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112TH CONGRESS
1st Session
HOUSE OF REPRESENTATIVES
REPORT
112–65

TO REPEAL MANDATORY FUNDING PROVIDED TO STATES IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES

APRIL 27, 2011.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

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

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 1213]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 1213) to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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99–006

PURPOSE AND SUMMARY

H.R. 1213, a bill to repeal the mandatory funding provided to States to establish American Health Benefits Exchanges in the Prevention and Public Health Fund in the Patient Protection and Affordable Care Act (PPACA)(Public Law No. 111–148), was introduced on March 29, 2011, by Rep. Fred Upton (R–MI), and was referred to the Committee on Energy and Commerce.

The goal of H.R. 1213 is to reduce federal spending, deficits, and debt by repealing mandatory programs with limited Congressional oversight.

BACKGROUND AND NEED FOR LEGISLATION

Section 1311(a) of PPACA provides the Secretary of Health and Human Services (HHS) a direct appropriation of such sums as necessary for grants to states to establish exchanges and facilitate the purchase of qualified health plans. The size of the direct appropriation is solely determined by the Secretary. The Secretary can determine the amount of spending and spend the funds without further Congressional action. The proposed legislation would strike the unlimited direct appropriation and rescind any unobligated funds.

The Congressional Research Service's (CRS) American Law Division confirmed these facts in a February 7, 2011 memo, stating that, "the total amount of money the Secretary may expend for grants to the states under this section is indefinite." CRS further stated that, "This section thus comprises both an authorization and an appropriation of federal funds and as such, it does not require any further congressional action to constitute an effective appropriation."

Section 1311(a) funds could be used by states for activities related to developing state insurance exchanges which could include hiring and retaining hundreds of employees to establish their state Exchanges, such as brokers, advertisers, and customer service agents. Grants under this language can be used to "facilitate enrollment" into exchange plans. However, this term is undefined in the statute and could allow the funds to go towards any activity the Secretary determines could "facilitate" enrollment. The vague definition of "facilitate" is especially troubling in light of the unlimited appropriation provided to the Secretary.

The unlimited appropriation made available under Section 1311(a) also comes at a time when the growth in federal spending, particularly health care spending, has fueled mounting deficits and debt. The President's Budget calls for $3.8 trillion in federal spending for FY 2011. These spending levels represent 25.3 percent of GDP and are well above the historical average of 20.3 percent.

Consequently, this record spending has lead to a FY 2011 deficit of $1.6 trillion (10.9 percent of GDP). Deficits for FY 2011 represent an all-time record both in nominal terms and as a share of the economy post-World War II.

Record deficits have also induced record borrowing. The federal government is now borrowing 42 cents for every dollar it spends. By the end of the decade, the federal debt will nearly double from $14 trillion to $26 trillion. Interest alone will increase to $841 billion annually by 2021.

In light of these sobering facts, reigning in government spending, especially programs with an unlimited appropriations, is the only responsible course if we are to avoid a debt crisis. H.R. 1213 helps achieve this goal by eliminating the unlimited appropriation made available to the Secretary under Section 1311(a) of PPACA.

HEARINGS

The Subcommittee on Health held a hearing on a discussion draft identical to H.R. 1213 on March 9, 2011. The following witnesses testified at the hearing:

- The Honorable Ernest J. Istook, The Heritage Foundation
- Dr. John Goodman, President and CEO, National Center for Policy Analysis
- The Honorable Joseph F. Vitale, New Jersey State Senate

The Secretary of HHS also testified before the Health Subcommittee at a March 3, 2011 hearing regarding the President's FY 2012 Budget and implementation of PPACA.

COMMITTEE CONSIDERATION

H.R. 1213 was introduced by Chairman Fred Upton on March 29, 2011, and was referred to the Committee on Energy and Commerce.

On March 31, 2011, the Subcommittee on Health met in open markup session to consider H.R. 1213. Subsequently, the Subcommittee ordered H.R. 1213 favorably reported by a recorded vote of 14–11.

On April 5, 2011, the Energy and Commerce Committee met in open markup session to consider H.R. 1213. Subsequently, the Committee ordered H.R. 1213 favorably reported by a vote of 31–20.

COMMITTEE VOTES

Clause 3(b) of rule XIII of the Rules of the House of Representatives requires the Committee to list the record votes on the motion to report legislation and amendments thereto.

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 11

BILL: **H.R. 1213,** to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges.

AMENDMENT: An amendment by Mr. Pallone, No. 1, to provide an exception to allow the Secretary to provide Exchange grants under Section 1311(a) without fiscal limitation.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 18 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns			
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush			
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel			
Mr. Terry		X		Mr. Green	X		
Mr. Rogers		X		Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky			
Mr. Burgess		X		Mr. Gonzalez			
Mrs. Blackburn		X		Mr. Inslee	X		
Mr. Bilbray		X		Ms. Baldwin	X		
Mr. Bass		X		Mr. Ross	X		
Mr. Gingrey		X		Mr. Weiner	X		
Mr. Scalise		X		Mr. Matheson	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Mr. Barrow	X		
Mr. Harper		X		Ms. Matsui	X		
Mr. Lance		X		Ms. Christensen	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

Current as of 03/14/2011

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 12

BILL: **H.R. 1213,** to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges.

AMENDMENT: An amendment by Mr. Markey, No. 2, to provide an exception to allow the Secretary to provide Exchange grants under Section 1311(a) without fiscal limitation.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 17 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman			
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey	X		
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush			
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel			
Mr. Terry		X		Mr. Green			
Mr. Rogers		X		Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky			
Mr. Burgess		X		Mr. Gonzalez			
Mrs. Blackburn		X		Mr. Inslee	X		
Mr. Bilbray		X		Ms. Baldwin	X		
Mr. Bass		X		Mr. Ross	X		
Mr. Gingrey		X		Mr. Weiner	X		
Mr. Scalise		X		Mr. Matheson	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Mr. Barrow	X		
Mr. Harper		X		Ms. Matsui	X		
Mr. Lance		X		Ms. Christensen	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

Current as of 03/14/2011

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 13

BILL: **H.R. 1213,** to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges.

AMENDMENT: An amendment by Ms. Baldwin, No. 3, to delay the effective date of the bill.

DISPOSITION: **NOT AGREED TO**, by a roll call vote of 18 yeas to 30 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey			
Mr. Whitfield		X		Mr. Towns	X		
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel			
Mr. Terry		X		Mr. Green			
Mr. Rogers		X		Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky			
Mr. Burgess		X		Mr. Gonzalez			
Mrs. Blackburn				Mr. Inslee	X		
Mr. Bilbray		X		Ms. Baldwin	X		
Mr. Bass		X		Mr. Ross	X		
Mr. Gingrey		X		Mr. Weiner	X		
Mr. Scalise		X		Mr. Matheson	X		
Mr. Latta		X		Mr. Butterfield	X		
Mrs. McMorris Rodgers		X		Mr. Barrow	X		
Mr. Harper		X		Ms. Matsui	X		
Mr. Lance		X		Ms. Christensen	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

Current as of 03/14/2011

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 14

BILL: **H.R. 1213,** to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges.

AMENDMENT: An amendment by Ms. Capps, No. 4, to allow the Secretary to provide Exchange grants under Section 1311(a) without fiscal limitation.

DISPOSITION: **NOT AGREED TO,** by a roll call vote of 18 yeas to 31 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton		X		Mr. Waxman	X		
Mr. Barton		X		Mr. Dingell	X		
Mr. Stearns		X		Mr. Markey			
Mr. Whitfield		X		Mr. Towns			
Mr. Shimkus		X		Mr. Pallone	X		
Mr. Pitts		X		Mr. Rush	X		
Mrs. Bono Mack		X		Ms. Eshoo	X		
Mr. Walden		X		Mr. Engel			
Mr. Terry		X		Mr. Green	X		
Mr. Rogers		X		Ms. DeGette	X		
Mrs. Myrick		X		Mrs. Capps	X		
Mr. Sullivan		X		Mr. Doyle	X		
Mr. Murphy		X		Ms. Schakowsky			
Mr. Burgess		X		Mr. Gonzalez	X		
Mrs. Blackburn		X		Mr. Inslee	X		
Mr. Bilbray		X		Ms. Baldwin	X		
Mr. Bass		X		Mr. Ross	X		
Mr. Gingrey		X		Mr. Weiner	X		
Mr. Scalise		X		Mr. Matheson	X		
Mr. Latta		X		Mr. Butterfield			
Mrs. McMorris Rodgers		X		Mr. Barrow	X		
Mr. Harper		X		Ms. Matsui	X		
Mr. Lance		X		Ms. Christensen	X		
Mr. Cassidy		X					
Mr. Guthrie		X					
Mr. Olson		X					
Mr. McKinley		X					
Mr. Gardner		X					
Mr. Pompeo		X					
Mr. Kinzinger		X					
Mr. Griffith		X					

Current as of 03/14/2011

COMMITTEE ON ENERGY AND COMMERCE -- 112TH CONGRESS
ROLL CALL VOTE # 15

BILL: **H.R. 1213,** to repeal mandatory funding provided to States in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges.

AMENDMENT: A motion by Mr. Upton to order H.R. 1213 favorably reported to the House, without amendment. (Final Passage)

DISPOSITION: **AGREED TO**, by a roll call vote of 31 yeas to 20 nays.

REPRESENTATIVE	YEAS	NAYS	PRESENT	REPRESENTATIVE	YEAS	NAYS	PRESENT
Mr. Upton	X			Mr. Waxman		X	
Mr. Barton	X			Mr. Dingell		X	
Mr. Stearns	X			Mr. Markey			
Mr. Whitfield	X			Mr. Towns			
Mr. Shimkus	X			Mr. Pallone		X	
Mr. Pitts	X			Mr. Rush		X	
Mrs. Bono Mack	X			Ms. Eshoo		X	
Mr. Walden	X			Mr. Engel			
Mr. Terry	X			Mr. Green		X	
Mr. Rogers	X			Ms. DeGette		X	
Mrs. Myrick	X			Mrs. Capps		X	
Mr. Sullivan	X			Mr. Doyle		X	
Mr. Murphy	X			Ms. Schakowsky		X	
Mr. Burgess	X			Mr. Gonzalez		X	
Mrs. Blackburn	X			Mr. Inslee		X	
Mr. Bilbray	X			Ms. Baldwin		X	
Mr. Bass	X			Mr. Ross		X	
Mr. Gingrey	X			Mr. Weiner		X	
Mr. Scalise	X			Mr. Matheson		X	
Mr. Latta	X			Mr. Butterfield		X	
Mrs. McMorris Rodgers	X			Mr. Barrow		X	
Mr. Harper	X			Ms. Matsui		X	
Mr. Lance	X			Ms. Christensen		X	
Mr. Cassidy	X						
Mr. Guthrie	X						
Mr. Olson	X						
Mr. McKinley	X						
Mr. Gardner	X						
Mr. Pompeo	X						
Mr. Kinzinger	X						
Mr. Griffith	X						

Current as of 03/14/2011

COMMITTEE OVERSIGHT FINDINGS

Pursuant to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the oversight findings and recommendations of the Committee are reflected in the descriptive portions of this report, including the finding that reining in mandatory spending is necessary to avoid a debt crisis.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the performance goals and objectives of the Committee are reflected in the descriptive portions of this report, including the goal of avoiding a debt crisis by reining in mandatory spending.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee finds that H.R. 1213 would result in no new or increased budget authority, entitlement authority, or tax expenditures or revenues.

EARMARK

In compliance with clause 9(e), 9(f), and 9(g) of rule XXI, the Committee finds that H.R. 1213 contains no earmarks, limited tax benefits, or limited tariff benefits.

COMMITTEE COST ESTIMATE

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

CONGRESSIONAL BUDGET OFFICE ESTIMATE

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

H.R. 1213—A bill to repeal mandatory funding provided to states in the Patient Protection and Affordable Care Act to establish American Health Benefit Exchanges

Summary: H.R. 1213 would repeal mandatory funding established by the Patient Protection and Affordable Care Act (PPACA) to provide grants to states to establish health insurance exchanges.

CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting the legislation would reduce deficits by almost $13 billion over the 2012–2016 period and by about $14 billion over the 2012–2021 period. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending and revenues.

Enacting H.R. 1213 could also lead to changes in spending subject to appropriation. While CBO has not yet completed an estimate of those potential effects on discretionary spending, we expect that the Department of Health and Human Services (HHS) would need

additional resources because of increased responsibility for establishing health insurance exchanges.

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

Estimated cost to the Federal Government: The estimated budgetary impact of H.R. 1213 is shown in the following table. The costs of this legislation fall within budget function 550 (health).

	By fiscal year, in billions of dollars—											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2012–2016	2012–2021
CHANGES IN DIRECT SPENDING												
Repeal Grant Authority: [a]												
Estimated Budget Authority	−0.6	−0.8	−0.4	−0.2	0	0	0	0	0	0	−1.9	−1.9
Estimated Outlays	−0.6	−0.8	−0.4	−0.2	0	0	0	0	0	0	−1.9	−1.9
Other Effects:												
Estimated Budget Authority	0	0	−2.1	−4.5	−4.7	−1.4	0	0	0	0	−11.3	−12.6
Estimated Outlays	0	0	−2.1	−4.5	−4.7	−1.4	0	0	0	0	−11.3	−12.6
Total:												
Estimated Budget Authority	−0.6	−0.8	−2.5	−4.7	−4.7	−1.4	0	0	0	0	−13.2	−14.6
Estimated Outlays	−0.6	−0.8	−2.5	−4.7	−4.7	−1.4	0	0	0	0	−13.2	−14.6
CHANGES IN REVENUES												
Estimated Revenues	0	0	*	−0.4	*	0.2	0	0	0	0	−0.4	−0.2
On-Budget	0	0	0.2	0.1	0.4	0.3	0	0	0	0	0.7	0.9
Off-Budget	0	0	−0.2	−0.5	−0.4	−0.1	0	0	0	0	−1.1	−1.2
NET CHANGES IN THE DEFICIT												
Net Increase or Decrease (−) in the Budget Deficit	−0.6	−0.8	−2.5	−4.3	−4.7	−1.5	0	0	0	0	−12.8	−14.4
On-Budget	−0.6	−0.8	−2.7	−4.8	−5.1	−1.6	0	0	0	0	−13.9	−15.5
Off-Budget	0	0	0.2	0.5	0.4	0.1	0	0	0	0	1.1	1.2

Notes: Numbers may not sum to totals because of rounding.
*=increase or decrease in revenues of less than $50 million.
[a] Repealing mandatory funding for states to establish insurance exchanges would increase the workload for the Department of Health and Human Services for establishing such exchanges. As a result, there could be an increase in discretionary spending under H.R. 1213. CBO has not completed an estimate of those potential increases in spending subject to appropriation.
[b] All off-budget effects would come from changes in revenues. (The payroll taxes for Social Security are classified as ''off-budget.'')

Basis of estimate: H.R. 1213 would repeal section 1311 of PPACA. Section 1311 appropriates funds to the Secretary of HHS to make grants to states for planning and establishing health insurance exchanges. The Secretary has the discretion to determine the amounts awarded to states to establish exchanges until January 1, 2015, when that authority to provide grants expires. CBO estimates that under current law, spending for state grants to establish health insurance exchanges will be $1.9 billion between 2012 and 2015. By repealing section 1311, H.R. 1213 would eliminate that spending; in addition, the repeal would probably lead to some delay in the establishment of insurance exchanges and consequent changes in insurance coverage and federal spending.

The Role of States and the Federal Government in Establishing Exchanges

States operating health insurance exchanges are responsible for certifying health plans as qualified plans under PPACA, providing consumer assistance and information for comparing plans, enrolling individuals and families into plans, determining eligibility for premium assistance credits and cost-sharing subsidies, and referring eligible applicants to Medicaid programs, among other activi-

ties. Health insurance exchanges will have the authority to charge assessments or user fees to participating health insurance issuers and after January 1, 2015, all health insurance exchanges must generate sufficient funds to meet their operating costs. Under PPACA, the Secretary of HHS will determine, by January 2013, whether a state will have an operational exchange by January 2014, and, if not, the federal government is required to set one up.

CBO's and JCT's estimate of the number of people receiving subsidies through exchanges under current law is based in part on the assumption that most states would set up their own exchanges and that nearly all exchanges would be operational by January 2014. Under current law, however, exchanges are not expected to reach full enrollment until 2016. That expectation reflects the likelihood that some states will encounter delays in achieving fully operational exchanges in the first few years. In addition, participation rates among potential enrollees are expected to be lower in the first few years (beginning in 2014) as employers and individuals adjust to the features of PPACA.

Changes in Establishing Exchanges and Insurance Coverage Under the Legislation

Under H.R. 1213, CBO assumes that some states will move forward without federal funding to establish exchanges, but that the federal government will be required to take responsibility for setting up exchanges in more states than is expected under current law. While there may be some increased efficiency in the federal government implementing similar mechanisms across additional states, there are also reasons to believe that the federal government would face added challenges. In particular, coordinating with states' Medicaid agencies to establish enrollment rules as required under PPACA and communicating and coordinating with local health insurers and managed care organizations would probably slow the federal government's pace of implementation.

Because of the reduced availability of funds to set up exchanges under H.R. 1213, states that establish exchanges without federal funding also may face greater challenges in becoming fully operational. We assume that such challenges for states and the federal government would temporarily limit the desirability of exchanges as an alternative to other sources of coverage, reduce the capacity of some exchanges to process enrollment and ultimately lower enrollment by an estimated 5 percent to 10 percent below the levels expected under current law between 2014 and 2016. In 2015, we estimate that there would be almost 2 million fewer people enrolled in state exchanges. By January 2017, we assume that all exchanges will be fully operational whether set up by states or the federal government and that enrollment will be the same as projected under current law.

The slowdown in establishing exchanges caused by H.R. 1213 would also lead to other changes in health insurance coverage for the 2014–2016 period. The number of people offered insurance through an employer is expected to increase in response to the reduced availability and desirability of exchanges; CBO and JCT estimate that roughly half of the people who will not enroll in exchanges under H.R. 1213 will be covered by employer-sponsored insurance. Small reductions in Medicaid enrollment compared with

current law are also expected because some exchanges will also have reduced ability to provide an alternative entry point to the Medicaid program. The number of people without health insurance is expected to increase by about half a million in 2015. We estimate that insurance coverage by January 2017 would be the same under H.R. 1213 as under current law.

Impact on Federal Spending

Enacting H.R. 1213 would reduce direct spending by an estimated $14.6 billion over the next 10 years, and would reduce revenues by a net amount of $0.2 billion over that same period. For this estimate, CBO assumes that the legislation will be enacted by the end of September 2011.

Outlays for state grants would be reduced by $1.9 billion—the entire amount that CBO has assumed will be spent under current law on such grants between 2012 and 2015.

CBO and JCT estimate that most of the budgetary effect of eliminating grants for states under H.R. 1213 would come from reductions in subsidies for health insurance purchased through exchanges. Payments for premium and cost-sharing subsidies (which affect both revenues and direct spending) would be reduced over the 2012–2021 period.[1] The net reduction would reflect savings from the reduction in exchange subsidies stemming from the reduction in exchange enrollment and the increase in subsidies that would occur in states that offset the loss of grant funds for establishing their exchanges by adding an additional surcharge for participating health insurance issuers. That surcharge would have the effect of raising premiums slightly for health insurance offered through those exchanges with an increase in estimated subsidies.

Other smaller effects include savings to the Medicaid program because of the reductions in enrollment discussed above and a small reduction in revenues because of changes in the amount of taxable compensation from an increase in the number of people with employer-sponsored health insurance.

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

[1] Subsidies for health insurance premiums are structured as refundable tax credits; the portions of such credits that exceed taxpayers' liabilities are classified as outlays, while the portions that reduce tax payments are reflected in the budget as reductions in revenues.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR H.R. 1213, AS ORDERED REPORTED BY THE HOUSE COMMITTEE ON ENERGY AND COMMERCE ON APRIL 5, 2011

	By fiscal year, in millions of dollars—												
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011–2016	2011–2021
NET INCREASE OR DECREASE (−) IN THE ON-BUDGET DEFICIT													
Statutory Pay-As-You-Go Impact	0	−550	−750	−2,650	−4,800	−5,100	−1,600	0	0	0	0	−13,850	−15,450
Memorandum:													
Changes in Outlays	0	−550	−750	−2,500	−4,700	−4,700	−1,350	0	0	0	0	−13,200	−14,550
Changes in Revenues	0	0	0	150	100	400	250	0	0	0	0	650	900

Intergovernmental and private-sector impact: H.R. 1213 contains no intergovernmental or private-sector mandates as defined in UMRA. By eliminating funding made available by PPACA, the bill would decrease the amount of resources that state, local, and tribal governments receive to establish health exchanges.

Estimate prepared by: Federal Costs: Jean Hearne, Paul Jacobs, and Sarah Anders; Impact on State Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Sarah Axeen.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

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

ADVISORY COMMITTEE STATEMENT

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

APPLICABILITY TO LEGISLATIVE BRANCH

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

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Repealing Mandatory Funding to States to Establish American Health Benefit Exchanges

Section 1 repeals Section 1311(a) of PPACA and rescinds unobligated funds made available by such Section 1311(a).

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

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

PATIENT PROTECTION AND AFFORDABLE CARE ACT

* * * * * * *

Title I—Quality, Affordable Health Care for all Americans

* * * * * * *

Subtitle D—Available Coverage Choices for All Americans

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PART 2—CONSUMER CHOICES AND INSURANCE COMPETITION THROUGH HEALTH BENEFIT EXCHANGES

SEC. 1311. AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS.

[(a) ASSISTANCE TO STATES TO ESTABLISH AMERICAN HEALTH BENEFIT EXCHANGES.—

[(1) PLANNING AND ESTABLISHMENT GRANTS.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after the date of enactment of this Act, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

[(2) AMOUNT SPECIFIED.—For each fiscal year, the Secretary shall determine the total amount that the Secretary will make available to each State for grants under this subsection.

[(3) USE OF FUNDS.—A State shall use amounts awarded under this subsection for activities (including planning activities) related to establishing an American Health Benefit Exchange, as described in subsection (b).

[(4) RENEWABILITY OF GRANT.—

[(A) IN GENERAL.—Subject to subsection (d)(4), the Secretary may renew a grant awarded under paragraph (1) if the State recipient of such grant—

[(i) is making progress, as determined by the Secretary, toward—

[(I) establishing an Exchange; and

[(II) implementing the reforms described in subtitles A and C (and the amendments made by such subtitles); and

[(ii) is meeting such other benchmarks as the Secretary may establish.

[(B) LIMITATION.—No grant shall be awarded under this subsection after January 1, 2015.

[(5) TECHNICAL ASSISTANCE TO FACILITATE PARTICIPATION IN SHOP EXCHANGES.—The Secretary shall provide technical assistance to States to facilitate the participation of qualified small businesses in such States in SHOP Exchanges.]

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DISSENTING VIEWS

We, the undersigned Members of the Committee on Energy and Commerce, oppose the passage of H.R. 1213, *to repeal mandatory funding provided to states in the Patient Protection and Affordable Care Act (ACA) to establish American Health Benefit Exchanges,* and accordingly, submit the following comments to express our concerns about this deeply flawed and deeply divisive legislation.

Private Insurance Marketplace Prior to Health Reform Exchanges

Private health coverage is provided primarily through employers. In 2010, about 157 million nonelderly people were insured through employer sponsored health insurance.[1] While 99% of large firms offer health insurance coverage, just 59% of firms with fewer than 10 workers offered insurance in 2010; this was a jump from 49% in 2008 and 2009.[2] In 2010, 76% of firms with 10 to 24 workers and 92% of firms with 25 to 49 workers offered insurance.[3]

For the smallest firms, those with less than 10 workers, premiums were 18% higher than those paid by firms with 100 or more workers and still may not have included broker fees.[4] According to the Congressional Budget Office, administrative costs make up 27% of premiums for the very small firms compared with 9% for firms with at least 100 employees.[5] Increasing costs of health insurance have led some small employers to drop coverage, with the share of small business employees enrolled in employer-sponsored coverage decreasing from 43 to 36% from 1999 to 2009.[6]

People without access to employer-sponsored insurance may obtain health insurance on their own, usually through the individual health insurance market. Only 14 million nonelderly people bought health insurance in the individual or non-group market while 50

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[1] Kaiser Family Foundation, *The Uninsured: A Primer* (Oct. 2009) (online at *http://www.uiowa.edu/~/documents/KFF-UninsuredPrimer.pdf*).

[2] G. Claxton et al., *Employer Health Benefits, 2010 Annual Survey,* The Kaiser Family Foundation and Health Research and Education Trust (Sept. 2010) (online at *http://ehbs.kff.org/pdf/2010/8085.pdf*).

[3] *Id.*

[4] S. Collins et al., *Realizing Health Reform's Potential: Small Businesses and the Affordable Care Act of 2010* (Sept. 2010) (online at *http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Sep/Small%20Business/1437_Collins_realizing_hlt_reform_potential_small_business_ACA_ib.pdf*).

[5] Letter from Douglas W. Eldmendorf, Director, Congressional Budget Office, to Senator Evan Bayh (Nov. 30, 2009) (online at *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf*).

[6] HealthCare.gov, *Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform* (Jan. 28, 2011) (online at *http://www.healthcare.gov/center/reports/premiums01282011a.pdf*).

million people were uninsured.[7] About half the uninsured were self-employed or worked for a small business.[8]

Unlike employer-sponsored group coverage, in which eligibility in a group is guaranteed by federal and state laws and premiums are generally based on the risks associated with a group of beneficiaries, eligibility and initial premiums in the individual markets of many states are based largely on an individual's health status and risk characteristics.

The Commonwealth Biennial Health Insurance Survey found 43% of adults who shopped for coverage in the individual market found it very difficult or impossible to find a plan that fit their needs.[9] More than one-third of applicants were turned down by an insurance carrier or were charged a higher premium due to a health problem or were offered insurance that did not cover that health problem.[10]

Practices of denying sick people insurance, charging them more, or offering them coverage that does not cover the illnesses they had when they sought insurance protect insurer risk pools and help lower premiums. But they are detrimental to a vibrant, healthy, and financially secure marketplace. These practices limit meaningful access to coverage for people that have developed health problems and results in uncertainty in coverage for those that receive insurance. They also hamper movement from jobs where insurance is offered to self-employment or employment in a small business, resulting in job lock.

American Health Benefit Exchanges

The enactment of the ACA in March 2010 started to put the American people back in charge of their health care by requiring insurance companies to be more transparent and accountable for their costs and actions. Within 6 months of enactment, this law ended many of the worst insurance industry abuses, including arbitrary recessions of coverage when a person gets sick and denials of insurance for children with pre-existing conditions.[11] In 2014, additional insurance reforms will bring Americans new rights and benefits, and increase the quality of their health care and lower their costs. These reforms include no discrimination in premiums based on gender, no denials for pre-existing conditions for anyone, coverage of basic set of benefits and services, and no annual and lifetime limits on coverage for essential health benefits.[12]

The successes of these reforms rely on the new health insurance exchange marketplaces that will be established in 2014 as required by the ACA. An exchange is a mechanism for organizing the health

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[7] Kaiser Family Foundation, Survey Report: *Survey of People Who Purchase Their Own Insurance* (June 2010) (online at *http://www.kff.org/kaiserpolls/upload/8077-R.pdf*); and C. DeNavas et al., *Income, Poverty, and Health Insurance Coverage in the United States: 2009,* U.S. Census Bureau (Sept. 2010) (online at *http://www.census.gov/prod/2010pubs/p60-238.pdf*).

[8] Small Business Majority, *Healthcare: Statistics, Small Business and the Healthcare Crisis* (online at *http://www.smallbusinessmajority.org/small-business-research/statistics.php*) (accessed Apr. 25, 2011).

[9] S. Collins, et al., *Help on the Horizon,* Findings from the Commonwealth Biennial Health Insurance Survey of 2010 (Mar. 2011) (online at *http://www.commonwealthfund.org/~/media/Files/Surveys/2011/1486__Collins__help__on__the__horizon__2010__biennial__survey__report__FINAL__31611.pdf*).

[10] *Id.*

[11] The ACA is comprised of two public laws, P.L. 111–148 and P.L. 111–152.

[12] *Id.*

insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. Exchanges will provide a transparent, competitive marketplace for individuals and small businesses to buy coverage.

The new marketplace will provide families and businesses advantages of pooling risk that were previously only available to the largest employers by creating a single risk pool within the individual and small business exchanges.[13] By pooling people together, reducing transaction costs, and increasing transparency, exchanges create more efficient and competitive markets for individuals and small employers. The new marketplace keeps intact America's employer based system while expanding access to tens of millions of people. Tax credits will make coverage more affordable for low and middle-income families and eligible small businesses.

Beginning with an open enrollment period in 2013, exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges will assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs.[14] By providing one-stop shopping, exchanges will make purchasing health insurance easier and more transparent. Health plans offered in exchanges shall be required to be transparent and make disclosure of claims payment policies, enrollment and disenrollment data, data on denied claims, information on cost sharing and coverage, and more.[15]

When fully implemented, health plans offered through exchanges will compete based on price and quality rather than market segmentation and risk selection. This directly relates with prohibition on medical underwriting and rate reforms that would also take effect in 2014.[16] The non-partisan Congressional Budget Office (CBO) estimated that by 2021, approximately 24 million people will purchase their health insurance through exchanges.[17]

State versus Federal Exchanges

The ACA requires that exchanges be developed and operational in every state for individual and small businesses by January 1, 2014.[18] A state is first given the opportunity to set up a state exchange and can apply for grants for the establishment of this exchange. If the state does not elect to set up a state exchange, the Secretary of Health and Human Services (the Secretary) will set one up in the state for individuals and small businesses.

The state has significant flexibility in the type of exchange it would operate if it elects to establish a state exchange. The state could determine which insurers are permitted to offer products in the exchange. It could determine the variety of plans that could be offered, for example whether consumer driven health plans and

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[13] ACA Section 1312(c).
[14] ACA Sections 1311(b) and 1311(d)(4).
[15] ACA Section 1311(e)(3).
[16] The Kaiser Family Foundation, *Focus on Health Reform* (Apr. 2010) (online at *http://www.kff.org/healthreform/upload/7908-02.pdf*).
[17] House Committee on Energy and Commerce, Subcommittee on Health, Testimony of CBO Director Douglas Elmendorf, *Hearing on the Cost of the ACA,* 112th Cong. (2011).
[18] ACA Section 1311.

health savings accounts are offered. The state could determine the governance structure. The state could determine whether to merge the individual and small group markets. The state could determine whether employers with over 50 employees are permitted into the exchange to purchase insurance over time. The state could determine the financing mechanism that will be used to operate the exchange in the future. The state could determine whether the exchange will be an active purchaser in selecting health plans to get the best price and quality for its citizens. The state could determine how involved the exchange will be in enforcing health insurance market standards as a part of their certification in tandem with the state health insurance commissioner.

An exchange may operate in multiple states if each state agrees to the operation of the exchange and if the Secretary approves.[19] A state may have more than one exchange, called subsidiary exchanges if each serves a geographically distinct area and the area served is adequately large.[20]

If the state does not elect to set up an exchange or the Secretary determines before 2013 that a state will not have an exchange operational by 2014 the Secretary is required to establish and operate an exchange in the state and to implement the standards.[21] In the case the federal government establishes and operates the exchange, it will make these decisions.

Oversight of Exchanges

The Secretary, in coordination with the HHS Inspector General, will have authority to investigate exchanges. Exchanges will be subject to annual HHS audits.[22] If the Secretary finds serious misconduct, payment otherwise due to the exchange may be rescinded, up to 1% of such payments, until corrective actions are taken that are deemed adequate by the Secretary.[23] Payments made under the exchange provisions of the ACA are subject to the False Claims Act.[24] The Government Accountability Office is required to review the operations and administration of the exchange.[25] In addition, the committee on Energy and Commerce, and the Committee on Oversight and Government Reform, other congressional committees, and others can provide oversight of the implementation of the activities and expenditures under section 1311 of the Affordable Care Act.[26]

Funding for Exchanges

Section 1311 of the ACA requires the Secretary, within one year of enactment, to award grants to states to plan and establish exchanges.[27] By January 1, 2014, each state must have an exchange to facilitate access to qualified health plans. The grants are provided to states making progress in establishing an exchange, implementing ACA's private health insurance market reforms, and meet-

[19] ACA Section 1311(f).
[20] *Id.*
[21] ACA Section 1321.
[22] ACA Section 1313.
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] ACA Section 1311.

ing other benchmarks. However, no grant may be awarded after January 1, 2015, and after this date, operations of the exchange must be self-sustaining using assessments on insurers or some other way to generate funds to support their operations.[28] In addition, the grants must be used solely for the activities and functions listed in section 1311.[29]

Thus far, the Center for Consumer Information and Insurance Oversight (CCIIO) has awarded $54 million in exchange planning grants to 49 states and the District of Columbia along with four territories. States may use grants for a number of important planning activities including research of their insurance markets, efforts to obtain the legislative authority to create exchanges, and steps to establish the governing structures of exchanges.[30]

In addition, 7 grantees across 12 states have received $241 million to develop model Information Technology (IT) systems to operate the functions of the exchange.[31] Whatever systems are developed and best practices learned can be used by other states for development of information technology systems that will help with eligibility and enrollment. Such systems can be combined with state Medicaid systems and others, but all monies for the development of combined technology must be allocated according to the different programs. According to November 3, 2010, guidance from CMS, "State Exchange grants will provide 100 percent support for Exchange IT infrastructure and now this [Medicaid] 90 percent matching rate will be available for the Exchange-related (accessed Apr. 8, 2011). Medicaid eligibility system changes well as for those Medicaid system changes not directly related to the Exchanges."[32]

Structure of Funding

The structure of the funding for the establishment of exchanges has been criticized as being an open ended mandatory funding stream. However, mandatory, time limited funding is consistent with previous laws passed by both parties.

Having a mandatory and stable stream of funding for this central feature of the health insurance reforms is critical. Senator Harkin stated, in testimony for the record, that "[T]o ensure the success of the Affordable Care Act, we needed to guarantee that reliable and predictable funding would be available for key programs. As the Chairman of both the Senate Committee on Health, Education, Labor, and Pensions and the Appropriations Subcommittee for Labor, Health and Human Services, and Education, I understand the implications of this guarantee—that Congress should mandate

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[28] See *e.g.,* ACA Section 1311 (relating to assistance to States to establish Exchanges).

[29] ACA Section 1311.

[30] U.S. Department of Health and Human Services, News Release: *HHS Announces New Resources to Help States Implement Affordable Care Act* (Jan. 20, 2011) (online at *http://www.hhs.gov/news/press/2011pres/01/20110120b.html*).

[31] Healthcare.gov, *States Leading the Way on Implementation: HHS Awards "Early Innovator" Grants to Seven States* (online at *http://www.healthcare.gov/news/factsheets/Exchanges02162011a.html*) (accessed Apr. 8, 2011). Medicaid eligibility system changes well as for those Medicaid system changes not directly related to the Exchanges."[32]

[32] Letter from Joel Ario, Director, Office of Health Insurance Exchanges, Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services and Cindy Mann, CMS Deputy Administrator and Director, Center for Medicaid, CHIP and Survey & Certification, Centers for Medicare & Medicaid Services, to State Medicaid Directors, State Health Officials, and State Health Insurance Commissioners (Nov. 3, 2010) (online at *http://www.healthcare.gov/center/letters/improved__it__sys.pdf*).

appropriations for certain programs in the Affordable Care Act that are fundamental to its success. This is a process that Congress has done many times in the past in various areas and there has been no controversy. It is now clear that those who want to repeal the Act are seeking to starve these important elements of funds in an effort to derail health reform." [33]

In fact, in this regard, the Affordable Care Act was little different from other laws passed by Congress in recent years. It included a mix of discretionary program authorizations and mandatory spending. That mandatory spending was well-documented at the time of passage and included in each CBO score of the legislation from the summer of 2009 through passage in March, 2010.

Two examples of laws considered by the Energy & Commerce Committee when it was last under the control of Republicans in the 108th and 109th Congresses illustrate how Congress has previously used mandatory appropriations. These laws are the Medicare Prescription Drug Improvement and Modernization Act [34] and the Deficit Reduction Act,[35] both of which were spearheaded by Republican congressional leadership. These laws contained billions of dollars of mandatory appropriations funding a wide array of government activities.[36]

The Medicare Prescription Drug Improvement and Modernization Act included specific mandatory appropriations, including an open ended but time limited mandatory appropriation for a drug assistance program. That program, like the exchange grants, served as a bridge until the full Medicare prescription drug benefit became effective.

Analysis and Impact of H.R. 1213

H.R. 1213 repeals the mandatory funding provided to states under the ACA to establish exchanges. This denies States the necessary funding to establish the new health insurance marketplace and undermines the work they have already done to implement exchanges. This legislation would rescind unobligated funds from the $54 million states have been awarded in planning grants, and would prohibit further funding, limiting states ability to advance on the establishment of their exchanges.

According to Alan Weil, Executive Director of the National Academy for State Health Policy, "[S]tates are doing their best to comply with the federal law and to implement the law in a manner that conforms to their own needs. Federal support for those activities is critical. One likely consequence of reduced federal funding is poor implementation, with state officials on the hook for failures that are not of their own making. Another likely consequence is states deciding to cede authority for implementation to the federal

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[33] House Energy and Commerce Committee, Subcommittee on Health, Testimony of Senator Tom Harkin, Chairman of the U.S. Senate Committee on Health, Education, Labor, and Pensions and the U.S. Senate Committee on Appropriations, *Hearing on Setting Fiscal Priorities in Health Care Funding,* 112th Cong. (Mar. 9, 2011).

[34] The Medicare Prescription Drug Improvement and Modernization Act is P.L. 108–173.

[35] The Deficit Reduction Act is P.L. 109–171.

[36] House Committee on Energy and Commerce, *The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act* (Mar. 2011) (online at *http://democrats.energycommerce.house.gov/sites/default/files/image_uploads/Fact%20Sheet_03.09.11pdf*).

government—a decision most states would strongly prefer not to make." [37]

Current budget deficits in most states have created difficult economic environments to establish state-based exchanges. Without grants from the Department of Health and Human Services, states will be forced to pay for exchange activities, along with outreach and education activities, on their own if they wish to establish a state run exchange. Exchange grants provide states the financially security needed to avoid wrestling with budget issues and worrying about self-sustainability before January 1, 2015. The inevitable result of enactment of this legislation is that a number of states that would prefer to run their own exchanges will be unable to do so, and the default to federal control will be more likely to occur. Yet states are best positioned to establish the new marketplace for their residents.

Already 49 states and the District of Columbia have shown an interest in the setting up an exchange marketplace on their own. A repeal of the exchange grants is effectively taking away from states the ability to set up exchanges.

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[37] House Committee on Energy and Commerce, Testimony of Alan Weil, Executive Director, National Academy for State Health Policy, *Hearing on Setting Fiscal Priorities in Health Care Funding,* 112th Cong. (Mar. 9, 2011).