adopting ICD-10 that is tying the use of a diagnostic coding  
15 system with a medical billing system; and

16 WHEREAS, the CMS has anticipated significant claims  
17 and payment disruptions to physicians and others, causing an  
18 increased amount of administrative constraints to be placed  
19 upon physicians and their office staff, ultimately hurting  
20 small business medical practices and impeding access to care  
21 for Alabama patients; and

22 WHEREAS, ICD-10 transition could not come at a worse  
23 time, as many medical practices are maximizing administrative  
24 and financial resources to comply with the challenges of the

SJR79

1 Affordable Care Act and electronic health record mandates; now  
2 therefore,

3 BE IT RESOLVED BY THE LEGISLATURE OF ALABAMA, BOTH  
4 HOUSES THEREOF CONCURRING, That we hereby urge the United  
5 States Congress to delay the implementation of ICD-10 and  
6 create an impartial committee to study the problems with  
7 implementation and develop recommendations to address the many  
8 unintended consequences that have not been adequately  
9 evaluated.

10 BE IT FURTHER RESOLVED, That if a delay of ICD-10  
11 implementation is not feasible, we urge Congress to allow a  
12 two-year grace period for ICD-10 transition, during which time  
13 physicians will not be penalized for errors, mistakes, and/or  
14 malfunctions of the system, and that physician payments will  
15 also not be withheld based on ICD-10 coding mistakes,  
16 providing for a true transition where physicians and their  
17 offices can work with ICD-10 over a period of time and not be  
18 penalized.

19 BE IT FURTHER RESOLVED, That we urge Congress to  
20 consider appropriating funds to cover the significant cost and  
21 administrative burden of this unfunded mandate on medical  
22 practices.

23 BE IT FURTHER RESOLVED, That a copy of this  
24 resolution be made available to all members of the Alabama

SJR79

1 Congressional Delegation as well as to all members of  
2 Congress.

SJR79

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*Ray Ivey*

President and Presiding Officer of the Senate

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*Tommy Blanton*

Speaker of the House of Representatives

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SJR79

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Senate 21-MAY-15

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I hereby certify that the within Senate Joint Resolution  
originated in and was adopted by the Senate.

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Patrick Harris  
Secretary

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House of Representatives

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Adopted: 26-MAY-15

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21

By: Senator Melson

APPROVED

*June 2, 2015*

TIME

*8:30 AM*

*Robert Bentley*

GOVERNOR

Alabama Secretary Of State

Act Num....: 2015-279  
Bill Num....: SJR-79

Recv'd 06/02/15 10:19amSLF



REPORT OF RULES COMMITTEE  
This resolution having been referred by  
the House to its standing committee on  
\_\_\_\_\_ RULES \_\_\_\_\_ was acted upon  
by such committee in session, and  
returned therefrom to the House with  
the recommendation that it be adopted  
Mr. [Signature] Chairman



June 9, 2015

c/o: [waysandmeans.submissions@mail.house.gov](mailto:waysandmeans.submissions@mail.house.gov)

Chairman Paul Ryan  
1233 Longworth HOB  
Washington, D.C. 20515

Ranking Member Sander Levin  
1236 Longworth HOB  
Washington, D.C. 20515

RE: Hearing June 10, 2015 on Obamacare Implementation and HHS FY16 Budget Request

Dear Chairman Ryan and Ranking Member Levin:

Please receive the attached letter for the Committee record indicating support for President Obama's fiscal year (FY) 2016 child welfare budget proposals that seek to strengthen and make targeted investments in services and supports for abused and neglected children, including those in foster care across the country.

These leading child welfare advocacy organizations: First Focus Campaign for Children, Children's Defense Fund, Child Welfare League of America, Foster Family-based Treatment Association, Generations United, National Foster Care Coalition, and Voice for Adoption, coordinated the attached letter signed by 160 children's advocacy organizations.

Respectfully submitted:

Laura W. Boyd, Ph.D.  
Foster Family-based Treatment Assoc.  
294 Union Street  
Hackensack, NJ 07601  
405-503-1123 p  
405-217-2223 f  
[lboyd@ffta.org](mailto:lboyd@ffta.org)

Shadi Houshyar  
First Focus  
1110 Vermont Ave. NW, Ste. 900  
Washington, D.C. 20005  
202-657-0678 p  
202-657-0670 f  
[ShadiH@firstfocus.net](mailto:ShadiH@firstfocus.net)

Nicole Dobbins  
Voice for Adoption  
1220 L St. NW, Ste.100-344  
Washington, D.C. 20005  
202-210-8118 p  
no fax  
[voiceforadoption@gmail.com](mailto:voiceforadoption@gmail.com)

MaryLee Allen  
Children's Defense Fund  
23 E Street NW  
Washington, D.C. 20001  
202-662-3573 p  
202-662-3550 f  
[mallen@childrensdefense.org](mailto:mallen@childrensdefense.org)

John Sciamanna  
Child Welfare League of America  
1726 M St. NW, Ste. 500  
Washington, D.C. 20036  
410-533-5857 p  
202-833-1689 f  
[john.sciamanna962@gmail.com](mailto:john.sciamanna962@gmail.com)

Jaia Lent  
Generations United  
25 E. NW, 3rd Floor  
Washington, D.C. 20001  
202-777-0115 p  
202-289-3952  
[jlent@gu.org](mailto:jlent@gu.org)

June 1, 2015

The Honorable Charles Boustany  
Chairman, Human Resources Subcommittee  
House Ways and Means Committee  
United States House of Representatives  
Washington, DC 20515

The Honorable Lloyd Doggett  
Ranking Member, Human Resources  
Subcommittee  
House Ways and Means Committee  
United States House of Representatives  
Washington, DC 20515

Dear Chairman Boustany and Ranking Member Doggett:

As representatives of organizations committed to improving the health, safety and wellbeing of our nation's children and families, we are writing to urge your support for the Administration's FY 2016 child welfare budget proposals that seek to strengthen and make targeted investments in services and supports for abused and neglected children, including those in foster care across the country.

These proposals increase investments in evidence-based prevention and post-permanency supports for children at risk of entering foster care, encourage the broader use of family-based care including kinship care rather than congregate care for children and youth, and reduce overprescribing of psychotropic medications for children and youth in foster care, all areas of interest to the Committee. As a community, we share the Administration's vision for improving the child welfare system and firmly believe that investments in such a broad array of services and programs will help us to better serve vulnerable children and families.

Historically federal child welfare dollars have favored foster care over services that support and strengthen families. Recently child welfare waiver demonstration projects have helped states shift resources and efforts away from foster care maintenance and toward prevention, intervention and treatment approaches and highlighted the benefits of such investments. The Administration's Budget builds on lessons from the waivers and reinforces the importance of increased federal support for a range of prevention and early intervention services for children, youth and families who come to the attention of the child welfare system.

Title IV-E waiver authority was an opportunity to test innovation and learn about what works best for meeting the critical needs of children and families who come to the attention of the child welfare system. However, these waivers will end in FY 2019 making it even more urgent that we invest now to sustain a range of prevention and early intervention services for children, youth and families involved in child welfare. Recognizing that waivers were meant to be temporary and

informative, we know that greater long-term federal investments are needed to keep children safe and in permanent families.

We urge your support and leadership to ensure passage and adequate funding for the child welfare system improvements outlined in the Administration's FY 2016 budget. We stand ready to work with you to enact the following critical initiatives outlined within the Administration's FY2016 Budget:

- Increase federal investments on the front-end of the child welfare service delivery system to prevent removals and foster care placements for children by allowing title IV-E funds to be used for evidence-based and evidence-informed pre-placement services for candidates for foster care and post-placement services. This includes supports and services for children who have been diverted from the child welfare system and placed with kin.
- Amend title IV-E to promote specialized family-based care as an alternative to congregate care for children with behavioral health needs and provide oversight when congregate placements are used.
- Create a five-year Administration for Children and Families/Centers for Medicare and Medicaid Services demonstration to encourage states to implement evidence-based psychosocial interventions to improve outcomes for children and youth in foster care suffering from trauma, while reducing the current over-prescription of psychotropic medications for foster children.
- Allow title IV-E agencies to use Chafee Foster Care Independence Program funds to serve young people formerly in foster care through the age of 23.
- Provide enhanced capacity building funds for Indian tribes, tribal organizations or consortia that are approved to operate a title IV-E program to assist with implementing the program.

These proposed federal child welfare investments provide an important vehicle for supporting states in efforts to improve the health and wellbeing outcomes for child welfare involved children, youth and families, some of the most vulnerable in our society.

Vulnerable children and families need your support. Thank you for your leadership on these critical reforms.

Sincerely,

A New Leaf (AZ)  
 Adolescent and Family Growth Center, Inc. (VA)  
 Adoption Rhode Island (RI)  
 Adoptions Unlimited, Inc. (IL)  
 Advocates for Children and Youth (MD)  
 Advocates for Children of New Jersey (NJ)  
 Advokids (CA)

Alabama MENTOR (AL)  
 Albany County Dept. for Children, Youth and Families (NY)  
 Aldea (CA)  
 Alexander County Department of Social Services (NC)  
 Alliance for Strong Families and Communities  
 American Academy of Pediatrics  
 American Psychological Association  
 Arizona's Children Association (AZ)  
 Arkansas Advocates for Children and Families (AR)  
 Association for Community Affiliated Plans  
 Association of Administrators of the Interstate Compact on Adoption and Medical Assistance (AAICAMA)  
 Association on American Indian Affairs  
 Attachment & Trauma Network, Inc.  
 Association of University Centers on Disabilities  
 Boys' and Girls' Haven (KY)  
 Cabarrus County DHS (NC)  
 California Alliance of Child and Family Services (CA)  
 Camelot Care Centers, Inc. (IL)  
 CASA/GAL of Eastern Montana (MT)  
 Catholic Charities Archdiocese of New Orleans (LA)  
 Cenpatico  
 Center for Adoption Support and Education  
 Center for Children Inc (MD)  
 Centerforce (CA)  
 Charlotte GAL Volunteers (NC)  
 Child and Family Policy Center (IA)  
 Child Welfare League of America  
 Children Awaiting Parents  
 Children's Action Alliance (AZ)  
 Children's Advocacy Alliance (NV)  
 Children's Defense Fund  
 Children's Home Society of America  
 Children's Home Society of North Carolina (NC)

Children's Hospital of Wisconsin (WI)  
Citizen Review Board (OR)  
Citizens' Committee for Children (NY)  
Clark County Department of Family Services (NV)  
Coconino Coalition for Children and Youth (AZ)  
Colorado Coalition of Adoptive Families (CO)  
Connecticut Voices for Children (CT)  
Consortium for Children  
County Welfare Directors Association of California (CA)  
Dave Thomas Foundation for Adoption  
Delaware Center for Justice, Inc. (DE)  
Department of Health and Mental Hygiene (MD)  
Detroit Center for Family Advocacy (MI)  
Devereux Arizona (AZ)  
Donaldson Adoption Institute  
Faith Communities Coalition on Foster Care (MI)  
Families And Children Together (ME)  
Families NOW  
Families On The Move, Inc (MI)  
Family & Youth Initiative (DC)  
Family & Youth Roundtable (CA)  
Family Care Network, Inc. (CA)  
Family Preservation Community Services  
Family Voices-NJ (NJ)  
Farmworker Association of Florida (FL)  
Field Center for Children's Policy, Practice & Research  
First Focus Campaign for Children  
Florida's Children First (FL)  
Foster Care Alumni of America, WA Chapter (WA)  
Foster Care to Success  
FosterClub  
Foster Family-based Treatment Association  
Generations United

GrandFamilies of America  
Growing Home Southeast, Inc. (SC)  
Hathaway-Sycamores Child and Family Services (CA)  
Hawaii Foster Youth Coalition (HI)  
Healthy Teen Network  
Hillsides (CA)  
Human Services Consultants (AZ)  
Institute for Child Success  
International Foster Care Alliance  
Juvenile Law Center  
Kentucky SAFE TFC (KY)  
Kentucky Youth Advocates (KY)  
KVC Health Systems  
La Familia, Inc. (NM)  
Lawyers For Children (NY)  
Lilliput Children's Services (CA)  
Lutheran Family Services of Virginia (VA)  
Lutheran Services in America  
Maine Children's Alliance (ME)  
Maple Star Colorado  
Massachusetts Law Reform Institute (MA)  
Michigan's Children (MI)  
Mid-South Health System (AR)  
Midwest Foster Care and Adoption Association (KS, MO)  
Mo. Alliance for Children & Families (MO)  
National Association for Children of Alcoholics- NACoA  
National Adoption Center  
National African American Drug Policy Coalition, Inc.  
National Association of County Human Services Administrators  
National Association of State Directors of Special Education  
National Center on Adoption and Permanency  
National Crittenton Foundation  
National Foster Care Coalition

National Foster Parent Association  
 National Indian Child Welfare Association  
 National Kinship Alliance for Children  
 National Youth Advocate Program, Inc.  
 Nebraska Appleseed (NE)  
 Nebraska Children's Home Society (NE)  
 Neighbor To Family  
 New Mexico Solutions (NM)  
 New Mexico Voices for Children (NM)  
 NJ Child Placement Advisory Council (NJ)  
 North American Council on Adoptable Children  
 Northwest Regional Council (WA)  
 NY Council on Adoptable Children (NY)  
 NYS Kinship Navigator (NY)  
 Oranewood Children's Foundation (CA)  
 Partners for Our Children (WA)  
 PATH (ID)  
 Pennsylvania Partnerships for Children (PA)  
 Pressley Ridge  
 Public Policy Center of Mississippi (MS)  
 Robert F. Kennedy Charter School (NM)  
 San Elizario High School (TX)  
 SBC Global Consultants  
 School Social Work Association of America  
 Schubert Center for Child Studies, CWRU (OH)  
 Spaulding for Children (MI)  
 St. Paul Public Schools (MN)  
 Statewide Parent Advocacy Network (NJ)  
 STOKES DSS (NC)  
 Sunlight Children's Advocacy & Rights Foundation (KS)  
 Tennessee Alliance for Children and Families (TN)  
 Tennessee Commission on Children and Youth (TN)  
 Texans Care for Children (TX)



The Center for Youth and Family Solutions (IL)  
The Children's Guild (MD)  
The Children's Partnership  
The MENTOR Network  
The Phoenix Institute (IN)  
The Village Network (OH)  
TN Alliance for Children and Families (TN)  
Tuolumne County Health Department (CA)  
University of California, Los Angeles (CA)  
University of Pennsylvania (PA)  
Vermont Kin As Parents (VT)  
Voice for Adoption  
Voices for Children in Nebraska (NE)  
Voices for Ohio's Children (OH)  
Voices for Ohio's Children (OH)  
Voices for Vermont's Children (VT)  
Voices for Virginia's Children (VA)  
Walker County Department of Family and Children Services (GA)  
Wayne State University Transition to Independence Program (MI)  
Wilkes DSS (NC)  
Youth in Transition (NC)

**William Jefferson Terry Sr, M.D.**

**As a member of the**

**American Urological Association**

**American Medical Association**

**Medical Association of the State of Alabama**

**Written Testimony for the Record**

**Before the House Committee on Ways and Means**

**Hearing Entitled**

**“Obamacare Implementation and the Department of Health and Human Services FY16 Budget request”**

**Wednesday, June 10, 2015**

Chairman Ryan, Ranking Member Levin, members of the Committee on Ways and Means, my name is Dr. William Jefferson Terry, Sr. and I am submitting this written testimony for you today as a member of the American Urological Association, the American Medical Association, the Medical Association of the State of Alabama, and as a practicing urologist in Mobile, Alabama at Urology & Oncology Specialists, PC. I have been intimately involved with organized medicine’s response to the

implementation of ICD-10 and I testified to the House Energy and Commerce Subcommittee on Health during a hearing entitled "Examining ICD-10 Implementation" on Wednesday, February 11, 2015. I am actually speaking for myself and the hundreds of thousands of physicians across this country that are working too hard taking care of their patients to realize that they could be put out of business by a coding system referred to as ICD-10 which is mandated by our government. This is a coding system designed for statistics and epidemiological data and will not help take care of patients in the doctor's office. Even though I speak for myself, my testimony represents the policy of the organizations listed on the cover sheet. I am an active member of these organizations and helped to form their policy.

I am testifying with my concern about the implementation of the ICD-10 coding system on October 1, 2015. I feel strongly that this will have serious consequences for both patients and physicians. The vast majority of physicians are in medicine to provide excellent medical care to their patients and not to become experts in medical information technology. The substantial impact of this all in one day implementation of ICD-10 with its intimate coupling to our billing system will be devastating for many physicians in small practices, rural health care centers and most likely some state Medicaid programs who have lacked the financial resources, staff expertise and time to make the necessary changes especially with regards to technology.

Physicians are the true patient advocates in the health care system, and there is serious concern for maintaining the high quality and standards of our medical profession. We feel that it is now time to forge a compromise that all should be able to accept. The American Medical Association passed new policy on June 8, 2015 which says that they now will accept implementing ICD-10 on October 1, 2015 if CMS and other payers will allow a two-year transition (grace) period during which time physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. We cannot sit idly by and watch a coding system actually destroy the practice of many physicians. For every physician that retires

early or is put out of business there will be thousands of patients looking for a new physician.

I would like to ask the members of Ways and Means to support H. R. 2652 by Congressman Gary Palmer (AL-6). It will allow for ICD-10 to be implemented as planned on October 1<sup>st</sup> and it will give physicians a two year transition (grace) period during which time they will not be penalized. This legislation also sets up a study by the GAO to be completed by April 1, 2016 to look at the entire process. The important part of this legislation is that it will not delay ICD-10 implementation and it will protect both patients and physicians. It is also important to have this two year transition period apply to all payers and not just Medicare.

I understand that H. R. 2652 will be scored as if it will cost the government money and therefore will need a pay for. It is a shame that ICD-10 will save the government money by denying care to patients because the new coding system will make doctors less efficient and see fewer patients, and also by taking away payments to physicians for care given based on coding errors and increased audits. By scoring the bill in this manner the government is admitting that the implementation of this new ICD-10 coding system will make money off the physicians of America by increasing denial of payments for services rendered, and will make money off the patients by decreasing care since the physicians will not be able to see the same number of patients. A conservative estimate is that there will be 1,500,000 fewer patient visits a day with a savings of \$30,000,000,000 per year to the government and insurance companies. It is a sad day for our profession when we have to direct all of our energies on this new coding system and away from patient care.

There are also several other very important items that CMS needs to address in order to make the ICD system function appropriately. I have summarized these on the last page of this testimony. With good communication between the CMS and the AMA all of these issues can be worked out. We must remember that the final objective is to not disrupt patient care.

Thank you for your attention to this matter. October 1, 2015 is less than 4 months away and Congress does not meet in August. Please communicate these ideas to CMS and to others in Congress. CMS should be asked to do these things with or without passage of H. R. 2652. This is truly a bipartisan issue which all can be united behind. I am also submitting as an attachment a joint resolution passed by both houses of our Alabama State Legislature and signed by Governor Robert Bentley because they understand the serious consequences of this flawed ICD-10 implementation on the citizens of Alabama.

Sincerely,

William Jefferson Terry, Sr, MD  
Urology & Oncology Specialists, PC  
101 Memorial Hospital Drive, Suite #100  
Mobile, Alabama 36608  
251-343-9090 (phone)  
251-380-1013 (fax)  
251-423-7713 (cell)  
[jeffterry@usa.net](mailto:jeffterry@usa.net)

**Brief Summary of Important Items for Successful Transition to ICD-10**

- 1) Implementation date to be October 1, 2015
- 2) Two year transition (grace) period by CMS and all payers during which time physicians will not be penalized for errors, mistakes, and/or malfunctions of the system.
- 3) Some type of study during implementation to look at unintended consequences that may develop such as: 1) impact on reporting of quality measures and subsequent penalties, 2) how ICD-10 implementation affects patients' access to care, 3) how it changes physician practice patterns, such as early retirement and leaving private practice for academic or employed settings, 4) physicians' productivity, and many others.
- 4) Payers must publish their ICD-9 to ICD-10 crosswalks so physicians can better understand the payer's rules and the ICD system does not turn into a guessing game.
- 5) ICD-10 documentation requirements should be loosened such that a competent coder can clinically interpret the medical record within reasonable parameters and assign an appropriate and defensible code thus preventing a payer or Recovery Auditor from denying payment when the circumstances are obvious.
- 6) Future meetings of the Clinical Coding Advisory Committee should be made public.
- 7) Add a 5<sup>th</sup> "Cooperating Party" to consist of physicians appointed by the AMA with equal power of the current four Cooperating Parties (CMS, CDC, AHIMA, AHA) in the planning, interpretation and deployment of present and future ICD coding systems.
- 8) Work with a designated group of individuals set up by the AMA to further develop this transition plan, further improve the ICD system, and communicate with American medicine the best way to take care of our patients in this new environment.

