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SETTING FISCAL PRIORITIES IN HEALTH CARE FUNDING

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

MARCH 9, 2011

Serial No. 112–17

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE
68-055 PDF WASHINGTON : 2011

For sale by the Superintendent of Documents, U.S. Government Printing Office
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SETTING FISCAL PRIORITIES IN HEALTH CARE FUNDING

WEDNESDAY, MARCH 9, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:33 a.m., in room 2322 of the Rayburn House Office Building, Hon. Joe Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Rogers, Murphy, Blackburn, Gingrey, Latta, McMorris Rodgers, Lance, Cassidy, Guthrie, Barton, Pallone, Dingell, Engel, Capps, Schakowsky, Gonzalez, Baldwin, Weiner, and Waxman (ex officio).

Staff present: Clay Alspach, Counsel, Health; Howard Cohen, Chief Health Counsel; Brenda Destro, Professional Staff Member, Health; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Todd Harrison, Chief Counsel, Oversight/Investigations; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Carly McWilliams, Legislative Clerk; Monica Popp, Professional Staff Member, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Heidi Stirrup, Health Policy Coordinator; Tom Wilbur, Staff Assistant; Jimmy Widmer, Health Intern; Phil Barnett, Democratic Staff Director; Stephen Cha, Democratic Senior Professional Staff Member; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Purvee Kempf, Democratic Senior Counsel; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director for Health; Mitch Smiley, Democratic Assistant Clerk; and Lindsay Vidal, Democratic Press Secretary.

Mr. PITTS. The subcommittee will come to order. Just a word about this morning's proceedings. Because we have a joint session of Congress today at 11:00, we will begin our hearing at 10:30 with members' opening statements and then recess shortly before 11:00 for members to move to the Capitol for the session at 11:00. We will reconvene our hearing immediately following the joint session at 12:15 and start with our introductions of witnesses, their 5-minute statements followed by the members' questions under the 5-minute rule. The chair will recognize himself for an opening statement for 5 minutes.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

The title of this hearing is "Setting Fiscal Priorities in Health Care Funding." And that is exactly what we must do: Assess and prioritize all of the things that we need to do and would like to do and then make difficult funding decisions with limited amounts of money.

Today, we will address five areas of the health reform law and determine if these funding streams are needed, if these programs are funded at the most responsible levels, and if they should be mandatory or discretionary.

Section 4002 of PPACA establishes a Prevention and Public Health Fund "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs." The section authorizes the appropriation of, and appropriates to the fund from the Treasury, the following amounts: $500 million for fiscal year 2010; $750 million for 2011; $1 billion for 2012; $1.25 billion for fiscal year 2013; and $1.5 billion for 2014, and for fiscal year 2015 and every fiscal year thereafter $2 billion.

The Secretary has full authority to use this account to fund any programs or activities under the Public Health Service Act that she chooses, without Congressional oversight.

On June 18, 2010, HHS announced $250 million in Prevention and Public Health Fund dollars would go "to support prevention activities and develop the Nation's public health infrastructure." On September 27, 2010, HHS announced another $320 million in grants from the fund to expand the primary care workforce. And on February 9, 2011, HHS announced an additional $750 million from the fund for various prevention activities, including preventing tobacco use, obesity, heart disease, stroke and other diseases, and increasing immunizations.

The goals of these three disbursements from the fund are laudable, and there is no doubt that we must focus on preventing disease. But we must remember that this funding is over and above the amount that Congress has decided should go to these activities and the amount that Congress has already appropriated for these activities. It is also disbursed at the sole discretion of the Secretary.

Last Thursday I asked Secretary Sebelius whether she needed further Congressional approval to spend the money from the 4002 fund, and she answered no. I then asked her if she could fund activities above and beyond the level Congress appropriated, and she stated yes. This should concern every Member that we have a created a slush fund that the Secretary can spend from without any Congressional oversight or approval.

By eliminating this fund, we are not cutting any specific program or activity. We are reclaiming our oversight role of how federal taxpayer dollars should be used.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The Chair will recognize himself for an opening statement.

The title of this hearing is "Setting Fiscal Priorities in Health Care Funding."

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By eliminating this fund, we are not cutting any specific program or activity. We are reclaiming our oversight role of how federal taxpayer dollars should be used.

Mr. PITTS. At this time I will yield 1 minute to the gentleman from Texas, Mr. Barton.

Mr. BARTON. Thank you, Mr. Chairman.

I want to welcome especially Dr. Istook and Dr. Goodman. They are both personal friends of mine, and Mr. Istook is a former Congressman.

This is a very important hearing, Mr. Chairman, because we are coming to find out every day more and more things about the health care law that should be of concern to every American citizen. The ability of the Secretary of HHS without any oversight or any authorization of the Congress to spend such sums as necessary which could total into the billions of dollars is something that should concern everybody in this room, and this hearing to look into that part of the law and then look at some of the other specific sums that are authorized, if we are really going to get spending under control, this is ground zero for starting it.

So I appreciate you holding the hearing. I appreciate all three witnesses for being here. And again to Dr. Goodman and Mr. Istook personally, welcome to the committee.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and yields the remaining time to Mr. Latta from Ohio.

Mr. LATTA. Thank you, Mr. Chairman, for holding this hearing today on fiscal priorities for health care spending. As we continue to discover more and more details of the ramifications of Obamacare, I am extremely troubled by the fact that this bill put in place programs and spending that bypass Congress and gives full control to the Administration.

There are several programs that have been identified in Obamacare that are duplicative government programs as well as mandatory spending programs. I have grave concerns about these duplications and the fact that the programs contained in section 2953 are of this nature. I am very supportive of the discussion draft before us that will convert the appropriation of payment in this section of $75 million for each of the fiscal years 2010 through 2014 into an authorization. Congress needs to be the one that determines funding for these programs and determines if in fact they are duplicative and determine this through the normal appropriations process. Making this change could potentially save $375 million over 5 years. We must get our fiscal house in order and there are many more savings by further repealing Obamacare.

This past month, the Congressional Research Service updated an October 2010 report that appropriations and fund transfers in the Patient Protection and Affordable Care Act. The new report found that unbeknownst to almost every Member of Congress, that Obamacare contains $150 in direct implementation spending to bypass this Congress's normal appropriation process.

Thank you, Mr. Chairman, and I yield back.

Mr. PITTS. The gentleman's time is expired. The chair yields for 5 minutes for opening statement to Ranking Member Pallone.

OPENING STATEMENT OF HON. FRANK PALLONE JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

Here we go again, same song, different verse, another hearing that continues the Republican hollow agenda of round-the-clock complaints of Democrat legislation without a glimmer of their own innovation or substance. The American people can do the math. Ten weeks, zero jobs bills from the GOP. Months after the election, Republicans continue to put partisan politics ahead of Americans' top priority, which is jobs.

But I should say, I welcome the opportunity to talk about health care reform and health security. I am very proud of the benefits it will bring to millions of hardworking Americans nationwide and for the families that live in every single Congressional district of the members of this committee. So while I welcome an honest discussion about reform, the issues raised today border on the absurd, in my opinion. The Republicans couldn't be more hypocritical with their seeming concern about the use of mandatory funding for some

of the programs in health care reform. This hearing isn't about funding streams, it is simply an effort to dismantle the health care reform law block by block by cherry-picking policies they don't care for without offering any solutions in return. The truth of the matter is, the last time Republicans were in charge, they embraced mandatory health care funding and they used it regularly in bills that passed through the Energy and Commerce Committee. The Medicare Modernization Act of 2003, I am sure we all remember that bill. It passed in the middle of the night after a 3-hour vote was held open on the floor, and that bill was chockfull of mandatory goodies. There was the $1.5 billion to fund start-up administrative costs for implementation of MMA and there was an unlimited appropriation to fund the transitional drug assistance program and there were a few hundred million in change for a health infrastructure program and another billion for emergency health services, all mandatory funding.

Then you can fast-forward a couple years and the committee once again decided to use mandatory funding for billions of dollars worth of programs throughout the so-called Deficit Reduction Act of 2005, and I could spend my whole 5 minutes on that but I am going to spare you that one.

The fact is that key programs under the jurisdiction of the Energy and Commerce Committee are and continue to be funded through mandatory spending authority. It is the way to ensure an adequate and sustained funding stream to ensure the success of important programs. And for the Republicans who cry foul because we happened to utilize this tool in the Affordable Care Act is simply not credible, and it continues to amaze me how the Republicans cry States' rights, States' rights at every turn and then undermine that same principle with gusto. They want to eliminate all the funding for State health exchange grants to tie the States' hands and you are not only going to throw an unfunded mandate on them but in effect you are ceding States' powers to the Federal Government and telling HHS to step in and tell States what insurance exchange model will work best for them. That wasn't our policy. We wanted State innovation in the health care reform bill, and we urge our Republican colleagues to rethink their misguided proposal.

As much as I disagree with the basis of this hearing, I am pleased to welcome my good friend, State Senator Joe Vitale, who is from New Jersey, who has testified before us several times on health care reform, and he will talk about how health care reform will help millions of New Jersey families and how New Jersey already benefited from more than $3 million in critical funding from the Prevention and Public Health Fund.

So at this time I would like to yield 1 minute to the gentleman from New York, Mr. Engel.

Mr. ENGEL. I thank my friend for yielding, and I agree with your sentiments.

Mr. Chairman, this hearing calls to mind the classic line from Yogi Berra, "It's déjà vu all over again." This hearing really isn't about the difference between mandatory and discretionary funding, this hearing is really another veiled attempt to undermine the Affordable Care Act and prevent 30 million Americans from accessing affordable health coverage. According to the Majority, the Afford-

able Care Act was "unusual in that it created mandatory spending on programs that would otherwise be considered discretionary." It seems my friends on the other side of the aisle have a short memory. The Republican Majority mandated open-ended spending on new programs in the Medicare Prescription Drug Improvement and Modernization Act and the Deficit Reduction Act, both of which have resulted in billions of dollars spent outside of the appropriations process and worst of all were unpaid-for federal mandates. No jobs created by the Majority, just tax breaks for the rich and big corporations, blowing a hole in the deficit and again and again and again, day in and day out, attempts to repeal the health care law, which is already helping millions and millions of Americans.

I yield back.

Mr. PALLONE. Whatever time I have left I yield to Ms. Schakowsky.

Ms. SCHAKOWSKY. Let us take a look at FactCheck.org. This ridiculous idea that somehow there is a dirty little secret, as our former colleague, Mr. Istook, said in the bill—what it is really about is what he said, pulling out Obamacare weed by weed. This is another attempt to repeal the legislation that will help 30 million Americans.

I look forward to having this conversation with Mr. Istook.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the vice chair of the committee, Dr. Burgess, for 3 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. I thank the chair for the recognition.

So here we are just 2 weeks shy of the anniversary date of that big signing ceremony down at the East Room of the White House. We all remember how the Vice President characterized that morning.

But this bill does represent, this law now represents a fundamental change in the relationship of the government with the people. We have gone from government with the consent of the governed to now the government telling the governed what they should get and when they should get it. Remember President Obama when he was running in 2008? He made two promises. One was if you like what you have, you can keep it, and the other was, we have to control costs, that way more people can buy insurance. Actually not bad ideas. What happened to, if you like what you have, you can keep it? Well, apparently that is gone by the wayside, and what the American people told us in the difficult summer of 2009 was, we are scared to death you are going to screw up what we have, please don't do that, and the other part of that equation was, could you do something to help us with costs because we are dreadfully concerned about the costs of health care. Turns out with the signing of this law, we screwed up what was working and we exploded the cost.

Now, I do understand the difference between an authorizer and an appropriator. I have been an authorizer during my short Congressional tenure. Mr. Istook when he was here was an appropriator. My first field trip out to the NIH, I was taken to all of these big beautiful buildings, all named after appropriators. I said where

is the building named after the authorizer; there aren't any. But I do understand the very fundamental nature of what we do as an authorizing committee. It is our heritage, and our strength comes from carefully investigating and carefully vetting those expenditures that we then pass off to the appropriators to eventually write the check, and the oversight function that occurs at the authorization level is something which cannot be minimized. We have gone through almost a year of this. In fact, we went through the first 10 months before we had a single oversight hearing from any of the relevant federal agencies over just what was going on with the implementation of this.

Now, look, we are hearing today about the problems with the federal budget. February, $223 billion overdraft. February, I might remind people, is the shortest month of the year. That means that is as good as it going to get this year, $223 billion overdraft, and what do we get for it? Do you see new clinics, do you see new schools? No, what you see is an overdraft, and it gets worse because as this thing is implemented, we go on to subsidies to middle-class families in the exchange to help them buy health insurance and the answer there is a tap with a high-pressure line into the federal Treasury. That $223 billion deficit is something for which we all wax nostalgic after that kicks in in this bill.

The mandatory spending which we are all talking about needs to be brought back under the control of this committee and be authorized. You don't have to be against something just because you want to label it "mandatory." It simply means you want to have the correct amount of Congressional oversight.

Let me yield at this point to the gentleman from Kentucky.

Mr. GUTHRIE. Thank you, Mr. Chairman, and I thank the gentleman for yielding.

You know, we are all working on jobs. Everywhere you go, you hear people and businesses are sitting on the sidelines not investing because they are not sure how much their employees are going to cost them because of the expense that is coming because of this bill, and also we need to address spending so American people and businesses can have money to create jobs. And every day families across this country are sitting around trying to figure out what to spend their money on, and I believe Congress should follow suit.

Unfortunately, during the annual appropriations process, Congress's equivalent of a family budget, a number of federal programs are off-limits because they are created as mandatory spending and not discretionary. These programs are subject to the same scrutiny or evaluated for effectiveness in order to earn their continued funding.

The new health care law created an unprecedented number of these mandatory programs. One that we will discuss today is an authorization of a mandatory spending program for graduate medical education. While I support graduate medical education and believe we need more residency physicians, particularly primary care, I support shifting this program to an authorization. This program should not be protected and prioritized over other similar programs. This change is not only fiscally responsible but good policy.

Thank you, Mr. Chairman, and I yield back the balance of my time.

Mr. PITTS. The chair thanks the gentleman and yields 5 minutes to the ranking Member, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

What the Republicans are conjuring up today is a completely contrived issue about funding for the Affordable Care Act that is entirely false and misleading. Don't fall for it. Republicans are trying to turn back the clock on the Affordable Care Act, a law that reduces the deficit by over $210 billion in the next decade, expands the health care coverage to 32 million people, closes the Medicare drug doughnut hole, provides free preventive care under Medicare and strengthens the Medicare trust fund, and it prohibits predatory, abusive behavior by insurance companies. It addresses public health challenges that confront our Nation such as obesity and health disparities through support of the public health infrastructure.

This hearing is about having appropriate resources to fund the Affordable Care Act. The Republicans tried to repeal that law but they weren't successful, so now they are trying to defund it in another way.

Every member of this committee has a history of voting for both mandatory and discretionary spending. In fact, a Republican-led Congress passed legislation that included over $400 billion of mandatory spending that was not paid for in the Medicare drug bill.

It is a fundamental part of the responsibility of an authorizing committee like Energy and Commerce that has jurisdiction over programs like Medicare, Medicaid and CHIP to determine where mandatory funding is needed to ensure a program's sustainability. Similarly, assuring funding to implement and support the Affordable Care Act is critical to its viability and success.

The legislative proposals being discussed today are marked by irony and hypocrisy. For example, one proposal repeals the monies for the States to establish their exchanges. Just last week we had a hearing where Republicans argued the need for State flexibility under health reform and discussed the fiscal constraints that face States today. This proposal would take away monies that allow the States to do the work necessary to design a health insurance exchange that meets the needs of their residents.

Our members have been discussing the need for expanding the health care workforce, especially primary care physicians to serve the growing demands for service. According to his testimony, Dr. Goodman agrees. It is ironic that one of the Republican proposals cuts support from our health care workforce. In a third proposal, they claim that education programs aimed at decreasing teen pregnancies should not have a stable funding source. However, Republicans, including Representative Istook, fully support mandatory funding for abstinence-only programs and have voted numerous times for such programs.

Well, I look forward, I suppose, to hearing from our witnesses and seeing where this bill will go. I want to apologize ahead of time. I will need to leave this committee to attend another hearing

in another subcommittee. I want to yield my 1 minute to Ms. Capps and then take back my time after that to yield further to Mr. Dingell.

Mrs. CAPPS. Thank you, Mr. Waxman.

I will add that today's hearing is another effort by this subcommittee to do everything it can to repeal the Affordable Care Act and avoid the issue Americans care most about, which is jobs. But unlike previous efforts that just ignored job creation altogether, today's hearing is on legislation that will flat out hurt our economy and keep people out of the workforce.

For example, the school-based health center construction grants will enhance the health of children and their families but also stimulate the economy of local communities with new construction jobs. Similarly, the teaching health centers program not only expands primary care services to those who need it most but also trains new providers with the expertise needed to serve these expanding populations. The Republican majority has placed both of these programs on the chopping block. Let us be clear: These proposals take away funding from shovel-ready projects in our communities and they keep qualified applicants away from the primary care workforce.

I know many of our colleagues will say that our budget requires us to make tough calls. It is not being tough to go after kids and the underserved. These aren't tough calls; they are bad calls.

I yield back the balance of my time to Mr. Waxman.

Mr. WAXMAN. Thank you very much. I want to yield 1 minute to the distinguished chairman emeritus of our committee, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Thank you very much for that. I appreciate your courtesy.

Today's hearing is a wasted opportunity to have a substantive conversation as to how this committee can work together in a bipartisan fashion to further improve our health care system. I understand that the Majority has concerns about the reform. So do we. But we have also heard repeatedly about how the health care reform law will destroy State budgets, kill jobs, drive up health care costs and overwhelm Medicare and Medicaid. But I see nothing that they are putting on the table to address these problems.

And while my colleagues take great joy in extolling the problems of the health care reform law, they have not brought forward a single substantive suggestion for improvement. We can see clearly from the five discussion drafts before us today that the Majority has no intention of working with the Minority to improve the health care reform law.

I have long said that no law is perfect. The last perfect law that came into the hands of men came on stone tablets off the top of Mount Sinai in the hands of Moses, and I believe that we are going to find that the draft legislation that you have submitted to us or will be submitting to us is going to be bad legislation, and indeed, you are letting the perfect be the enemy of the good.

It is my sincere hope that this committee will work together to improve this bill and not blindly tear it down. Further, I hope that

the next hearing before this subcommittee will take some time to deal with the real problems in health reform and not the politics. Thank you.

[The prepared statement of Mr. Dingell follows:]

PREPARED STATEMENT OF HON. JOHN D. DINGELL

Thank you, Mr. Chairman.

Today's hearing is yet another example of the Majority's strong commitment to improving the Affordable Care Act.

Rather than bringing substantive suggestions as to how we can work today to improve our health system, the Majority comes to the table once again with a sledgehammer and a long list of myths about what health reform will do.

The Majority continues to warn about the dangers and deficiencies in the health reform. It is their misguided belief that the health reform law will destroy State budgets, kill jobs, drive up health care costs, and overwhelm Medicare and Medicaid.

And while my colleagues seem to take great joy in extolling the problems with the health reform law, they have yet to bring a single, substantive suggestion for improvement. You can see clearly from the five discussion drafts before us today that the Majority has no intention of working with the Minority to improve the health reform law.

The process of drafting good legislation is a difficult one, but as Members of Congress it is our responsibility to draft legislation that will improve the lives of our constituents and communities. A straight repeal of the funding for these public health programs is not in the interest of American families, it is not in the interest of public health, and it is not in the interest of State budgets.

I have long said that no law is perfect, and I strongly believe that as you draft legislation you cannot let the perfect be the enemy of the good. I hope to work with my colleagues to improve this bill and not blindly tear it down. I hope that the next hearing before this subcommittee will deal with the substance and not the politics.

Mr. PITTS. The gentleman's time is expired. The opening statements are concluded. We will recess for the joint session at 11:00. The joint session may end early, so I would urge the members to return 15 minutes after the close of the joint session. So we will recess until approximately 12:00 or before if we can do that.

The committee is in recess.

[Recess.]

Mr. PITTS. The time of recess having expired, the subcommittee will come to order, and I would like to welcome the three witnesses at this time. Note that your written testimony will be entered into the record and we will ask you to summarize, each of you for 5 minutes.

Let me introduce two of the witnesses, and then I will ask the ranking member to introduce the third witness. First of all, the Hon. Ernest Istook serves as a Distinguished Fellow at the Heritage Foundation. Prior to joining Heritage, Mr. Istook served the people of Oklahoma's 5th district for 14 years, and he was a member of the House Appropriations Committee. Secondly, Dr. John Goodman is with us. He is the president and CEO of the National Center for Policy Analysis. Dr. Goodman is an expert on consumer-driven health care reform. He received his PhD in economics from Columbia University. Welcome.

And I will turn to the ranking Member to introduce his witness.

Mr. PALLONE. Thank you, Mr. Chairman.

I already mentioned that Senator Joe Vitale, he has testified before our subcommittee on at least two occasions in the last Congress, I believe, and he was the chairman of the health committee

in the State senate. He continues to be a senior member of the health committee. And he doesn't actually live in my district but a majority or a good portion of his State senate district is in my congressional district. He is a friend, but beyond that, I would say most people in the State would consider him the number one expert on health care in New Jersey, so good to see you.

Mr. PITTS. Thank you, and welcome.

Now the chair recognizes the gentleman Mr. Istook for 5 minutes for his opening statement.

STATEMENTS OF ERNEST J. ISTOOK, DISTINGUISHED FELLOW, THE HERITAGE FOUNDATION; JOHN C. GOODMAN, PRESIDENT AND CEO, NATIONAL CENTER FOR POLICY ANALYSIS; AND JOSEPH F. VITALE, NEW JERSEY STATE SENATE

STATEMENT OF ERNEST J. ISTOOK

Mr. ISTOOK. Thank you, Mr. Chairman, and of course, you have my written testimony. We are here talking of course about the authority for funding and the actual appropriations that were made within what is known both as the Patient Protection and Affordable Care Act, or PPACA, and also known as——

Mr. PITTS. Is your mic on?

Mr. ISTOOK. Let us try it now.

Mr. PITTS. That is better.

Mr. ISTOOK. I will begin again, if I may.

Thank you, Mr. Chairman, for having us here. We are here of course talking about the funding approaches within the health care legislation that was passed last year, formally known as the Patient Protection and Affordable Care Act, PPACA, also known to many of us as Obamacare because of President Obama's crucial role as the driving force.

This legislation was so unwieldy and complicated that even now people are discovering things that they didn't realize about the legislation, and I compare it to the ability to hide a lot of needles inside a haystack that contains 2,700 pages, and people are at different times finding the challenges presented by that. Although original estimates said that the bill created 159 new government agencies, the Congressional Research Service later concluded the actual number of new agencies, boards and so forth is currently unknowable because so many of those are given the authority to sprout off new entities in return.

The new law attempts to bypass the normal appropriations process, which is another feature that makes it more difficult to deal with it, and for we who believe that the bill should be repealed, and if not repealed, then defunded, that presents special challenges because so many advanced appropriations were made. Advance appropriations are actual appropriations for future fiscal years. The comparison is to think in terms of writing checks. If you say I am not going to write any future checks for something, you are trying to defund it. However, if there is already a series of postdated checks out there, you have not defunded it. And I realize that is the subject of a major political battle that we have in Washington.

And of course, that violates the typical Congressional process of appropriations. I spent 14 years as a Member of the House Appropriations Committee, several of those years as a subcommittee chairman. Typically, the normal process is, you create enacting legislation, so-called authorization bills that authorize spending and then the second half of the process is that appropriations are made in the amount that they deem to be proper at the time.

Now, I am not aware personally of any occasions where we have had advance appropriations not just for one fiscal year in the future, not just for two fiscal years in the future but for three, four, five, six, seven. In fact, the legislation actually contained funding actual appropriations spread out over ten different appropriations and fiscal years.

Now, what happens when you do that is, in essence you make an attempt to handcuff the current elected Members of Congress. You can just as easily decide spending levels for a future fiscal year, say, 2079. You could pass a bill now that seeks to control what spending is going to be 5 years, 10 years, 50 years in the future but it would not be good practice.

The people who should make the key funding decisions for the current time are the people who are elected to serve and represent the public at this particular time. So I am glad that you are looking at legislation to pull back funds previously appropriated to PPACA, or Obamacare, which in essence is putting a stop-payment order on these postdated checks. But it is important that this be done both through the authorizing process and through the appropriations process where there is also authority to repeal these existing appropriations and to pull them back.

Defunding is a very routine policy tool for Congress and for the White House. So is funding at levels below what is authorized. As noted by the Congressional Research Service, Congress is not required to provide funds for every agency or purpose authorized by law. One of our founding fathers, James Madison, said it is the power over the purse, which is the most complete and effectual weapon with which any constitution can arm the immediate representatives of the people. However, if the decisions were made by the last Congress, by the prior representatives of the people, then you don't have the same power that James Madison said was essential as a safeguard of the public purse.

I should mention that the White House also routinely proposes not funding programs which have been authorized or funding them at beneath authorized levels. If we intend for a policy to bind future generations, we should follow the supermajority process that would actually enshrine that in the Constitution but we should not accept that a simple act of Congress today should be elevated to handcuff a future Congress not that the last Congress should handcuff the current Congress.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Istook follows:]

TESTIMONY OF ERNEST J. ISTOOK, JR.
FORMER MEMBER OF CONGRESS, 5TH DISTRICT OF OKLAHOMA

TO THE HEALTH SUBCOMMITTEE
HOUSE COMMITTEE ON ENERGY & COMMERCE

MARCH 9, 2011

Mr. Chairman, Members of the committee, thank you for the opportunity to testify today.

Although I am a Distinguished Fellow at The Heritage Foundation, the views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My comments regard the creative use—and abuse—of the appropriations process within the health care legislation enacted into law during the last Congress. It is formally known as the Patient Protection and Affordable Care Act (PPACA), but also known to many of us as Obamacare because of President Obama's crucial role as the driving force.

Because the bill was so unwieldy and complicated, many are only now discovering many of its details and implications. You can hide a lot of needles inside a haystack that contains 2,700 pages.

The massive 2,700-page health care law is deliberately designed to make defunding and dismantlement difficult. Although original estimates reported that it created 159 new government agencies, the Congressional Research Service later concluded that the actual number of new agencies, boards, etc., "is currently unknowable," because so many of them are empowered to spawn additional entities, just as weeds grow by sending out runners and seeds.

The complexity and confusion extends to the funding process created in that legislation.

The new law attempts to bypass the normal appropriations process, another feature that makes defunding more difficult. By making advance appropriations for tens of billions of dollars up to the year 2019, these provisions of Obamacare seek to remove spending decisions from the reach of the current Congress and from future Congresses and Presidents. Although Obamacare was not pitched to the public as a mandatory spending entitlement, the details of the legislation reveal an intent to block any future Congress from controlling Obamacare's spending.

One largely unknown fact is that $6-billion or more was immediately appropriated in the new law and approximately $105-billion more was appropriated for FY2011 and beyond. That violates the typical Congressional process of appropriations. The normal process typically involves enacting authorization bills that authorize spending, and then follows those with separate legislation that actually appropriates the money. This enables those to be balanced with other spending decisions. The PPACA contained large authorizations for future appropriations as well as containing these actual appropriations. That made it quite different from most bills, even major legislation.

This funding also stayed below the radar screen because it was so often reported—inaccurately—that Congress had not passed any appropriations for the current fiscal year. Obviously, the last Congress chose to fund Obamacare even though they failed to pass any of the regular appropriations bills.

For those who support that new law, this may present no problem. But the process should nevertheless offend their sense of an open, well-publicized and orderly process. The funding of Obamacare is a major concern for those many Americans-- including me--who consider the law unwise, unaffordable, and detrimental to affordable and quality health care.

To de-fund Obamacare, it is insufficient simply to deny future funding. Until the full law can be repealed, at least the existing and advance appropriations need to be rescinded, just as the House last month voted to repeal billions of dollars from previous appropriations to 123 federal programs. An effort to restrict use of the funds appropriated within Obamacare was thwarted because the House did not waive the same point of order (House Rule XXI) as it waived to allow de-funding those 123 other programs. This was most unfortunate.

To any who do not realize that over $105-billion has already been appropriated to fund Obamacare, I direct your attention to the February 10, 2011, revision of the Congressional Research Service's paper, "Appropriations and Fund Transfers in the Patient Protection and Affordable Care Act (PPACA)," CRS number R41301. It documents the specific provisions that I'm discussing and the magnitude of those advance appropriations.

Speaking as a former Member of Congress who served 14 years on the House Appropriations Committee, and who chaired several of its subcommittees, I am not aware of any abuse of advance appropriations that even approaches the scale found in Obamacare. An *advance appropriation*, as defined and used by the Office of Management and Budget, is an appropriation made to become available one fiscal year or more beyond the fiscal year for which the appropriation act is passed. These are the exception and not the rule in the congressional appropriations process.

I am personally unaware of any occasion in which an advance appropriation has been made for more than one fiscal year in advance. But in Obamacare, passed during FY2010, we find advance appropriations are made for each and every year up to and including 2019. That is ten years of appropriations.

We know that some have suggested a biennial budget process, under which appropriations would be made for two years at a time. But nobody has proposed that any Congress should make spending decisions trying to bind a future Congresses a full decade in advance.

Making many years' worth of advance spending decisions is an attempt to handcuff the current Congress and prevent it from determining current levels of spending. By going far beyond any precedent for making appropriations for future years, Obamacare is an outrageous effort by the former Congress to bind the current and future Congresses. This may not breach the constitutional limits of Congress, but it certainly breaches the sense of propriety. Spending decisions should be made by those who currently hold office, not by those who have resigned or been turned out by the voters.

The common approach that I have seen in your proposed legislation is simple and straightforward. It changes these advance appropriations so they do not occur unless a future Congress and President decide to spend that money. That approval is not automatic. This is a critical change from the default setting of Obamacare, which makes the spending automatic via advance appropriations.

I am glad that the committee is looking legislation to pull back the funds previously appropriated for Obamacare, but I must caution you that timing and leverage are important parts of your effort. If it

takes years to halt the funding stream, then meantime billions of taxpayer dollars will already have flowed out of the Treasury. The underlying law will have sunk its roots deeper into the nation, making it more difficult to uproot. That is why I believe the appropriations process itself must also be used to extinguish these advance appropriations, since it provides proper legislative vehicles that are considered must-pass legislation.

Defunding is a routine policy tool for Congress. So is funding that is well below the amounts authorized.

As noted by the Congressional Research Service (CRS), "Congress is not required to provide funds for every agency or purpose authorized by law." Defunding is a legitimate use of the power of the purse that the Founding Fathers wisely granted to Congress. As James Madison said, "This power over the purse may, in fact, be regarded as the most complete and effectual weapon with which any constitution can arm the immediate representatives of the people, for obtaining a redress of every grievance, and fo carrying into effect every just and salutary measure."

The White House also routinely proposes zero funding for many federal programs. In his latest budget proposal, President Obama proposes what his budget office describes as 211 program terminations and reductions.

So when a repeal of legislation is blocked, defunding is the obvious and proper next approach. In the case of Obamacare, this is tricky because the law is designed to be difficult to uproot, just like a plant with an elaborate root system. Everyone who has a lawn and has pulled weeds knows this problem firsthand.

But defunding can be done and should be done, and internal Congressional protocols should not be used to block this. Undoing what was done last year is a proper pursuit. Dr. Ed Feulner, president of The Heritage Foundation, often reminds us that in Washington there are no permanent victories and no permanent defeats.

If we intend for a policy to bind future generations, we should follow the super-majority process that would enshrine it in our Constitution. But we should not accept that a simple act of Congress today should be elevated to handcuff a future Congress.

Thank you for the opportunity to testify today, and I look forward to your questions.

Mr. PITTS. The chair thanks the gentleman and recognizes Dr. Goodman for 5 minutes for an opening statement.

STATEMENT OF JOHN C. GOODMAN

Mr. GOODMAN. Thank you, Mr. Chairman, members of the committee. My name is John Goodman. I am president of the National Center for Policy Analysis.

I would like to begin by saying there are serious structural problems in the Affordable Care Act and they are so serious that even if the critics weren't around, the Congress is going to have to go in and make major structural changes to this bill. Let me just draw your attention to a few of them.

First, people are going to be required to buy an insurance plan whose cost is going to grow at twice the rate of growth of their income. You don't have to be a mathematician or an accountant or an economist to know that if you have to buy something whose cost is growing at twice the rate of growth of your income, eventually it is going to crowd out everything else that you are consuming. That is an impossible path. It wasn't created by President Obama or by Congress, but the bill, the Affordable Care Act, locks us onto that path and takes away a lot of the ability that people need in order to get off of it and move to a lower-cost health care system.

Secondly, there is a bizarre system of subsidies in the act under which people at the same income level get radically different amounts of help from the Federal Government depending upon whether they are on Medicaid, whether they are in an employer plan or whether they are in an exchange. For example, a family at an income level of $30,000 a year in the health insurance exchange will get more than $16,000 of help from the Federal Government. That same family at work gets the current tax break which is a little over $2,000. I think this huge discrepancy of subsidies is one of the why the job market is not responding better than it is right now. There is enormous uncertainty right now on the employer side but eventually this is going to be very, very disruptive and eventually I think everybody who is average income or below average income is going to lose his employer-provided health insurance. The numbers are just so large and the incentives are just so great. They will either go into Medicaid or they will go into an exchange, or the subsidized plans, if we follow the Massachusetts example, will pay little better than Medicaid rates. Essentially you can think of it as Medicaid Plus.

Number three, in the exchange itself we are creating perverse incentives for insurers. They will have to take all comers for the same premium. They will try to attract the healthy and avoid the sick. After people enroll, they have an incentive to overprovide to the healthy because those are the ones they want to keep. They want to attract more just like them. They will have an incentive to underprovide to the sick because they didn't want them in the first place and they certainly don't want to attract any more just like them. I think this is one of the worst features of the bill and it is the one that has been the least talked about in Congress and outside Congress.

On the other side of the exchange from the buyer's point of view, the incentives are also perverse. In Massachusetts, people are

going bare while they are healthy. They get sick, they enroll, they pay premiums for a few months, get their health care, get their bills paid and then they drop coverage again. So far, we are only talking about a few thousand people although the number is growing every year. In a State like Texas where we are signing up people for Medicaid in the emergency room, this would be absolutely disastrous.

Number five, we have promises that we can't possibly keep. This bill will insure between 32, 34 million additional people if the economic studies are correct. These people will try to consume twice as much health care as they have been consuming. In addition, almost everybody else is going to be pushed into a plan where benefits are more generous than they are now. There is a whole long list of preventive services that have to be made available with no deductible, no copayment. Bottom line, we are going to have a huge increase in demand for care. The bill has no provision for increasing supplies. We are going to have a huge rationing problem, and that is going to be very, very bad for anyone whose plan pays below market rates, and who are those people? That is everybody in Medicare, everybody in Medicaid and maybe everybody who is getting subsidized insurance in the health insurance exchange.

And finally, we have impossible benefit cuts for seniors. We are paying for more than half the cost by cutting spending on Medicare. What are we talking about? Well, for someone reaching the age of 65 this year, the reduction in Medicare spending will be about $35,000 in present value terms. That is equal to about 3 years' worth of benefits. For a 55-year-old, the day that President Obama signed the bill, they lost $60,000 in spending, and for 45-year-olds, it is $100,000 in spending. Where are all these dollars coming from? I heard on TV this morning they were going to come from eliminating waste, fraud and abuse. Well, that is ridiculous. Where it is going to come from is in reduced payments to doctors and hospitals and other providers. According to the Medicare chief actuary, by the end of this decade Medicare will be paying doctors and hospitals less than Medicaid. Senior citizens will be behind welfare mothers in terms of their attractiveness to physicians. In 3 years, most of you will be flooded by phone calls from constituents telling you they can't find a doctor. I think it is a very, very serious problem and one that Congress has not yet addressed.

The appropriations process is not the only way to deal with this but Congressional oversight is certainly a beginning.

[The prepared statement of Mr. Goodman follows:]

Statement of

John C. Goodman

President and CEO

National Center for Policy Analysis

on

Putting Health Care on a Sustainable Path

Energy and Commerce Subcommittee on Health

United States House of Representatives

March 9, 2011

Mr. Chairman and members of the Subcommittee, I am John Goodman, President of the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

Structural Flaws in the New Health Reform Law[1]

There are major structural flaws in the Patient Protection and Affordable Care Act (PPACA). Each is so potentially damaging, Congress will have to resort to major corrective action even if critics of the new health care law are not part of it. Further, each must be addressed in any new attempt to create workable health care reform.

Because Congress chose to fund much of the PPACA through direct appropriations, the structural flaws I am going to explain become even more damaging because they are much harder to address through the regular appropriations process, where spending priorities are usually debated and decided. Instead, Congress chose to implement much of the PPACA through direct appropriations, rather than annual appropriations, making it more difficult to oversee, review and adjust the funding levels of these new programs. Unlike many of you, I am not an expert on the Congressional appropriations process, but going forward I can see how it will become more difficult for Congress to prioritize spending decisions because many of these long-term spending levels have already been set in law. And when funding runs out for several

[1] Some of this testimony was taken from John C. Goodman, "Repeal and Replace: 10 Necessary Changes," National Center for Policy Analysis, Special Publications, January 17, 2011. Available at http://www.ncpa.org/pub/repeal-and-replace-10-necessary-changes.

of the programs, they will face a so-called budget cliff, creating an incentive for Congress to simply renew funding, rather than evaluate the success or failure of their funding decisions.

An Ever-More-Costly Mandate[2]

Health costs per capita have been rising at twice the rate of per capita income for the past 40 years. This is not a uniquely American problem. On the average, the same trend is in place for the entire developed world. But here is the bottom line: If you have to buy something whose cost is rising at twice the rate of growth of your income, that mandated purchase will consume more and more of your disposable income with each passing year.

Fortunately, there is a better way to achieve the same desirable end: 1) Repeal the individual and employer mandates, 2) offer a generous tax subsidy to people to obtain insurance, but 3) allow them the freedom and flexibility to adjust their benefits and cost-sharing in order to control costs.[3]

A Bizarre System of Subsidies[4]

One problem with the PPACA is that it offers radically different subsidies to people at the same income level,[5] depending on where they obtain their health insurance — at work, through an

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[2]John C. Goodman, "Four Trojan Horses," Health Alerts, National Center for Policy Analysis, April 15, 2010. Available at http://healthblog.ncpa.org/four-trojan-horses/.

[3] John C. Goodman, "Characteristics Of An Ideal Health Care System," National Center for Policy Analysis, NCPA Policy Report No. 242, April 30, 2001. Available at http://www.ncpa.org/pdfs/st242.pdf.

[4] Stephen Entin, "Health Insurance Exchange Subsidies Create Inequities," National Center for Policy Analysis, Brief Analysis No. 696, March 3, 2010. Available at http://www.ncpa.org/pdfs/Health-Insurance-Exchange-Subsidies-Create-Inequities.pdf.

exchange or through Medicaid. The subsidies (and the accompanying mandates) will cause millions of employees to lose their employer plans and may cause them to lose their jobs as well. At a minimum, these subsidies will cause a huge, uneconomical restructuring of American industry.[6]

Look at it from the employee's point of view. The new law says that an employee must have insurance costing, say, $15,000 for family coverage in 2016. Remembering that employee benefits are a dollar-for-dollar substitute for wages, that implies that a previously uninsured $30,000-a-year worker will get a 50% cut in pay. Further, the only help this worker will get from Uncle Sam will be the ability of the employer to pay the premiums with pretax dollars. That's worth about $2,298. (See the chart.) On the other hand, if this worker can get the same insurance through the newly created health insurance exchange, the federal government will pay almost all the premium and reimburse most out-of-pocket expenses. That's a total net subsidy worth more than $16,000.

It follows that every worker at this income level is going to want to work for a firm that does not offer health insurance and pays cash wages instead. Yes, this employer will have to pay a $2,000 fine. But the fine is well worth the opportunity to obtain a net benefit of more than $13,000.

As family income rises, the subsidy in the health insurance exchange falls. A family earning $42,000 would qualify for an exchange subsidy of $12,512; but the same coverage through work

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[5] Stephanie Rennane and C. Eugene Steuerle, "Health Reform: A Two-Subsidy System," Tax Policy Center (Brookings Institution and Urban Institute), S10-0001, April 2, 2010. Available at www.taxpolicycenter.org/numbers/Content/PDF/S10-0001.pdf.

[6] John C. Goodman, "Four Trojan Horses."

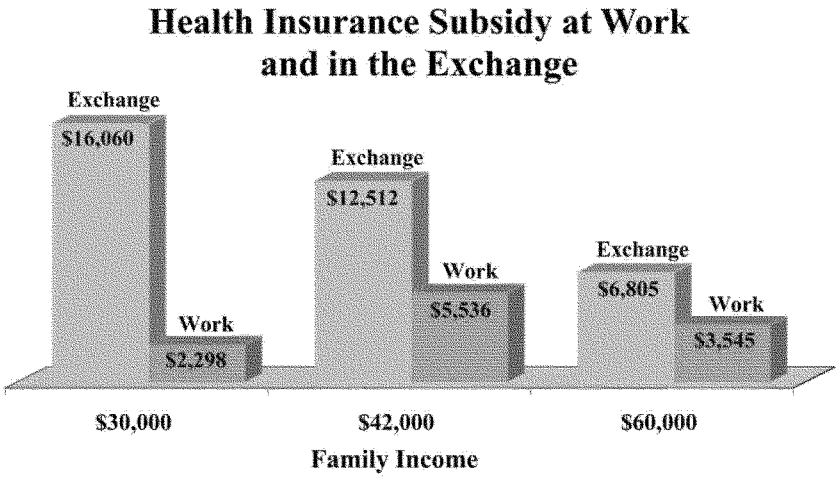
would result in a tax subsidy of $5,536. At $60,000 the exchange subsidy would only be worth $6,805 while the subsidy at work would be worth $3,545.

Now consider a $100,000-a-year worker (not shown in the chart). This employee will get no subsidy in the exchange. But insurance premiums paid by the employee will avoid a 15.3% payroll (FICA) tax, a 25% federal income tax and, say, a 5% state and local income tax. So at work, the federal government is prepared to pay almost half the cost of this employee's health insurance. It follows that any worker at this income level will want to work for a company that does offer health insurance.

In competition for labor, therefore, companies and entire industries will reorganize. Low-income workers will congregate in companies that do not provide insurance; high-income employees will work for firms that do provide it. Firms that ignore these worker preferences will not survive.

This implies two bad results: 1) much higher burdens for taxpayers as millions more take advantage of the subsidies than the Congressional Budget Office (CBO) has predicted and 2) an entire economy whose structure is based not on sound economics, but on gaming an irrational subsidy system. Again, there is a better way: Offer people the same tax relief for health insurance, regardless of where it is obtained or purchased — preferably in the form of a lump-sum, refundable tax credit. [7]

[7] John C. Goodman, "Characteristics Of An Ideal Health Care System."



Source: Stephanie Rennane and C. Eugene Steuerle, "Health Reform: A Two-Subsidy System," Tax Policy Center (Brookings Institution and Urban Institute), S10-0001, April 02, 2010.

Perverse Incentives for Insurers[8]

We have heard much from the White House and congressional leaders about how insurance companies are abusing people. You haven't seen anything yet. Inside the health insurance exchange, no insurer will be able to charge a sick person more or a healthy person less. So insurers will try to attract the healthy and avoid the sick — even more than they do today!

Furthermore, after enrollment the perverse incentives will not end. Health plans will tend to overprovide to the healthy (to keep the ones they have and attract more) and underprovide to the sick (to discourage the arrival of new ones and encourage the departure of the ones they already

[8] John C. Goodman, "Rational Health Insurance," National Center for Policy Analysis, Health Alert, April 10, 2009. Available at http://healthblog.ncpa.org/rational-health-insurance/.

have). Of course, there are countervailing forces: professional ethics, malpractice law, regulatory agencies. But ask yourself this question: Would you want to eat at a restaurant that you know does not want your business? You should think the same way about health plans.

The alternative: Instead of requiring insurers to ignore the fact that some people are sicker and more costly to insure than others, we should adopt a system that compensates them for the higher expected costs — ideally making a high-cost enrollee just as attractive to an insurer as a low-cost enrollee.

Perverse Incentives for Individuals

The PPACA allows individuals to remain uninsured while they are healthy (paying a small fine or no fine at all) and to enroll in a health plan after they get sick (paying the same premium everyone else is paying). No insurance pool can survive the gaming of the system that is likely to ensue.

A poorly reported development in Massachusetts, for example, is the growing number of people who are gaming the system.[9] People remain uninsured while they are healthy and get insurance after they get sick. Then, after they receive care and their medical bills are paid, they drop their coverage again. This behavior is more likely the lower the penalty for being uninsured and more weakly the individual mandate is enforced.

Under the federal health reform law, the fines for being uninsured are low. When fully phased in, the fine is $695 for individuals and $2,085 for families, or up to 2.5% of income. Thus, those

[9] John C. Goodman, "In Massachusetts People are Gaming the System," National Center for Policy Analysis, Health Alert, July 1, 2010. Available at http://healthblog.ncpa.org/in-massachusetts-people-are-gaming-the-system/.

who do not pay thousands of dollars worth of premiums may face only a few hundred dollars in penalties — which is a bargain.

Individuals gaming the system could be the death knell for private insurance.

A better solution: People who remain continuously insured should not be penalized if they have to change insurers; however, people who are willfully uninsured should not be able to completely free-ride on others by gaming the system.[10]

Impossible Expectations/A Tattered Safety Net

The PPACA aims to provide expanded coverage for most Americans who have insurance, and to insure as many as 34 million uninsured people. Economic studies suggest the newly insured will try to double their consumption of medical care. Yet the Act will not create the new doctors, nurses or paramedical personnel that will be required to provide health care to these newly insured patients. In fact, we can expect as many as 900,000 additional emergency room visits every year — mainly by new enrollees in Medicaid — and still, 23 million of these individuals are expected to remain uninsured. Yet, as was the case in Massachusetts, there no mechanism to ensure that funding will be there for safety net institutions that will shoulder the biggest burdens. Their "disproportionate share" funds are slated to be cut.[11]

Again, there are better alternatives: 1) Liberate the supply side of the market by allowing nurses, paramedics and pharmacists to deliver care they are competent to deliver; 2) allow

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[10] John C. Goodman, "Do We Need an Individual Mandate?" National Center for Policy Analysis, Health Alert, May 26, 2010. Available at http://healthblog.ncpa.org/do-we-need-an-individual-mandate-2/.

[11] John C. Goodman, "Empty Promises, National Center for Policy Analysis, Health Alert, October 13, 2010. Available at http://healthblog.ncpa.org/empty-promises/.

Medicare and Medicaid to cover walk-in clinics at shopping malls and other unconventional care — paying market prices; 3) free doctors to provide lower-cost, higher-quality services by allowing them to share in any savings they create from efficiencies in the delivery of that care; and 4) redirect unclaimed health insurance tax credits (for people who elect to remain uninsured) to the safety net institutions in the areas where they live — to provide a source of funds in case they cannot pay their own medical bills.[12]

Impossible Benefit Cuts for Seniors

The PPACA's cuts in Medicare are draconian:[13]

- More than half the cost of health reform will be paid for by $523 billion in reduced Medicare spending over the next 10 years.[14]
- In general, these Medicare spending cuts exceed the new benefits by a factor of more than 10 to one.[15]
- More than $200 billion in spending cuts are directed at Medicare Advantage (MA) plans. By 2017, seniors in such cities as Dallas, Houston and San Antonio will lose one-third of their benefits.[16]

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[12] John C. Goodman, "Characteristics Of An Ideal Health Care System."

[13] "What Does Health Reform Mean to You? National Center for Policy Analysis, Special Publication, 2010. Available at http://www.ncpa.org/pdfs/What-Does-Health-Reform-Mean-for-You-A-Consumers-Guide.pdf.

[14] CBO Letter to Nancy Pelosi, Congressional Budget Office, March 20, 2010.

[15] Ibid.

[16] Robert A. Book and James C. Capretta, "Reductions in Medicare Advantage Payments: The Impact on Seniors by Region," Heritage Foundation, Backgrounder No. 2464, September 14, 2010.

- As a result, one of every two people expected to participate in Medicare Advantage over the next 10 years (7.4 million of 14 million) will lose their coverage entirely, according to Medicare's chief actuary; and those who retain their MA coverage will face steep cuts in benefits or hefty increases in premiums, or both.
- In addition to these direct costs there are indirect costs, including new taxes on drugs and medical devices — items that are disproportionately used by seniors and the disabled.

To make matters worse, the planned cuts in Medicare fees may cause some doctors to retire and force some hospitals out of business, according to Medicare's chief actuary. Moreover, as 100 million newly and more generously insured people try to increase their consumption of medical care, the elderly may find it increasingly difficult to obtain the care they need.

By 2020, regular fee-for-service Medicare nationwide will pay doctors and hospitals less than what Medicaid pays. And in succeeding years, reduced payments get really brutal. Seniors will be lined up behind Medicaid patients at community health centers and safety net hospitals unless this is changed. Either 1) these cuts were never a serious way to fund the PPACA, because Congress will cave and restore them, or 2) the elderly and the disabled will be in a separate (and inferior) health care system.[17]

The PPACA reduces total Medicare spending.[18] While lower Medicare spending means that premiums paid by the beneficiaries will be reduced, as will the taxes they have to pay to support Medicare, this reduced spending will surely result in reduced access and lower-quality care.

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[17] John Goodman, "What Will President Obama Say About Medicare?" *Kaiser Health News*, January 25, 2011.

[18] Courtney Collins and Andrew J. Rettenmaier, "The Impact of the Affordable Care Act on the Generational Burden of Medicare," National Center for Policy Analysis, forthcoming, 2011.

Among the solutions for seniors: In order to avoid a two-tier health care system, many of the cuts to Medicare required by the PPACA will have to be restored. However, Medicare cost increases can be slowed by empowering patients and allowing doctors to repackage and reprice their services in a way that encouraged them to compete for patients based on both price and quality of care.

The goal of these arrangements is not to save as much money as possible for Medicare. The goal is to encourage a competitive market on the provider side — in which every doctor and every facility is encouraged to continuously search for ways to rebundle and reprice medical services in quality-enhancing, cost-reducing ways.

Once one hospital or doctor group implements an arrangement with better payment for better results, there will be competitive pressures on other providers to find new and innovative ways of raising quality and lowering costs. Plus, once Medicare takes these steps, private insurers can adopt similar payment systems more easily. Medicare and the private sector will be pushing in the same direction, for better care — not just more services.[19]

Conclusion

Ideally, one hopes the two parties will work together to reform health care in a way that's good for doctors and patients. Congress should begin by voting to repeal the most politically unpopular features of health care reform. That means no individual mandates, no individual or employer fines, and no regulations of the type that might cause an employer, such as

[19] John C. Goodman, "A Framework for Medicare Reform."

McDonald's, to drop coverage for 30,000 low-wage employees and the 3M Corporation to drop coverage for all its retirees. Then Congress should come to the rescue of senior citizens.

If there is a budgetary cost for these measures, pay for them by pushing back the date when all the subsidies and mandates are supposed to kick in (Jan. 1, 2014). The short-term goal should be to push back the dates of these rate cuts by an election cycle or two. And in order to compensate for pushing back the rate cuts, push back the date of implementation as well. Just as the draconian cuts to Medicare provider fees get postponed year after year, the dates of other PPACA provisions should also be postponed year after year.

Let's hope Republicans and Democrats agree on Medicare reforms that will really control runaway entitlement spending. In the meantime, the approach should be to cancel cuts that are never going to be made anyway and pay for the cancellation by delaying the implementation of key provisions of the PPACA.[20]

[20] Some of these ideas were discussed in John C. Goodman, "What Can Republicans Do About Obamacare?" *National Review Online*, November 10, 2010.

Mr. PITTS. The chair thanks the gentleman and recognizes Senator Vitale for 5 minutes for an opening statement.

STATEMENT OF JOSEPH F. VITALE

Mr. VITALE. Thank you, Mr. Chairman. Good afternoon, Chairman Pitts and members of the Subcommittee on Health. My name is Joe Vitale. I was elected to the New Jersey State Senate in 1998 and had the distinct pleasure of serving with your colleague, Congressman Leonard Lance. In fact, he is my Congressman. Congressman Pitts, Congressman Pallone and Congressman Waxman, thank you for the invitation to testify regarding proposals that would defund critical pieces of the Patient Protection and Affordable Care Act.

I want to limit my testimony to how PPACA will benefit New Jersey citizens and how the act has already begun to do so and how defunding elements of reform will only serve to undermine access to our State's uninsured citizens. In addition, I will cover some ground on how the federal and State health care partnerships have already made a significant difference in the wellbeing of hundreds of thousands of New Jerseyans.

New Jersey was recently awarded a $1 million health exchange planning grant. The State department of banking and insurance awarded nearly $250,000 of that money to the Rutgers University Center for State Health Policy, which is a nonpartisan evidence-based think tank, to hold shareholder sensing meetings. The center will provide it gathers through these meetings and to provide to the State and other stakeholders including legislators. With the remaining funding, the department has planned to hire consultants to inform policymakers of aspects of an exchange such as design, development and oversight. In short, an exchange designed specific for New Jersey will contemplate and deliver a well-thought-out mechanism where hundreds of thousands of currently uninsured New Jerseyans will gain access to affordable and sustainable health care coverage. It is my belief that a properly financed and implemented exchange as made available through PPACA is smart, efficient and a sustainable way to access the appropriate care.

The public health initiatives are the single-most proven method of controlling health care costs. Vaccinations, workplace safety, infectious disease control, safe food handling, prenatal care and family planning are just a few examples of how population-based prevention and public health programs are the most effective investment Congress can make to control future health care costs.

One example through PPACA is where New Jersey received $350,000 for an HIV prevention grant. With these funds, we have tested an alternate means of confirming HIV that replaces a more expensive test at a fraction of the cost. Defunding public health initiatives will have a devastating consequence for all the people we serve.

Of all the components of PPACA that are being considered for defunding, rolling back expansion of school-based health centers may be the most shortsighted. Five years ago, I worked with the Visiting Nurse Association of Central New Jersey to create a nontraditional school-based health services program in the suburban middle-class town in which I live. Children enrolled in the program

are able to see a visiting advanced practice nurse within the school nurse's office. APNs are licensed and able to diagnose and recommend treatment. Prescriptions are called in to the student's pharmacy so that they are ready for their parents to pick up on the way home. Children are treated faster, return to their classroom sooner and parents miss less work that many times adds up to less income and employee productivity. At the request of parents, the Visiting Nurse Association now provides annual sports evaluations for their students. School-based health centers require a relatively small investment and provide an enormous return on that investment.

Through PPACA, New Jersey has received several grants to address primary care workforce shortages. Defunding programs aimed at addressing these critical shortages for me may be the most reckless. The primary care workforce shortages impact every State and will reach critical levels as access to health care coverage is expanded. It takes 10 years to produce a physician and 8 years to produce an advanced practice nurse. In New Jersey, we already aggressively addressing this issue but we cannot go it alone and PPACA will make an enormous difference. A loan redemption program has been created to encourage nurses to pursue nursing faculty careers. PPACA dedicated $800,000 to this program and will help ensure that New Jersey's health care system can handle the increased demand.

Through PPACA, New Jersey Department of Labor was awarded $150,000 workforce development primary care grant and has received $10,560,000 to increase the number of resident physicians trained in family medicine, general internal medicine and pediatrics. Defunding primary care workforce development will cripple health care delivery in States that do not already have existing health care workforce development programs in place.

As one of the original authors and ongoing supporters of New Jersey's SCHIP program, I can tell you firsthand just how effective federal and State partnerships can be. Currently, New Jersey enrolls over 600,000 children in SCHIP and in Medicaid, an additional 600,000 parents and adults without children in SCHIP and in Medicaid as well. Many also contribute to that insurance.

I will close by saying that most of us elected officials enjoy some of the best health insurance that taxpayer dollars can subsidize. I think it is fair and right that we extend that same generosity to millions of Americans who may never have that same opportunity. Thank you.

[The prepared statement of Mr. Vitale follows:]

U.S. House of Representatives
Committee on Energy & Commerce
Subcommittee on Health Hearing
Wednesday, March 9, 2011

Testimony of Joseph F. Vitale
New Jersey Senate

Good morning, Chairman Pitts and members of the Subcommittee on Health. My name is Joe Vitale. I was elected to the New Jersey State Senate in 1998 and had the distinct pleasure of serving many of those years with your colleague Congressman Leonard Lance. I am also a small business owner who understands first hand the crippling impact that double digit health insurance premium increases have on a business with limited cash flow flexibility.

Chairman Pitts, Congressman Pallone, Congressman Waxman, thank you for the invitation to testify today regarding proposals before this Committee that would defund critical pieces of the Patient Protection and Affordable Care Act (P-PACA). As members of this Committee, you all have found yourselves at a critical crossroads. I urge you to stay the course. P-PACA, while imperfect, has created a framework for States to follow to provide universal, portable, affordable and sustainable health care access to the 47 Million uninsured people in the United States.

NEW JERSEY'S EXPERIENCE LEADING UP TO PASSAGE OF P-PACA

Finding real ways to cover the uninsured has been largely a bipartisan effort in New Jersey. In fact, some might argue that my Republican colleagues in the Legislature have been the leading force behind such efforts. Our SCHIP program -- which was first called KidCare -- was implemented by legislation sponsored by former Governor Donald DiFrancesco, a Republican. Republican Governor Christie Whitman expanded that program to some of the highest eligibility levels in our country and to populations that the Clinton Administration refused to provide matching funds for: childless adults.

As a result of Governor Whitman's leadership, New Jersey SCHIP first enrolled parents and childless adults in October 2000. In 2001, the cost of hospital charity care provided to the uninsured decreased by $75 million. The large number of applicants, along with a multi-billion dollar budget deficit, forced the state to stop taking applications in 2002. As a result, documented charity care increased more than $100 million. The shift was socially unfair and economically wasteful: charity care is a much more expensive model of care per capita and less reliably provided. In contrast, health insurance through the New Jersey SCHIP program provides preventive care and saves government money - more than $900 per person per year -- while achieving better patient outcomes (see Appendix A).

Prior to passage of P-PACA, New Jersey worked incrementally toward health reform. In 2006, I asked David Knowlton of the New Jersey Health Care Quality Institute and the

President of LeapFrog to chair a working group of twenty-two health policy experts representing a wide variety of professional experience to examine how New Jersey could build a framework for providing universal, portable, affordable and sustainable health care access to New Jersey's remaining 1.3 million uninsured.

I believed then, as I do today, that New Jersey could not have enacted our most recent reforms without taking the time to painstakingly understand the complexity of those reforms' impact on the diverse group of stakeholders that health care encompasses. It was through those efforts that we were able to offer a thorough and well planned legislative proposal that enjoyed overwhelming bi-partisan approval moving from announcement to passage into law in four months.

New Jersey has learned many lessons as we grappled with the complexity of providing access to health care for the uninsured over the past several years. Our state's efforts have only been enhanced by passage of P-PACA. The proposals you are considering today would drive our efforts in New Jersey to a screeching halt.

DEFUNDING STATE-BASED HEALTH INSURANCE EXCHANGE GRANTS

Defunding State-based health insurance exchanges will only serve to eliminate State flexibility, paving the way for a single Federally-based health insurance exchange. The irony that I find in such a proposal is that it is coming from those who are typically

ideologically-opposed to the expansion of federal government in favor of greater state autonomy.

As many of you may remember, Congressman Weiner has advocated for the incremental expansion of a Federally-based health insurance exchange from the very beginning of this debate, but was opposed by Republicans in Congress at every turn. That expanded federal exchange that Congressman Weiner advocated for is called Medicare.

New Jersey was awarded a $1,000,000 Health Insurance Exchange Planning Grant. The State Department of Banking and Insurance awarded nearly $250,000 to the Rutgers University Center for State Health Policy, a nonpartisan, evidence-based think tank, to hold stakeholder sensing meetings. Meetings have already begun with various stakeholder groups, including consumers, providers, and insurers. The Center will compile input it gathers through these meetings and provide it to the State.

With the remaining funding, the Department plans to hire consultants to inform policymakers about such aspects of the Health Insurance Exchange such as benefit design, interface development and oversight. The value in this exercise is in the consensus it achieves and while it may seem unnecessary to duplicate such a process in each State, you will find that each State's exchange will be different. This controlled flexibility provides the opportunity for best practices to emerge across the nation, and for state policymakers to learn from the experience of their colleagues in other states.

DEFUNDING PREVENTION AND PUBLIC HEALTH FUND

Public health initiatives are the single most proven method for controlling health care costs. Vaccination, motor-vehicle safety, workplace safety, infectious disease control, safe food handling, nearly-universal access to prenatal care, family planning, and fluoridated water are all examples of how population-based, prevention and public health programs are the most cost effective investment Congress can make to control future health care costs.

New Jersey has received nearly $3,000,000 in Prevention and Public Health Fund grants. In one of the funded initiatives, we are bringing primary health care services to people in their behavioral/mental health care setting. This population is one of the most expensive to manage and we have learned that it pays to take the care to the client.

New Jersey is also working with CMS on an exciting demonstration project that seeks to better manage the care of our most expensive hospital charity care cases. This effort expands on the innovative work of Jeff Brenner, a family doctor in Camden, NJ. Dr. Brenner analyzed charity care data for the three hospitals that serve the Camden area. He found that most people accessing hospital charity care lived in one particular housing complex. Last month he met with the residents of the building and offered to open a primary health care office in the basement of their building. Physicians, advanced practice nurses and social workers will provide for the primary health care needs of the tenants at a fraction of the cost of care in the emergency room.

Another important function of P-PACA Prevention Public Health funding has been to add stability to discretionary programs such as AIDS Services Programs throughout the country. To give you a sense of the real life impact of Congress's failure to pass a budget, CMS is left only able to provide State programs with partial grants. As a result, programs are left with the difficult decision to accept clients without knowing whether the funding to care for those clients will be eliminated in three months and even worse now, in just two weeks.

Through P-PACA, New Jersey has received a $350,000 HIV Prevention Grant. With these funds we have tested an alternate means of confirming HIV that replaces the expensive Western Blot Test with a second rapid test at a fraction of the cost. In doing so we have become more effective in getting an individual found to be HIV-positive into treatment right away. By decreasing the turn-around time for confirmation of an HIV-positive diagnosis, we can help infected individuals control their disease, and we can effectively reduce the transmission rate of HIV/AIDS in New Jersey. The CDC is now considering modifying its surveillance requirements by adopting the rapid-response protocol tested in New Jersey.

Innovative, cost saving programs such as those I have just described would abruptly end if you were to defund the P-PACA Prevention and Public Health Fund. I urge you to view this funding as a critical investment in your own States' economies. When I hear people voice criticism about how much of our nation's gross domestic product is spent on health care, I scratch my head. Health care is made in the USA, and

consumed in the USA. It can not be outsourced. It requires an educated workforce and, for the most part, pays self-sustaining wages. The end result of health care program cut-backs are health care provider lay-offs, and increased difficulty for health care consumers to access care. Passing the P-PACA defunding proposals before you today will have a dire consequences for the constituents you serve.

DEFUNDING SCHOOL-BASED HEALTH CENTERS

Of all the different components of P-PACA that are being considered for defunding today, rolling back the expansion of our country's School-based Health Centers may be the most short-sighted. Five years ago, I worked with the Visiting Nurses Association of Central Jersey to create non-traditional school-based health services in the suburban, middle-class town where I live, Woodbridge Township.

Parents enrolled in the program are able to see a visiting Advanced Practice Nurse within the school nurses office when they are sick. When a student enrolled in the program reports to his school nurse, an APN is dispatched to that school to evaluate the child, provide a diagnosis and recommend treatment. Prescriptions are called into the student's pharmacy so that they are ready for parents to pick up on their way home. Children are treated faster, return to class sooner and parents miss less work, adding to employee productivity. At the request of parents, the visiting advanced practice nurse now provides annual sports evaluations for students.

This is what's called low-hanging fruit - a small investment with a huge return. If only all of our investments assured us similar returns.

DEFUNDING PRIMARY HEALTH CARE WORKFORCE DEVELOPMENT

Through P-PACA, New Jersey has received several grants to address projected primary health care workforce shortages. Defunding programs aimed at addressing the critical shortage of primary care providers may very well be the most irresponsible of the proposals before you today. The primary care workforce shortage is not solely a New Jersey problem; it is a problem in every single state that will reach a critical level as access to health care coverage is expanded to currently uninsured populations. It takes ten years to produce a physician. It takes six to eight years to produce an advanced practice nurse.

The New Jersey Nursing Initiative, funded by the New Jersey State Chamber of Commerce and the Robert Wood Johnson Foundation, was formed in 2007 and has been a comprehensive effort to expand the capacity of nursing education throughout the State. I have been closely involved in this specific project and while implementation has taken time, we are just now starting to see the fruits of our coordinated efforts. Community colleges have begun to establish relationships with four-year schools to create nursing bachelor degree completion programs throughout New Jersey. A loan

redemption program has been created to encourage nurses to pursue nursing faculty careers. P-PACA dedicates $800,000 to this program and will help to ensure New Jersey's health care system can handle the increased demand in health care services that will be created when persons currently uninsured are able to access affordable health care coverage.

The New Jersey Department of Labor was awarded a $150,000 workforce development primary care grant to study the full scope of the primary care needs that will result from implementation of P-PACA. We have also received $10,560,000 to increase the number of resident physicians trained in family medicine, general internal medicine and general pediatrics.

Defunding primary care workforce development will cripple health care delivery in states that do not already have existing health care workforce development programs in place. While states like New Jersey will be set back by the decision to defund health care workforce development, states that have not already implemented programs will be left in crisis, unable to produce the doctors and nurses needed to care for their residents.

CONCLUSION

There is only so much that any individual state can afford to do on its own in this difficult economic climate. Our hard work in New Jersey, to date -- in partnership with the

Federal Government -- has assisted countless New Jersey families and children who would otherwise have had their health jeopardized because they were uninsured.

In the course of the national health care reform debate, there are those who have said that they believe that a government-backed plan will be too expensive, that it will leave millions of Americans behind, that it will dictate the amount of health care apportioned to the newly insured, and that it will destroy the competitive advantages that privately funded insurers offer. Respectfully, I disagree.

I believe that the P-PACA does what government is meant to do. It fills the void that has been left by the private sector. It does so by leveling the playing field and ensuring that health coverage remains a partnership between individuals and their employers. It does not expand government's role in the health care arena, and it's certainly not a government take over of the health care industry. It is an assurance that the dollars on the table today, remain on the table tomorrow and are spent effectively on the most efficient model of care possible.

Government already pays more into the health care system than any private entity. Taxpayers already finance subsidies to companies who provide health coverage for their employees through generous tax breaks. We also fund a considerable amount of health care research and development. The Government invests in building the infrastructure through which health care is delivered, and in the education of those that deliver it. Taxpayers pay for services to the elderly, the disabled and the poor, while

also providing billions of dollars to hospitals to care for the uninsured. P-PACA balances these resources so all Americans benefit from their investment in our nations' health care system.

At the end of the day, the interest of American consumers must remain at the nexus of your debate.

I have read comments from some who worry that a government plan will cause prices to be controlled. The irony in their commentary is that they completely ignore the fact that the single largest problem facing our health care system today *is* COST. We spend more in the United State on health care than any other industrialized nation and have worse health outcomes for our investment.

For as long as I can remember, high cost, waste, inefficiency, medical errors, antiquated medical records, and a lack of comprehensive, reliable preventive care have driven costs in the existing marketplace to ever-growing, unsustainable levels. So many Americans who struggle every day, work hard for their families and do the right thing, will by and large never afford the cost of health insurance and the care that all of us with an insurance card enjoy. They can't even afford to fill the prescription a doctor writes.

Trust your states – the "laboratories of democracy" - to build working models and study solutions where there is not yet national consensus. It may take time, but we cannot afford to fail. Toward that end, I pledge New Jersey's continued cooperation. We will

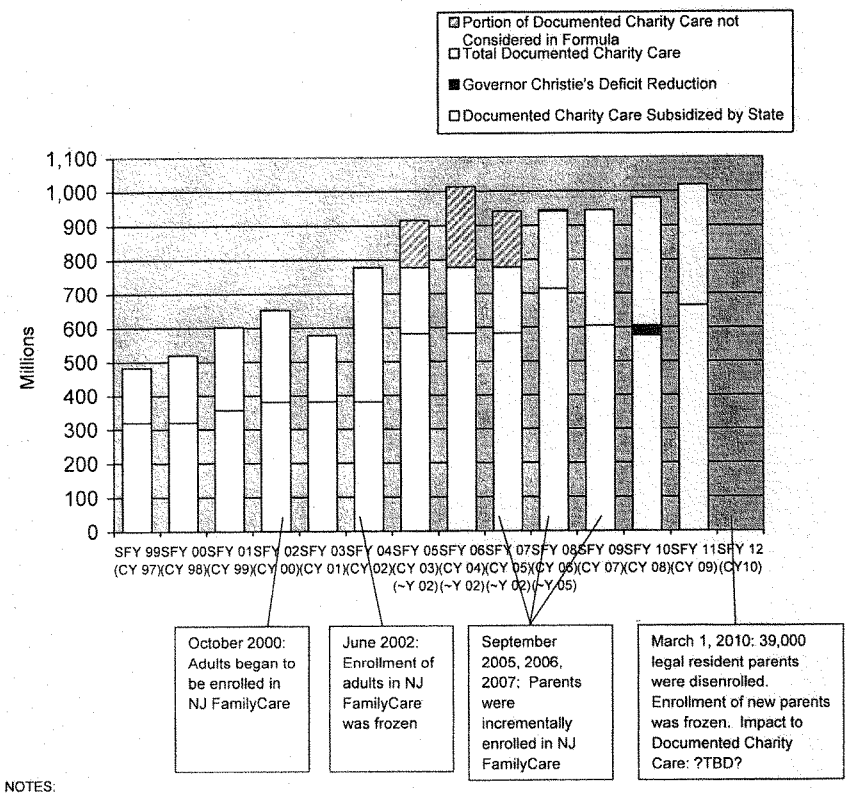
gladly share with you our years of research and experience, our failures and successes. I pledge my personal commitment to work as tirelessly as you all have to see this through.

It costs so much more to do nothing. The status quo is simply not sustainable.

Thank you for the opportunity to be with you today.

APPENDIX A

Impact adult coverage in NJ FamilyCare has on documented charity care claims



NOTES:

(~Y 02) and (~Y 05): The methodology used to calculate documented charity care was changed beginning in SFY 08. Graduate Medical Education had been factored in the former formula in such a way that it would begin to inflate documented charity care over time. This provoked the use of CY 02 data for SFYs 04-07

Impact Adult Coverage in NJ FamilyCare has on Documented Charity Care Claims

NJ FamilyCare began enrolling parents and childless adults in October 2000. In 2001, documented charity care fell $75 million. The large number of applicants coupled with State and Federal budget deficits, caused the State to stop accepting applications for childless adults beginning September 1, 2001, and from parents beginning June 15, 2002. In the year after, documented charity care grew more than $200 million and continued to rise each year.

The incremental expansion of eligibility for parents in NJ FamilyCare, which began in January 2006, has had a direct impact on documented charity care. Since, more than 130,000 new parents enrolled in NJ FamilyCare. In just the first year of the NJ FamilyCare expansion, documented charity care decreased $71 million and the rate of documented charity care growth stabilized

Maintaining enrollment of parents up to 200% of the federal poverty level in NJ FamilyCare is essential to the long term funding of major health care reform. The reason is twofold. First, 96.3% of all charity care is used to pay for the care of persons with income below 200% of the federal poverty level. Documented charity care will only be reduced by making affordable health insurance coverage available to this population of the uninsured.

Charity care is a more expensive model of care per capita and is only provided episodically whereas health insurance provides preventive care and is less costly. It costs more than $900

per client per year to serve an adult on charity care than it does to serve them on NJ FamilyCare.

Secondly, the amount of disproportionate share dollars that New Jersey can leverage from the federal government to help fund charity care is capped and any additional dollar that is committed to charity care will not leverage as much federal funding. By investing in NJ FamilyCare, New Jersey is sure to maximize federal funding opportunities.

Charity care is not a comprehensive solution for the uninsured. While charity care covers all or most of the hospital costs incurred by an uninsured, eligible person; it leaves them completely exposed to the additional costs charged by the providers that deliver their care within the walls of the hospital These are the bills that bankrupt New Jersey residents. NJ FamilyCare provides a comprehensive benefit to the uninsured. In addition to the hospital bill, it covers physician charges, lab costs, radiology, infusions, prescription drugs, and more.

New Jersey tax dollars go farther and help more people when used to fund NJ FamilyCare than to fund Charity Care

Mr. PITTS. The chair thanks the gentleman. Thanks to all the witnesses for their testimony and we will now turn to questioning. The chair recognizes himself for 5 minutes for questioning.

Mr. Istook, regarding State exchange grants with unlimited mandatory expenditures and the size of the appropriations really at the discretion of the Secretary with such sums, in your years as an appropriator and legislator, have you ever seen Congress grant an Administration official an unlimited tap into the U.S. Treasury?

Mr. ISTOOK. No, Mr. Chairman. I can recall no such instance, and furthermore, I think it violates what the Constitution intends when it says no spending shall be made except by appropriations from the Congress, and to leave the amount at the discretion of any public official, whether it be the Secretary of HHS or anyone else, I think is not in keeping with the constitutional intent.

Mr. PITTS. As our national debt currently sits at over $14 trillion, each citizen is individually responsible for roughly $45,000 of debt. We also heard news earlier this week that in February, the shortest month of the year, the Federal Government ran its single largest monthly deficit in U.S. history, $223 billion. In analyzing this law, we have found 2,000 "the Secretary shall" statements. With these facts in mind, do you think it is appropriate to give a single Administration official an unlimited tap into the U.S. Treasury?

Mr. ISTOOK. No, sir, I do not believe that is an appropriate thing to do, just as it would not be appropriate for you to entrust all of your personal finances and investment to some individual and leave out your own discretion and control over them.

Mr. PITTS. Now, section 4002 of PPACA creates a fund to provide funding for programs authorized by the Public Health Service Act for prevention, wellness and public health activities. From the period fiscal year 2012 to fiscal year 2021, there will be $17.75 billion deposited in that fund. Who has the authority, Mr. Istook, on how to determine how these funds are spent?

Mr. ISTOOK. Under the statute, that authority appears to rest solely with the Secretary of Health and Human Services.

Mr. PITTS. And so the Secretary can spend this money without any further Congressional action. Is that correct?

Mr. ISTOOK. Yes. Because it is already appropriated, the Secretary is given discretion to decide how it has been spent. Then Congress does not need to take further action to authorize the Secretary to do that but it would need to take further action to stop the Secretary from spending that fund freely as they may see fit.

Mr. PITTS. Does the program's appropriations sunset at any point?

Mr. ISTOOK. I do not find any sunset in the legislation. If it is there, I am sure somebody else would point it out to us.

Mr. PITTS. So the HHS Secretary will receive a $2 billion annual appropriation for this program in 2030, in 2040 or in perpetuity regardless of the effectiveness of the program or the need for these funds?

Mr. ISTOOK. So long as the Secretary doth live. That appears to be the case.

Mr. PITTS. All right. Let us to go to Dr. Goodman. As a general proposition, do you believe the massive health care law signed by

President Obama responsibly sets federal spending priorities in the health care field?

Mr. GOODMAN. No, I do not. Just my back-of-the-envelope calculations suggest that for every $2 of spending, only $1 is actually paid for, and if Congress has to restore the spending for seniors, that means only one of every $4 of promises is actually paid for. So there is a commitment here to spend an enormous amount of money and no one can tell me where the money is going to come from.

Mr. PITTS. All right. Senator, in your testimony you argue that the massive new health care law does not expand government's role in the health care arena. Are you aware that PPACA adds 20 million Americans into the government-run Medicaid program?

Mr. VITALE. Yes.

Mr. PITTS. Are you aware the health care law creates at least 159 new agencies, boards and commissions?

Mr. VITALE. I am not aware of the total number but I will take your word for it, Mr. Chairman.

Mr. PITTS. Are you aware that the Secretary of HHS has the power to prevent doctors and hospitals from contracting with insurers if they fail to meet new federal guidelines and standards?

Mr. VITALE. Yes, and I agree with her.

Mr. PITTS. Are you aware that the Secretary of HHS can dictate the benefits, the network requirements, the medical loss ratios, the actuarial value and the other terms of every health plan in America including new requirements on plans that Americans have and like today?

Mr. VITALE. Someone should, and the responsibility rests with her.

Mr. PITTS. Thank you. I am sorry I am out of time.

I yield 5 minutes to the ranking member, Mr. Pallone, for questioning.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to ask a question of Senator Vitale. Forty-eight States and D.C. receive grants for the purpose of planning and establishing an exchange. In addition, six early innovator grants were awarded to develop an array of models for exchange information technology systems that can be used by other States. So about $296 million has gone out to States for these grants related to the exchange. Now, the Republicans criticize again and again that they do not want a federal solution for health reform but the fact is, if a State does not or is unable to establish a State exchange, the Federal Government would establish one for them. So these planning and establishment grants provide the necessary support to ensure States are able to work with their stakeholders. You know, if it is an active exchange, it negotiates with insurers to leverage the best quality choices for best prices or it is an open exchange that invites all insurers to offer products that consumers can be aware of or choose from. These grants basically make all this possible and make for good exchanges.

So I wanted to ask you, Senator, if Congress were to repeal this provision providing for grants for the States for exchanges, does New Jersey have the money to do this work on its own, and what is the fiscal situation in New Jersey that relates to that?

Mr. VITALE. Well, I don't believe that we have the money to do it on our own, and I think earlier in my testimony I described the level of federal-State partnerships that have always been successful when run properly and really in good coordination have always made sense. Having a one-size-fits-all exchange model that would be implemented by the Federal Government I don't think would work in New Jersey, but be that as it may, in terms of the dollars and cents, we don't have the resources to not only design but also implement the exchange, and of course, our condition economically is as bad or worse than most other States, the worst recession since the Great Depression. And so our resources are limited and already the governor has decided that he is going to eliminate and reduce programs to the uninsured, to the Medicaid recipients in our State. So I don't see how it is in New Jersey or any other State, for that matter, unless they find a pot of gold and can come out from underneath this recession without the partnership of the Federal Government.

Mr. PALLONE. I appreciate that. Let me ask you about the prevention and the public health investment fund because again we are trying to provide Americans with better choices about prevention. Both Democrats and Republicans keep talking about prevention as a way to provide better quality care and save money, and I think if you talk about where we are today before this act, the health care reform goes into place, you know, be more apt to describe the situation as sick care rather than wellness care, and that is why we created this prevention fund to provide Americans with options to keep themselves healthy instead.

There are over 530 organizations that support the prevention and public health fund because it has already shown it can deliver on the promise of creating a better pathway to prevention. So many people on both sides of the aisle have supported prevention because it holds a promise to reduce health spending, and I know this has been important to you both improving health and reducing spending.

My question, Senator, again is, New Jersey has received over $15 million in grants from the fund. It supported activities such as quit lines, HIV prevention, other important activities. Are you able to comment on how prevention and public health fund awards like these help to complement your own state efforts, and is this an investment that is worth making because obviously the Republican option is to eliminate it?

Mr. VITALE. Well, I think everyone in this room will agree that we want to have smart public health opportunities and options for every American, but the States can't go it alone, but we also know that it makes smarter financial sense to address these issues early on in terms of prevention not only in terms primary care, spending money in the beginning of life prevention and not at the back end of life but also on all the public health initiatives that the Federal Government and the State government by itself certainly lowers cost, lowers the instances of contagious disease and infections and the variety of things that happen to people in the public health field and so reducing those costs is paramount and it makes financial sense. You know, we have to spend so much more not wellness but on sickness, as you said earlier, as opposed to spending it up

front. It makes sense to spend it now and do it in a way that is appropriate and provides the greatest bang for the buck.

Mr. PALLONE. I appreciate that. I don't want us to be fooled by these arguments about mandatory versus discretionary spending in this fund. Seventy-one percent of Americans favor increased investment in community health and disease prevention. I think it is tragic that we are even considering striking the fund, given what it can do.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. The gentleman's time is expired. The chairman recognizes the vice chairman of the committee, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Goodman, did you want to respond to that last question?

Mr. GOODMAN. Yes. I agree with Congressman Pallone that both Republicans and Democrats are out there saying that by spending money on preventive care we will save money overall but it is just not true. There are an enormous number of studies of this issue. They overwhelmingly show that preventive medicine by and large does not save money, that yes, you will save money if you catch a disease in its early stage with one person but to get to that person you have to spend money on 10,000 other healthy people, and it turns out that there are very few preventive procedures that actually save money. I think the political reason why we hear so much about preventive medicine is, it is the only thing you can do for healthy people, and most people are healthy. So it makes political sense to talk about spending money on preventive care but it is not a way to overall health care costs. Pregnant women at risk, smoking cessation advice, immunizations, they will pay for themselves but giving free checkups to the elderly, that will never save money.

Mr. BURGESS. Interesting observation. And we do appreciate all of you being here. Let me just say that again.

Mr. Vitale, let me ask you a question. In your testimony, you talk about the rollback of the funding of the country's school-based health centers and maintain that in fact that is shortsighted. I don't know, you may be being a little tough on the President but let us explore this a little bit. In the law as it is now, section 4101(a), the mandatory funding that we are talking about today is actually for school-based clinic construction, correct? Is that yes? That is a yes. The clerk will note that is a yes.

Mr. VITALE. Yes.

Mr. BURGESS. What about the money for the doctors and nurses that are going to be in the clinic? Is that mandatory or discretionary?

Mr. VITALE. I am not sure.

Mr. BURGESS. Well, 4101(b) is discretionary. Do you know the dollar amount that President Obama requested in his latest budget that he sent up here to the Hill just a little over a month ago?

Mr. VITALE. For which part?

Mr. BURGESS. For the staffing of the school-based clinics.

Mr. VITALE. I am not aware of it but any staffing would be helpful. If the money doesn't in that proposal, then it is what it is, but what is important to recognize is that whether it is for bricks and

mortar or whether it is for individuals to serve in those capacities is vitally important.

Mr. BURGESS. Well, the actual dollar figure requested by the President was zero, so I think maybe you are stating the President was shortsighted with that budgetary amount. I don't know. I will leave that up to you.

But what good are the bricks and mortar if you don't have the doctors and nurses there to receive the children, the patients when they come in to be seen? How are you going to have a child seen at a school site if there is no doctor or nurse in the clinic?

Mr. VITALE. Well, the elements of reform in PPACA and what we do in New Jersey is to encourage primary care workforce development so primary——

Mr. BURGESS. Yes, encourage it by not funding it in the discretionary part of the President's budget, and that is a discrepancy and that is one of the things—you know, the Secretary couldn't answer the question when I asked her why it was that it was constructed like that. I am going to accept that it was a drafting error on the part of the Senate. I am going to accept the fact that this bill was a poorly constructed product that was rushed through on the Senate Floor to get the Senators out of town before a snowstorm hit on Christmas Eve. We all accept that. They never got to a conference committee because we know that 2 weeks later Scott Brown gets elected, they lose the 60-vote margin. Nancy Pelosi said there is not 100 votes for this damn thing over in the House, and it took 3 months to twist enough arms and crack enough skulls to get it passed, and that is precisely the reason why, because it doesn't deliver on the promise that was intended.

Now, another aspect is, what are the duplicative aspects of this? You had a stimulus bill that passed in February 2009, $3 billion, I believe, for community health centers. Was there not enough to scrape together for the $50 million that would fund the school-based health clinics in this program? Did the Congress have to fund it twice to get to your level of satisfaction?

Mr. VITALE. Well, you know, I would certainly welcome and support legislation that you could introduce that would fund those programs and put those doctors and nurses in those buildings.

Mr. BURGESS. Well, oK. There is the other part of the problem, last month, a $223 billion overdraft by the United States Congress. If you multiply that out over the 10-year budgetary window, that is almost $27 trillion. That is twice what the debt limit is going to be expanded later this year. That is twice what the debt limit already is, and that is irrespective of any money collected in taxes. So that is the problem. There is no money there, and that is an important concept.

Let me just ask you a question. Governor Christie, did he sign on a letter asking for relief of maintenance of effort to the Congress?

Mr. VITALE. Yes, he did.

Mr. BURGESS. And was he correct or incorrect in that?

Mr. VITALE. He was incorrect, sir.

Mr. BURGESS. I believe he was correct, and again, the answer is, $223 billion overdraft, it is unsustainable.

Mr. Chairman, thank you. I hope we have time for a second round because I have some questions of the other witnesses, and I will yield back.

Mr. PITTS. The chair thanks the gentleman. The gentleman's time is expired. The chair recognizes the ranking member emeritus of the committee, Mr. Dingell, for 5 minutes for questions.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy to me, and I want to welcome our panel, particularly my old friend, Mr. Istook. I am delighted to see you here.

I am troubled about the committee and what it is doing. I am very much troubled that instead of trying to improve the legislation, we are concentrating on trying to repeal it. At the same time, I note that those who would repeal the legislation and who are trying to impede the implementation of this legislation are coming forward with no suggestions as to alternatives and no differences that they would make because of either amendments or replacement legislation.

This is a yes or no question, old friend. You have great familiarity with the differences between mandatory and discretionary funding and the importance of both, and I know my colleagues have concerns that they have expressed about mandatory spending under the Affordable Care Act but I would point out that the majority of the members on the other side of the aisle have voted for this kind of funding when it suits their purposes, particularly in the instance of the Medicare Part D or the Medicare Prescription Drug Improvement and Modernization Act. There was a lot of funding of this particular kind, and a similar situation in which many of the members on the other side of the aisle also voted for the SCHIP program in the Deficit Reduction Act.

Would you agree, old friend, that mandatory appropriations are from time to time a necessary part of legislating and particularly so in the case of the Medicare Prescription Drug Improvement and Modernization Act and in the Deficit Reduction Act? Yes or no.

Mr. ISTOOK. One, I always appreciate your courtesy, Mr. Dingell. The challenge is, there are different types of mandatory appropriations. They have been used in different mechanisms. I have never seen them used in the same way that they are here. For example, in the prescription drug benefit bill, you had an existing program which receives permanent appropriations, namely Medicare, and there is an expansion of its scope rather than a creation of a new mandatory stream of funding.

Mr. DINGELL. But we are following a precedent long established in many differences.

Mr. ISTOOK. I don't see it in the manner it is done here.

Mr. DINGELL. Now, as a former Member, you served here with distinction, do you agree that Medicare and Medicaid programs are essential cornerstones of the health care system in this country?

Mr. ISTOOK. I think they certainly have become cornerstones upon which people depend. Is it necessary, especially for Medicaid, to be its current scale? I don't believe so.

Mr. DINGELL. And those bills that we have been discussing have been funded by mandatory appropriations over the years.

Well, I want to thank the panel for being here. I notice I have a minute and 27 seconds and I just want to maintain that I con-

tinue to appeal to my friends on the Majority. Let us work together to get a good piece of legislation made better and to meet the concerns that are expressed by all of us here about different components of this legislation. I have heard that the Members on the other side want to repeal it. I think that would be extraordinarily unwise, and I would hope that they would join us in trying to improve our Nation's public health, to save our health care system, to see to it we have the money in the system that we need and that we have a workable program that will head off the appalling increase in cost which we see going forward on a continuing basis under the old system, and I thank you for your courtesy, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. The gentleman's time is expired. The chair recognizes the gentleman from Ohio, Mr. Latta, for 5 minutes for questions.

Mr. LATTA. Thank you very much, Mr. Chairman. I appreciate it. And to our panel, thanks very much for being here. I really appreciate it. It is always enlightening to get the testimony from you all.

Dr. Goodman, if I could maybe start with you. It is kind of interesting, because I know that this has been discussed a lot during the debate on the health care legislation. On page 7 of your testimony you were talking about Massachusetts and what has happened up there. It is interesting that you stated that people remain uninsured while they were healthy and get insurance after they are sick. Then they receive care and their medical bills are paid, they drop their insurance coverage again. And I guess some of the questions I would like to ask is first of all, what is the enforcement mechanism they have in Massachusetts or lack thereof to try to change this or get people to be on insurance all the time?

Mr. GOODMAN. Well, the Massachusetts model has a fine, and the general Massachusetts approach was copied. I do agree with President Obama on this. The federal model did in large part come from Massachusetts, and it is a strange model because, you know, in other health care programs that we have, we don't let people game the system. In Medicare Part B, in Medi-gap insurance and prescription drugs, you don't let people just go until they get sick and then sign up for the same price everybody else is paying. There is a penalty if you do not sign up when you are eligible, and yet in Massachusetts, people can wait until they can sick, they can sign up at any time. There is a 12-month open season. They pay a small penalty when they are not insured but the penalty is small compared to the cost of insurance so the real incentive there and the real incentive under the Affordable Care Act is go bare while you are healthy, pay the fine and wait until you get sick and then sign up for the most generous—and if you are really sick, you will sign up for the most generous of the options that you have.

Mr. LATTA. Do you know what that penalty is, out of curiosity?

Mr. GOODMAN. In Massachusetts? I don't remember. But under the Affordable Care Act, it will be less than $1,000 a person.

Mr. LATTA. This might be a rhetorical question then, because I already know what the answer is. Who makes up that difference?

Mr. GOODMAN. Well, the cost of care falls on everyone else, and if you allow people to game the system, stay outside when they are healthy, let them join when they are sick for the same premium

everybody else pays, premiums have got to rise. Everybody else has to pick up that difference. And through time costs just get higher and higher and higher as people are allowed to game the system in that way.

Mr. LATTA. Thank you.

Congressman, a question for you. As a former appropriator, you know, when you look at this, and you stated in your testimony but is it right that Congress should really abdicate its responsibility by saying that we are going to have these going out year after year after year in these mandatory's instead of us looking at every year? As Dr. Burgess pointed out, we had a $233 billion shortfall in the month of February. You know, should that be abdicated by Congress?

Mr. ISTOOK. No, neither in the case of Obamacare nor for that matter in the case of Medicare or Medicaid should we have unrestricted, open-ended appropriations or permanent appropriations rather than putting things upon a defined budget that is defined by what Congress is able to provide what the Nation can afford at a particular time. So this is a common problem with any form of mandatory appropriation whether it be the permanent appropriations that go out, for example, to Medicare or the different process that was used here, passing a series of annual appropriations for consecutive years. Either way, you are not matching your current resources with what you are trying to provide, and that of course is what leads to deficits such as the $1.6 trillion that we have for this current fiscal year.

Mr. LATTA. Thank you very much.

If I could, I would yield the remainder of my time to Dr. Burgess.

Mr. BURGESS. Thank you.

Dr. Goodman, you mentioned in your testimony that the mandate is going to become ever more costly. You already alluded to the amount of money the deficit is for February of this year and what future projections are. How expensive is that going to be for the taxpayer in the years ahead?

Mr. GOODMAN. Well, I don't have an estimate off the top of my head but it is going to be very expensive and it is going to be more expensive and it is going to be more expensive than I think the Congressional Budget Office has estimated, and the reason is because of these different subsidies that I have talked about. It is going to be foolish for modern income employees to try to get insurance from an employer. They are all going to find their way into the exchange, and the subsidies in the exchange are paid for by the federal taxpayer. So I think the Congressional Budget Office was estimating maybe 17 million people would go over into the exchange. Douglas Holtz-Eakin, former director of the Congressional Budget Office, thought it might be twice that many, but it could be much higher than that. I think eventually everybody who can get a better deal will be in the exchange.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from New York, Mr. Engel, for 5 minutes for questions.

Mr. ENGEL. Well, thank you, Mr. Chairman. I would like to first ask unanimous consent to introduce for the record a letter from the public health commissioners from 10 of our Nation's biggest cities,

which provides great examples of the ways the fund is being used in our Nation's cities.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

March 8, 2011

The Honorable Harry Reid
Majority Leader
United States Senate
Washington, DC 20510

The Honorable Mitch McConnell
Minority Leader
United States Senate
Washington, DC 20510

The Honorable John A. Boehner
Speaker of the House
U.S. House of Representatives
Washington, DC 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, DC 20515

Dear Majority Leader Reid, Minority Leader McConnell, Speaker Boehner and Minority Leader Pelosi,

On behalf of 10 big city health departments serving 33 million Americans, we write to oppose the very deep cuts to public health spending included in H.R. 1, the Continuing Resolution approved by the House of Representatives on February 18, 2011, and which are now being discussed as part of a potential Continuing Resolution for the rest of fiscal 2011.

H.R. 1, as written, diverts Prevention and Public Health Fund resources -- intended by Congress to invest in disease prevention -- to offset cuts made to existing CDC activities. If enacted, these cuts will set back America's most promising and proven efforts to prevent the chronic diseases, injuries, disabilities and mental illness that are key drivers of our nation's spiraling health costs.

In 2008, nearly 1 in 6 dollars of America's Gross Domestic Product was spent on health care, primarily on treating illnesses. Much of this surge in costs is due to the increasing rates of conditions such as cardiovascular disease, Type II diabetes and obesity, which are costly to treat and largely preventable.

Despite the clear advantages of preventing these illnesses, federal funding for disease prevention has until recently been a tiny fraction of funding to treat illnesses after they occur. For the first time, the Prevention and Public Health Fund offers a reliable source of support for proven, effective, community-based disease prevention efforts, such as those that reduce smoking, promote physical activity and nutrition, and prevent injuries.

Just as polio and tuberculosis were overcome by a strong federal and local commitment to public health, a similar commitment can halt the chronic diseases that are killing and disabling Americans today. Big city public health departments are pioneering strategies against chronic disease that are preventing illness and saving lives:

- Tobacco control efforts in New York City alone have contributed to 350,000 fewer smokers, and have thus far saved an estimated 6,300 lives from cardiovascular disease, cancer, and respiratory disease. One-third of smokers die from a smoking-related illness, and the number of lives saved is expected to increase as the effects of tobacco control policies on health become more evident over time.

- Reducing salt consumption in the US population by one third could save up to 92,000 lives annually; the New York City-led National Salt Reduction Initiative's goal is a 20% reduction in population intake by 2014.

Below are just a few examples of current efforts to prevent chronic disease prevention created by big city public health departments:

- **Los Angeles:** The Los Angeles County Department of Public Health and community partners have led the adoption of 93 local tobacco control ordinances within Los Angeles County since 2004. Adult smoking rates in Los Angeles have since dropped from 13.6 percent in 2005 to 10.4 percent in 2008–among the lowest rates of any municipality in the nation.

- **New York City:** The City's Health Department worked closely with City Hall to develop a mayoral order for city agencies to serve healthier foods and beverages, a step which improved the nutritional content of the over 260 million meals the City serves annually in schools, day care centers, senior centers and hospitals.

- **Seattle:** In 2010, King County's Board of Health adopted guidelines for including health community elements – for example, streets that encourage walking and biking – in local comprehensive plans. Local jurisdictions are now incorporating these elements as they revise their plans. Seattle's adult smoking rates have dropped from 19 percent in 2001 to 11 percent in 2009 - a 42 percent decline overall.

- **San Francisco:** The Department of Public Health and Recreation and Parks are creating a culture promoting water as a healthy and affordable choice through the Soda Free Summer and Shape Up SF programs, which decreases access to calorically sweetened beverages by summer camp staff and campers.

- **Philadelphia:** Nearly 500 corner stores have joined the Healthy Corner Store Initiative, which improves community's access to healthy foods by providing small grants to purchase shelving and refrigeration to sell produce, low-fat dairy products, and lean meats

- **Chicago:** In 2009, Chicago's Board of Health issued recommendations for day care providers regarding appropriate nutrition, physical activity and screen time for young children. In 2011, related rules will become effective and enforceable.

One of the primary purposes of the Prevention and Public Health Fund was to support the creation and evaluation of efforts such as these.

These deep cuts to disease prevention programs -- and in particular, the deep cuts to CDC's budget -- run directly counter to public support for these types of initiatives: a public opinion survey conducted by the Trust for America's Health and the Robert Wood Johnson Foundation found 71 percent of Americans favor an increased investment in disease prevention.

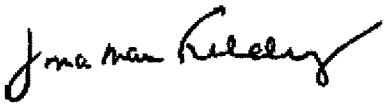
Strong public health agencies serve as our first line of defense against disease in our cities, counties and communities. At a time when today's children are in danger of becoming the first

generation in American history to live shorter, less healthy lives than their parents, cutting funding to programs that protect the public from epidemics and health hazards, prevent disease, and promote wellness will have severe consequences for the nation's future.

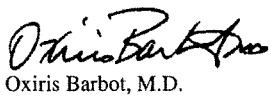
As you develop and negotiate a long-term Continuing Resolution for the rest of FY11, we urge you to support the continuation of the Prevention and Public Health Fund, and to preserve core funding for CDC, which is essential to our ability to prevent illness and save lives.

Sincerely,

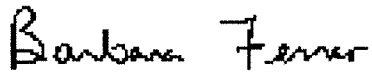
Thomas A. Farley, MD, MPH
Commissioner
NYC Department of Health & Mental Hygiene



Jonathan E. Fielding, MD, MPH, MBA
Health Officer and Director of Public Health
LA County Department of Public Health

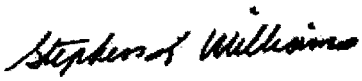


Oxiris Barbot, M.D.
Commissioner
Baltimore City Health Department



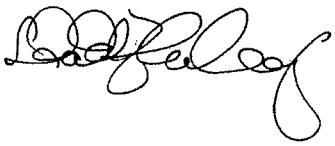
Barbara Ferrer, PhD, MPH, MED
Executive Director
Boston Public Health Commission

Bechara Choucair, MD
Commissioner
Chicago Department of Public Health



Stephen L. Williams, MEd, MPA
Director
City of Houston - Department of Health and Human Services

Bob England, MD, MPH
Director
Maricopa County Department of Public Health



Donald F. Schwarz, MD, MPH
Deputy Mayor Health & Opportunity
Health Commissioner
City of Philadelphia

Barbara A. Garcia, MPA
Director of Health
San Francisco Department of Public Health

David Fleming, MD
Director and Health Officer
Public Health—Seattle & King County

cc:
The Honorable Dan Inouye, Chairman, U.S. Senate Committee on Appropriations
The Honorable Thad Cochran, Ranking Member, U.S. Senate Committee on Appropriations

The Honorable Harold Rogers, Chairman, House Appropriations Committee
The Honorable Norm Dicks, Ranking Member, House Appropriations Committee

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. Chairman, Republicans have decided that this is the week to talk about mandatory spending in the Affordable Care Act. This has probably confused many Americans who thought that Congress was going to focus on creating jobs and reducing the deficit.

I want to welcome our three panelists. I want to welcome Congressman Istook back. But let us examine the issue of the Affordable Care Act mandatory spending provisions. One of our colleagues, Michelle Bachmann, on Meet the Press last weekend said that using mandatory funding was "gangster government" and she said that this mandatory funding was the bill's, and again I quote her, "dirty little secret." Congressman Istook, you said to FactCheck.org that this assessment was fair because these appropriations were, and I quote you, "not trumpeted loudly by sponsors of the measure." So I am going to ask you in a minute to comment, but let us review the history here.

For example, let us look at the prevention and wellness fund. This is a critically important fund to provide stable funding for our public health infrastructure. The fund will support State and community efforts to prevent disease and make our Nation healthier. Over 530 organizations have supported this fund because investing $10 per person per year on community-based prevention could save this Nation more than $16 billion annually. I have never considered this a "dirty little secret." I am proud of it. I have tried to trumpet it loudly. It was in just about every document we ever produced, every draft on the House and Senate side, every explanatory fact sheet and every full CBO score. So let me read to you from our fact sheet: "Provides $15 billion in mandatory spending to support prevention and wellness activities." Does that sound like we are trying to keep this a secret? Even FactCheck.org concluded that "No secret. Bachmann gets it wrong." And the Washington Post said, "This is bordering on ridiculous," and concluded that there is no bombshell beyond the bombast.

But let us take this chance to learn more about the fund. I would like to first ask Senator Vitale, according to Healthcare.gov, organizations in New Jersey have received nearly $15 million in prevention and public health grants from tobacco cessation programs to HIV prevention, to public health infrastructure to primary care training. Senator, you mentioned in your testimony the idea of bringing primary health care services to people in their behavioral mental health setting. I am told that people with serious mental illness die an average of 25 years sooner than the general population, largely due to untreated chronic disease. Can you tell us how bringing primary care and mental health together is actually an important shift in how we think about prevention?

Mr. VITALE. Well, thank you for that question, Congressman, and you are right. It is an incredibly important way in which to bring the care to them. I think that for a long time a lot of policymakers, even State legislatures, have overlooked the importance of those mental health and substance abuse issues, and in New Jersey we have the same issues. And I was a little blindsided and dumbfounded by a comment by my friend, Dr. Goodman, that prevention really doesn't save money. If you talk to any other health care expert in the Nation that is learned as he is, we would get a different

answer, that that prevention model is incredibly important. It means the world to people even in terms of life and death, and so I would support those initiatives. They make a whole lot of sense.

Mr. ENGEL. Thank you. This fund is much more than simply providing more funds for good things. It is about changing the way we think about prevention. I can't think of a better use of tax dollars than to institute proven prevention strategies that could save the taxpayers money.

I just wanted to say, Dr. Goodman, I don't necessarily need a reply from you but I was interested when you were talking about the Massachusetts bill vis-a-vis the bill that we tried to put in, and I think you actually make a point many of us have been saying, that the fact of the matter is, it is not fair for someone not to belong and then when they get sick opt in because then everyone else's premium rises. That is why you have to everyone being directed to mandatorily purchase insurance, and I find it really ironic that Mr. Romney, who implemented as governor the law in Massachusetts which allows people to first get sick and then opt in is now one of the people who is cracking the bill.

Mr. Istook, I want to give you a chance to respond. You replied to an inquiry from FactCheck that Congresswoman Bachmann's "dirty little secret" remarks were fair and you said these appropriations were "not trumpeted loudly" by sponsors of the measure. I tell you, we trumpeted it loudly and I don't know why you can say that we tried to hide it, but I would like to give you a chance to respond.

Mr. ISTOOK. If I may, Mr. Chairman?

Mr. PITTS. Proceed.

Mr. ISTOOK. Thank you. Actually, particular things have been checked both by FactCheck, by the Washington Post and by PolitiFact. None of them had any criticism of what I have said on this. They had criticism of Ms. Bachmann but not of my characterization. As I said, her characterization I believe was a fair comment and opinion. Just because something is well known to some people such as, say, yourself does not mean that it has overall been well communicated to the American people. That is why I mentioned that we have a 2,700-page bill that is a huge haystack with a lot of needles still being discovered within that haystack, and I think the revelations are continuing and that is part of what the chairman is seeking to point out during this hearing.

Mr. ENGEL. Thank you, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The chair recognizes Mr. Lance for 5 minutes for questioning.

Mr. LANCE. Thank you, Mr. Chairman, and good afternoon to you all. I am new to this committee, and it is my honor to meet for the first time Congressman Istook and Dr. Goodman. I certainly know Senator Vitale. We served together in the State senate for the 7 years I was in the State senate. I believe Senator Vitale is completing his 14th year in the State senate, and not only is he an expert on health care, he and I served together on the State senate budget committee and worked on many issues together.

As a general matter, the National Governors Association writing our leaders, Speaker Boehner and leader Pelosi and leader Reid and leader McConnell, in January said that moving forward Congress should not impose maintenance-of-effort provisions on States

as a condition of funding. This was a general letter and it did not relate specifically to the health care bill. It was more in general in tone. I want to make that clear. I would like to have unanimous consent to introduce that letter into the record. It was signed in a bipartisan capacity by the chair and the vice chair of the National Governors Association.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Christine O. Gregoire
Governor of Washington
Chair

Dave Heineman
Governor of Nebraska
Vice Chair

Raymond C. Scheppach
Executive Director

January 24, 2011

The Honorable Harry Reid
Majority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable Mitch McConnell
Minority Leader
U.S. Senate
Washington, D.C. 20510

The Honorable John Boehner
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Majority Leader Reid, Senator McConnell, Speaker Boehner, and Representative Pelosi:

As a new Congress convenes and a new year begins, the nation's governors call on the federal government to work cooperatively with us to reduce deficits, restore fiscal discipline and promote economic growth and long-term prosperity.

This month 29 new governors—the largest class in history—assumed office with most facing collective budget deficits of $175 billion through 2013. This amount is on top of $230 billion in budget gaps states filled between fiscal years 2009 and 2011. As you know, unlike the federal government, states have to balance their budgets. This means that the $175 billion shortfall will have to be filled through spending cuts or increased fees and taxes.

Over the last two years the federal government put more than $151 billion into state coffers to help offset catastrophic declines in revenues. States also did their part cutting spending by more than 10.7 percent ($75 billion), tapping rainy day funds, shrinking the size of government and streamlining state services. More cuts will be necessary, but with all easy cuts exhausted, the next round will require more layoffs, fewer state services and potential cuts to core programs like K-12 education and public safety.

Despite states' difficult fiscal situation, governors are not calling for new one-time help from the federal treasury. In fact, we encourage the federal government to follow the lead of states and make the tough decisions necessary to get its fiscal house in order; federal fiscal stability is critical to the long-term strength of states and the country.

As federal lawmakers work to reduce deficits, reform programs and restore long-term stability, governors call on the Administration and Congress to adhere to the following principles for state-federal deficit reduction:

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- **Federal reforms should be designed to produce savings for both the federal government and states.** The shared responsibility for implementing and running state-federal programs should also mean shared savings when reductions or reforms are made at the federal level.

- **Deficit reduction should not be accomplished by merely shifting costs to states or imposing unfunded mandates.** The structural deficit facing federal lawmakers cannot be solved by the states. Good fiscal policy must take into account the effects of federal action on state government to avoid actions that harm the ability of governors to manage state budgets.

- **States should be given increased flexibility to create efficiencies and achieve results.** Decreases in funding should be accompanied by an increase in state authority to manage programs and find savings. For example, states must be allowed to consolidate funds from similar programs to produce better results. Federal mandates, even those that are paid for, fail to encourage state innovation or cost savings that can benefit both states and the federal government.

- **Congress should not impose maintenance of effort (MOE) provisions on states as a condition of funding.** MOE's curtail state authority to control their own budgets and fiscal systems and over time discourage investment in state-federal programs (see attached).

Governors have a duty to be good fiscal stewards of taxpayer dollars. The recession forced many states to take difficult short-term actions to balance budgets and to find innovative ways to make government a more efficient and productive instrument that can do more with less. The federal government must now do the same.

Sincerely,

Chris Gregoire

Governor Christine O. Gregoire
Chair

Dave Heineman

Governor Dave Heineman
Vice Chair

Enclosure

STATE PROGRAMS WITH MOE REQUIREMENTS

Grant Name:	State Match	MOE	Description of Requirements
Environment			
Clean Air Act - Section 105	X	X	40% match requirement
Non-Point Source Grants - Section 319 Grants	X	X	40% of total cost
Hazardous Waste Management State Program Support	X	X	25% of approved cost
Pipeline Safety	X	X	MOE was waived for 2009 and 2010. States currently providing 35% of funding
Transportation			
FTA - Section 5307 Urban Areas Formula Grants	X	X	50% of operating expenses; 20% of capital costs; 10% if related to Clean Air Act or Americans with Disabilities Act; 10% for bicycle-related projects
FTA - Section 5311 Non-Urban Areas Formula Grants	X	X	20% of capital costs; 10% if related to Clean Air Act or Americans with Disabilities Act; 50% of administrative costs; 10% for bicycle-related projects
Airport Improvement Program		X	
Community and Regional Development			
Appalachian Development Highway System	X	X	20% of total cost
Education			
Adult Education Basic Grant	X	X	25% of total funds spent, MOE not less than 90% of prior year level
Education Jobs		X	For FY11 states must maintain spending in K-12 and higher education at: (1) FY09 levels; (2) the same percentage share as total revenues available in FY10, or (3) for states with receipts below FY06 levels in FY09, the FY06 spending level or percentage share.
Title I - Grants to Local Education Agencies		X	
Special Education Grants to States		X	MOE based on expenditures from previous year.
Vocational Education - Basic State Grant	X	X	50% of admin. cost
Indian Education - Grants to Local Education Agencies		X	
Rehab. Services - Basic State Grant	X	X	21.3% of total cost; MOE based on previous two year spending
Special Education - Preschool Grants		X	
Special Education - Infants and Families		X	
Safe and Drug Free Schools & Communities State Grants		X	
Tech-Prep Education		X	
21st Century Community Learning Centers		X	
Higher Education			
Leveraging Educational Assistance Partnership	X	X	Match based on MOE level but not less than one-to-one basis. MOE based on expenditures from previous three years.
College Access Grant Program	X	X	One-third of program activities and services; in-kind allowed; Must maintain funding at previous five year average.
Employment and Training			
Senior Community Service Employment Program	X	X	10% of total cost; in-kind allowed
WIA Adult Activities		X	
WIA Youth		X	
WIA Dislocated Workers		X	
Social Services			
Prevention of Elder Abuse, Neglect and Exploitation		X	
Long-Term Care Ombudsman		X	
Support Services	X	X	15% of grant amount; 25% of administrative cost, in-kind allowed
Health			
Affordable Care Act		X	States may not change their Medicaid or CHIP eligibility policies or procedures that are more restrictive than they were on July 1, 2008. The MOE for adults is in effect until January 1, 2014, and for children until October 1, 2019

Public Health Emergency Preparedness	X	X	5% of federal funds in 2009, 10% in 2010; in-kind allowed; must maintain spending at the average of the amount provided annually during the previous two years
Consolidated Health Centers		X	
Ryan White Formula Grants	X	X	States with more than 1% of total HIV/AIDS cases reported during the previous two years must provide matching funds, amount varies based on the number of years a state meets the threshold, separate 20% of total cost matching requirement for ADAP supplemental; must maintain spending at previous year level
Community Mental Health Services Block Grant		X	Must maintain spending at the average of the amount provided annually during the previous two years
Substance Abuse Prevention and Treatment Block Grant		X	Must maintain spending at the average of the amount provided annually during the previous two years.
Maternal and Child Health Block Grant	X	X	45% of total cost; maintain spending at 1989 level
Income Security			
Temporary Assistance for Needy Families (TANF)		X	
Child Care Mandatory Matching Funds	X	X	Varies based on FMAP; MOE equal to the state's share of expenditures for FY 1994 or 1995, whichever is greater
Child Nutrition - State Administrative Expenses		X	
Public and Indian Housing		X	
Homeland Security			
Boating Safety Assistance	X	X	Generally 50% of total cost
Emergency Management Performance Grants	X	X	50% of total cost, in-kind allowed
Assistance to Firefighters Grant	X	X	varies based on award

Mr. LANCE. Thank you, Mr. Chairman.

And then more recently Governor Christie wrote the chair of the full committee, Chairman Upton, on March 1st relating specifically to the health care legislation. Governor Christie was unable to join the distinguished panel last week that included the Governors of Mississippi, Utah and Massachusetts, and as it relates directly to the health care issue, the Governor of New Jersey stated that we in New Jersey are facing an unprecedented Medicaid shortfall of approximately $1.3 billion in State fiscal year 2012 and he goes on to state that "our options to close this gap are severely affected by further restrictive maintenance-of-effort requirements in the health care legislation. Noncompliance with those requirements could result in our losing $5.4 billion federal funding. Governors need flexibility, not federal mandates."

To the panel in its entirety, if you would, gentlemen, beginning with you, Congressman Istook, address your views regarding the maintenance-of-effort requirement, specifically given the fact that it seems to me so many governors have suggested that we should look at that. And Mr. Chairman, might I place in the record of the subcommittee the letter from the Governor of New Jersey to Chairman Upton on March 1st?

Mr. PITTS. Without objection, so ordered.

[The information follows:]

State of New Jersey
OFFICE OF THE GOVERNOR
PO BOX 001
TRENTON, NJ 08625-0001

CHRIS CHRISTIE
Governor

March 1, 2011

Honorable Fred Upton
Chairman
Energy and Commerce Committee
US House of Representatives
Washington, DC 20515

Dear Chairman Upton:

Thank you for the opportunity to share with the Committee the significant challenges the State of New Jersey faces as a result of federal mandates in the Medicaid program and the Patient Protection and Affordable Care Act (PPACA). I commend you and Speaker Boehner's leadership in seeking Governors' input and advice on this critically important issue.

The unprecedented challenges facing Governors as we work to close huge budget shortfalls, exacerbated by the end of non-recurring stimulus funds that were spent on recurring expenses, provide an urgent call to Congress and the Administration for flexibility to improve healthcare services for our most vulnerable citizens while also containing costs. Given the size of the federal deficit, Congress should not extend enhanced federal Medicaid matching funds. Instead, Congress should relieve states of Medicaid and PPACA mandates and provide greater flexibility to manage the program at less cost.

Healthcare is the primary cost driver for most state budgets. And in these difficult economic times, Medicaid enrollment is up, revenues are down and states simply cannot afford the current Medicaid program. In New Jersey, our caseload has increased 9 percent each year for the past three years. The actuary office in the US Department of Health and Human Services (HHS) predicts that overall state Medicaid spending will increase by $90 billion between 2010 and 2014 and then $100 billion between 2014 and 2019. This is not a sustainable path.

New Jersey is facing an unprecedented Medicaid shortfall of approximately $1.3 billion in state fiscal year 2012. With Medicaid and the Children's Health Insurance Program (CHIP) comprising 17% of the state's total budget, our options to close this gap are severely impacted by further restrictive maintenance of effort (MOE) requirements in the PPACA. Noncompliance with those requirements could result in our losing $5.4 billion in federal funding. Governors need flexibility, not federal mandates.

In furtherance of this point, please note the letter from the National Governors Association on behalf of the Nation's Governors to House and Senate leadership dated January 24, 2011. Among other things, it seeks federal program reforms with increased flexibility to states as principles to restore fiscal discipline

and promote economic growth. It specifically cites forty-three federal programs with federal MOEs that restrict Governors' ability to manage their budgets and clearly states that Congress should not impose MOE requirements on states as a condition of funding. I have attached the letter for the record.

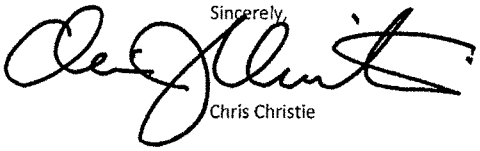
Without the flexibility to implement a new approach to Medicaid, a significant shortfall remains in our Medicaid program. Faced with a $1.3 billion gap in Medicaid, New Jersey's fiscal year 2012 budget proposes $240 million in reductions, including moving certain Medicaid services and populations into managed care, reducing provider rates, imposing cost-sharing, discontinuing coverage provided through a state-only supported program, and eliminating fraud. We also propose to reduce the reimbursement paid to nursing homes and to eliminate nursing home bed hold reimbursement. Still, even with those tough decisions, a shortfall of over $1 billion remains.

In light of New Jersey's Medicaid gap in FY 2012, we need to reform and restructure how and what benefits are provided. We will seek from HHS greater flexibility and simplification in how we make changes to the Medicaid program. In addition, my Administration will seek permission to create programs with wellness and prevention incentives that give beneficiaries more direct control over their healthcare spending. We will also request the flexibility to implement care management and medical homes, create new clinical levels of care, and to add new community based alternatives.

The Medicaid status quo is not acceptable and is not a common sense approach to healthcare; it is time for this 46 year old federal program to come into the 21st century. The federal government should stop treating Medicaid as a one-size-fits-all dictate, where every readjustment to the state program must be negotiated for as much as a year or more. Congress needs to provide a general framework within which states can make the adjustments themselves. The framework should drive innovation, best practices and ensure that states are focused on quality and cost containment. We should have the flexibility to design a consumer-driven health care system for our citizens. Without this flexibility, states are left with few options beyond cutting benefits to those in need or further reducing provider reimbursement.

Neither the PPACA or Medicaid provide the flexibility states need for the challenges of today or tomorrow. Congress needs to provide states with the freedom to determine how best to meet the needs of its citizens. I look forward to working with the Committee as we design a true federal/state healthcare partnership.

Sincerely,



Chris Christie

Mr. LANCE. Thank you.

Congressman Istook?

Mr. ISTOOK. Yes. Thank you, Mr. Lance. And having served in State government as well as Federal Government, I know that often States feel trapped by having gotten into a program and then told you have to maintain those efforts even if federal funding may be diminished or even if there are major changes in the federal program. A key example right now, the Obama Administration is saving we are trying to provide States some certain opt-out flexibility, but what the fine print says is we will only let you do it if we decide you are trying to the same thing that we are trying to do, if you are trying to do things our way. It is not really an opt-out. It is still another level of control. So I fear that the maintenance-of-effort requirements have become just another way for the Federal Government to dictate to the States they participate in a program that they cannot afford. Medicaid is if not the largest certainly an enormous budget item in so many States right now and they are finding that it is simply unaffordable, and providing some leeway on maintenance of effort is an important way to address that.

Mr. LANCE. Thank you, Congressman.

Dr. Goodman?

Mr. GOODMAN. Well, of course, the States are trapped, and all the programs that we are talking about here today further trap people in the existing health care system. We want lower costs and higher-quality care. We have to let people get out of the way we have been doing things and try something new. Probably the best way that we could spend money on preventive care for low-income folks is to pay the market price that minute clinics charge and shopping malls and at Walmart for basic preventive primary care. At least I could argue that that has a much better chance of getting care to people that anything else that we have talked about. In any event, people at the local level need to have these flexibility. These kinds of programs don't give it to them.

Mr. LANCE. Thank you.

Senator Vitale, my friend.

Mr. VITALE. Thank you. Well, you are right, Congressman Lance. The governor did sign onto that letter to remove the MOE from New Jersey's obligation, and I will tell you that could be the worst thing that could happen to the population. If this happened last year and the governor cut out tens of thousands of parents from SCHIP, he didn't go below 133 because that was the maintenance-of-effort level. If he were able to do this year, we would have tens of thousands of working parents who go to work every day without the ability to have health care and the access to health care that we all enjoy. He would also dismantle many of the benefit designs and programs in Medicaid to the aged, blind and disabled and to the vulnerable populations. So to say that the maintenance effort is a way in which it forces the States to provide their care, I know that at least in the case of our governor, he will take that opportunity to remove that care and it would be just devastating for that population and literally hundreds of thousands of New Jerseyans.

Mr. PITTS. The gentleman's time has expired. The chair recognizes the gentlelady from California, Ms. Capps, for 5 minutes for questions.

Mrs. CAPPS. Thank you, Mr. Chairman. I just want to take a minute to clarify one item regarding the application process for construction funds. Already 350 community clinics or schools have applied for funding for construction. Part of that process includes the requirement that as they apply for the funds that they demonstrate that they have adequate funding for adequate staffing for that facility.

I want to also welcome our witnesses and thank them for their testimony, and in particular, welcome to our former colleague, Mr. Istook.

As you all know, school-based health centers provide comprehensive and easily accessible preventive and primary care health services to approximately 2 million students nationwide, and there is no doubt about it, and I know this as many years of being a school nurse: Healthier children do better in school. At a time now when we are trying to out-compete and out-innovate other countries, we do need our kids healthy and in the classroom.

Now, there is a statement, Senator Vitale, that I would like you to respond to and see if you agree with this statement. It is a quote: "School-based health centers have proven that effective preventive and primary care for medically underserved children can decrease academic failure rates resulting from poor health." Is that something you would agree with?

Mr. VITALE. It is, Congresswoman, and thank you for being a school nurse. We have an example in the town in which I live, and I was interim mayor for a few months and I worked with the Department of Human Services and the Visiting Nurse Association of Central Jersey to establish a school-based health clinic in six of our communities out of 30 schools, six of the most medically underserved schools in our school district, and one of them which had very high special-needs population and now several years later when I visit and we assess the efficacy of that program, it clearly illustrates that those children receive care when they need it up front right in the school. Parents get the prescription. They are able to write those prescriptions because the advance practice nurses now can diagnose and prescribe. Kids get on their medication earlier. They get back to school quicker and they learn faster. And we have seen an enormous decrease in the amount of absenteeism for all those children in those six schools where previously those absentee rates were much higher. So they are learning better, they are learning faster, and parents who need to take time off from work in many ways can't afford to do that save them money as well.

Mrs. CAPPS. Absolutely. I agree with your testimony. It is eloquent. I also agree with the statement that I quoted, and I wish I could take credit for the quote but I wanted to point out that this comes from two of my colleagues who are members of this committee, Chairman Emeritus Barton and Mr. Burgess, and they sent a "dear colleague" highlighting their support along with their fellow Texan, Congresswoman Kay Granger, their support of school-based health centers. And after an endorsement like that one, I find it quite puzzling that our Republican colleagues are here trying to eliminate funds for communities across the Nation who want to benefit from the school-based health centers.

Mr. BURGESS. Will the gentlelady yield?

Mrs. CAPPS. I will yield after I finish my statement and question.

In fact, the interest in expanding school-based health centers is so great that HHS has received 350 applications for this funding. Requests come from 44 different States including the Congressional districts of nine of our Republican colleagues who are part of this subcommittee. So let us be clear. The need is there. While these centers benefit all children who have access to them, they are also a vital support for low-income Americans and I hope it is clear to us all that 40 percent of children treated at school-based health clinics either have no insurance or are enrolled in Medicare, SCHIP or other public coverage. For some children, school-based health centers are the only consistent access to health care that they or their families have, and we know there are many millions of other children who could benefit from them. With more access to these centers, these children could be spending more time learning in their classrooms and less time clogging up our emergency rooms.

And now, Senator Vitale, as a former mayor, which you mentioned, and current State senator, you do understand the economic needs of local communities during these tough times. The funding for school-based health clinic construction is the perfect shovel ready for today. So with so many people out of work, we are trying to provide more jobs for the American people. Maybe you can talk about what this means to your State of New Jersey.

Mr. VITALE. Well, we have many of the same challenges as every other State, in fact, New Jersey being so urbanized in so many areas and where there are so many medically underserved populations, school-based clinics are a perfect way to capture kids that are school age. Providing the bricks and mortar or the dollars for those bricks and mortar is certainly very important but the other elements of the act that would help us to train additional physicians, advance practice nurses, to put those bodies in those clinics from time to time are also important elements so we are dealing with both the bricks and mortar and those who would be future physicians and advance practice nurses. So those developments combined certainly make great sense and will make a great deal of difference in urbanized communities.

Mrs. CAPPS. Thank you.

I wanted to yield time to my colleague, and I would be happy to, but I could ask unanimous consent, Mr. Chairman, to insert two letters for the record, one from the Sex Education Coalition and also one from the American Nurses Association. These groups highlight the importance of personal responsibility education programs, and I think for the record we should include the "dear colleague" that was sent out by our colleagues.

Mr. BURGESS. Reserving the right to object until I have a chance to respond.

Mr. PITTS. All right. The gentlelady's time has expired.

Mr. BURGESS. I object to the insertion in the record.

Mr. PALLONE. Mr. Chairman, can I ask why——

Mr. PITTS. Would you provide us a copy so we can look at it?

Mr. BURGESS. I have a copy. The copy is not the issue. I asked for a chance to respond. I was denied that chance. I will object to the insertion in the record until I am given such chance to respond.

Mr. Chairman, I ask unanimous consent for 30 seconds to respond.

Mr. PITTS. All right. Without objection, go ahead. You can have 30 seconds.

Mr. BURGESS. The issue is not whether or not Chairman Barton and I support the program. The issue is to have mandatory funding for the construction of the clinic and zero funding for the doctors and nurses who staff it. The other issue is a $223 billion structural debt for the month of February. There are going to be all kinds of programs that I supported in the past that we simply cannot fund. We simply cannot pay for everything. This is a poor crafting in the bill that was signed into law a year ago. We should fix it. It is within our scope to do so. Let us make the construction an authorizing program, not a mandatory program, and I will yield back.

Mr. PALLONE. Does the gentleman withdraw his objection?

Mr. BURGESS. Objection withdrawn.

Mr. PITTS. All right. Without objection then, the letters are entered into the record.

[The information follows:]

March 9, 2011

Members of the Subcommittee on Health
House Energy and Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

Dear Members of the Subcommittee,

On behalf of the Sex Education Coalition, a group of national organizations working to advocate for the sexual health of young people across the United States, we submit this letter in support of the Personal Responsibility Education Program (PREP).

PREP is the only state-grant program that funds initiatives to address the inter-related prevention and health needs of adolescents. PREP was created to reduce the rates of unintended pregnancy and sexually transmitted infections (STIs), including HIV/AIDS, among young people. Funding for PREP totals $75 million per year for a period of five years, 2010–2014. Just over $55 million of PREP dollars is dedicated to state grants which are required to provide information on both abstinence and contraception for the prevention of unintended pregnancy and STIs, including HIV. These programs are required to place a substantial emphasis on both abstinence and contraceptive use and must be evidence-based. In addition, PREP programs must also address adulthood preparation subjects that assist young people in making informed and responsible decisions about their daily lives including: healthy relationships, adolescent development, financial literacy, educational and career success, and healthy life skills.

Statistics show that the need for this program is immense:

- According to the Centers for Disease Control and Prevention's (CDC's) Youth Risk Behavior Survey, in 2009, 46 percent of high school students had ever had sexual intercourse, while almost 40 percent of those students did not use a condom during last sexual intercourse.
- The United States has one of the highest rates of teen pregnancy rates in the developed world as each year more than 750,000 young women aged 15-19 become pregnant with more 80 percent of those pregnancies unintended.
- While young people in the U.S., aged 15–25, make up only one-quarter of the sexually active population, they contract about half of the 19 million STDs annually. The CDC estimates that one in four young women ages 15-19 has an STD.
- Young people aged 13–29 account for over one-third of the estimated 56,300 new HIV infections each year, the largest share of any age group. Two young people every hour are infected with HIV.

We need to redouble our efforts on preventing unintended pregnancy, HIV, and other sexually transmitted infections for our nation's adolescents—not cut off funding.

The evidence is clear. Comprehensive programs that include information about both abstinence and contraception assist young people in making informed, responsible decisions about their sexual health. Studies have shown that comprehensive sex education programs help young people delay sexual initiation and increase condom and contraceptive use when they do become sexually active. For

example, in November 2007, the National Campaign to Prevent Teen and Unplanned Pregnancy released *Emerging Answers 2007* which found strong evidence that comprehensive sex education programs that include information on both abstinence and the use of condoms and contraceptives for sexually active teens are effective and have positive behavioral effects. Programs delayed or reduced sexual activity, reduced the number of partners, or increased condom or contraceptive use. In addition, the CDC's Task Force on Community Preventive Services recently reviewed Comprehensive Risk Reduction programs and found sufficient evidence to recommend their use and support a conclusion that Comprehensive Risk Reduction interventions can have a beneficial effect on public health. Importantly, the evidence is strong that sex education programs that promote abstinence as well as the use of condoms do not increase sexual behavior. Studies show that when teens are educated about condoms and have access to them, levels of condom use at first intercourse increase while levels of sex stay the same. In addition, these comprehensive approaches are actually more effective at getting young people to delay sexual activity than are abstinence-only-until-marriage programs.

The PREP state-grant program requires that funded programs replicate evidence-based effective programs or substantially incorporate elements of effective programs that have been proven on the basis of rigorous scientific research to change behavior including delaying sexual activity, increasing condom or contraceptive use for sexually active youth, or reducing pregnancy among youth. Given the epidemics of unintended pregnancy, HIV, and other STDs facing our nation's young people, we should be providing them with evidence-based programs that give them the skills and information they need to make healthy and responsible decisions about delaying sex and using protection when they become sexually active.

Americans from across the country have united in their calls for comprehensive sex education programs for our youth. Parents and voters of every party affiliation and religion overwhelmingly support federal funding for programs that are medically accurate, age-appropriate, and educate youth about both abstinence and contraception, and are based on evidence. A survey conducted by the Kennedy School of Government, Kaiser Family Foundation, and NPR found that over 90% of parents of middle school and high school students believe that teens should receive "comprehensive sex education programs," including information on condoms and contraception for the prevention of pregnancy and STIs. Moreover, according to the results of a 2005–2006 nationally representative survey of U.S. adults published in the Archives of Pediatrics and Adolescent Medicine, there is far greater support for comprehensive sex education than for the abstinence-only approach, regardless of respondents' political leanings and frequency of attendance at religious services. Overall, 82% of those polled supported a comprehensive approach that includes discussion of abstinence and contraception, and 68% favored instruction on how to use a condom; while only 36% supported abstinence-only programs.

Leading public health and medical organizations, including the American Medical Association, the American Nurses Association, the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Public Health Association, the Institute of Medicine, and the Society of Adolescent Medicine, all support a comprehensive approach to educating young people about sex. As the American Medical Association noted, "federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex [is imperative]."

The Personal Responsibility Education state-grant program is a voluntary program for which states can choose whether or not they want to apply. Recognizing the need for such education for their young people, the response from states across the country has been overwhelmingly positive. In the first year of the program, a total of 43 states, the District of Columbia, the Federated States of Micronesia, and Puerto Rico applied for PREP funding, showing their own support for this important program. (By comparison, only 30 states and Puerto Rico applied for funding from the Title V abstinence-only program.) In addition, two of the states that chose not to apply for PREP—Hawaii and Nevada—plan to apply for Fiscal Year 2011 funds. States across the country are facing severe fiscal crises at the same time they are recognizing that they have to be doing better for their young people in helping them protect themselves from unintended pregnancy, HIV, and other sexually transmitted infections. As noted in the table below, of the members on this subcommittee, all Members, except the three Congressmen from Texas, represent states that have chosen to accept this funding.

STATE	MEMEMBER	PREP state grant
PA	Joe Pitts	$2,046,335
TX	Michael Burgess	none
IL	John Shimkus	$2,231,758
MI	Mike Rogers	$1,754,708
NC	Sue Myrick	$1,544,312
PA	Tim Murphy	$2,046,335
TN	Marsha Blackburn	$1,012,182
GA	Phil Gingrey	$1,707,218
OH	Bob Latta	$1,916,033
WA	Cathy McMorris Rodgers	$1,081,919
NJ	Leonard Lance	$1,412,929
LA	Bill Cassidy	$769,607
KY	Brett Guthrie	$696,997
TX	Joe Barton	none
MI	Fred Upton	$1,754,708
NJ	Frank Pallone	$1,412,929
MI	John Dingell	$1,754,708
NY	Edolphus Towns	$3,236,330
NY	Eliot Engel	$3,236,330
CA	Lois Capps	$6,553,554
IL	Jan Schakowsky	$2,231,758
TX	Charles Gonzalez	none
WI	Tammy Baldwin	$930,024
AR	Mike Ross	$485,372
NY	Anthony Weiner	$3,236,330
CA	Henry Waxman	$6,553,554

These dollars provides a clearly needed funding stream that will contribute to the stability and infrastructure of prevention programs for states at a time when fiscal uncertainty abounds.

PREP also provides $10 million for grants to implement innovative youth pregnancy prevention strategies and target services to high-risk, vulnerable, and culturally under-represented youth populations, including youth in foster care, homeless youth, youth with HIV/AIDS, and pregnant women and mothers who are under 21 years of age and their partners. A total of 13 grantees have already received funding to provide programming in 17 states—including for Members of the Subcommittee, the states of California, Illinois, New York, Ohio, Pennsylvania, and Texas. The majority of the grantees are community-based organizations, including two which are faith-based, and one is a hospital, Children's Hospital Los Angeles.

These grantees will primarily target Latino and African-American young people and direct programming to high-risk populations residing in low-income, urban areas where rates of unintended pregnancy, HIV, and other STDs are often highest. The combined age span of the young people these grantees will serve is 12–24. Four grantees will focus on pregnant and parenting teens and three grantees will focus on youth in foster care, two particularly vulnerable populations. In addition, one grantee will specifically serve young fathers while four grantees have developed programs specifically for teen girls. In total, these grantees will serve more than 10,000 young people.

All teens need accurate, complete information to help them both postpone sexual activity and protect themselves if they become sexually active. They also need the life skills necessary to make informed and healthy decisions. We ask you to work to preserve the Personal Responsibility Education Program and give young people the tools to make responsible decisions about their sexual health.

Respectfully,

Sarah Audelo
Senior Domestic Policy Manager
Advocates for Youth
Co-Chair, Sex Education Coalition

Jen Heitel Yakush
Director of Public Policy
Sexuality Information and Education Council of the U.S. (SIECUS)
Co-Chair, Sex Education Coalition

Statement
of the
American Nurses Association
to the
United States House Committee on Energy and Commerce

Setting Fiscal Priorities in Health Care Funding

March 8, 2011

The American Nurses Association (ANA) is deeply concerned over the proposed elimination of the $200 million mandatory appropriation for the construction of school-based health centers (SBHC) brought before Committee on March 9th. These cost-effective programs positively impact the lives of children across the country, and we strongly urge the members of the committee to preserve and commit these vital funds for SBHCs.

ANA is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses, and advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, and sharing a constructive and realistic view of nursing's contribution to the health of our nation.

Nurses are strong supporters of community and home-based models of care. We believe that the foundation for a wellness-based health care system is built in these settings, reducing the amount of both money and human suffering that accompany acute-care episodes. School-Based Health Centers are an excellent example of a community based model of care.

Almost 2,000 School-based primary care clinics across the country provide access to high quality, comprehensive medical care to approximately 1.7 million children and adolescents in 44 states and the District of Columbia. The SBHCs services provided by the school based health care team are determined locally through a collaborative process and may include but are not limited to: primary care for acute and chronic health conditions, mental health services, substance abuse services, dental health services, and nutrition education.

The recent *Future of Nursing: Leading Change, Advancing Health* report commissioned by the Robert Wood Johnson Foundation and the Institute of Medicine, stated that SBHCs nationwide, have the following positive characteristics and impacts:

- SBHCS are prevention and wellness oriented
- SBHCS see children who otherwise would not get care
- SBHCs offer the opportunity for one in four adolescents who are at risk for adverse health outcomes such as teen pregnancies, suicide and substance abuse to easily and readily access services in a setting where they spend the majority of their days

School-Based Health Centers are cost effective, providing an ideal environment to administer preventive health care to children. A study by Emory University, as well as other studies, has attributed school-based health centers to reductions in Medicaid expenditures related to inpatient, drug, and emergency room use; improvements in health outcomes, and a rise in school attendance and graduation.

Currently, more than 350 applicants are seeking funding through the first round of competitive grants created under the School-Based Health Center Capital (SBHCC) Program (HRSA-11-127). These applications came from all regions of the country, representing rural, urban, and suburban constituencies. Almost all of the SBHCs that receive funds from federal grant sources also receive grant funds from nonfederal sources, including state governments and private foundations (GAO-11-18R).
The one-time federal funding provided by the Affordable Care Act will be leveraged with other sources to provide needed primary, mental, and oral health care.

Because the question of the health of our Nation's children is so fundamental, ANA urges the Committee not to undermine funding for School-Based Health Centers.

ANA looks forward to working with Chairman Pitts, Ranking Member Pallone, the House Energy and Commerce Health Subcommittee, and other members of the Committee in order to ensure that we invest in SBHCs and other cost-effective models that improve access to primary and preventative care. Committing these resources to SBHCs is truly a wise investment in our children and our nation's health.

ANA would be happy to provide additional resources or assistance as the committee moves forward on this and other issues related to health care and nursing.

From: e-Dear Colleague
Sent: Wednesday, September 16, 2009 5:11 PM
To: E-DEARCOLL_ISSUES_G-Z_0000@ls2.house.gov
Subject: HealthCare: Dear Colleague: JPS School-Based Health Clinics

JPS School-Based Health Clinics

From: The Honorable Joe Barton
Sent By: sarah.whiting@mail.house.gov
Date: 9/16/2009

September 16, 2009

Dear Colleague:

As Congress discusses health care reform proposals, we would like to draw your attention to a program operated by JPS Health Network in Tarrant County, Texas. We believe this issue is so important that we have come together to share this information that is critical to America's children.

JPS Health Network serves as the public hospital in Tarrant County and includes many community health clinics and school based health centers. JPS provides a valuable service to our Tarrant County school-aged children through their school based health centers. School based health centers like these have proven that effective preventive and primary care for medically underserved children can decrease academic failure rates resulting from poor health.

JPS has partnered with several school districts throughout Tarrant County to offer parents an entry point for their children into primary care services not readily available in the community. The centers are a unique opportunity for parents and have led to healthier students, families and school campuses.

To learn more about their success, we ask that you take just two minutes to read the message below and click on the video link. You may also visit the official Web site of the National Assembly on School-Based Health Care at www.nasbhc.org to learn more about the school based health care model throughout the nation.

Sincerely,

/s/	/s/	/s/
Joe Barton	Michael Burgess	Kay Granger
Member of Congress	Member of Congress	Member of Congress

JPS School-Based Centers

JPS Health Network's 15 school-based health centers are helping children spend more time in the classroom with easy access to the exam room, providing a true benefit to area families and schools.

JPS is the tax-supported health care system located in Tarrant County, Texas. Our school-based health centers provide a unique partnership opportunity between health care organizations and school districts. School-aged children in Tarrant County school districts, and their siblings, are able to be seen by a nurse practitioner for only $5. This enables area families to afford immediate access to health care for their children to receive immunizations and care for colds and chronic diseases.

What makes JPS' school-based health centers unique?

- Parents are involved in the care of their child. They accompany their children to appointments and receive valuable information about their health.
- Siblings of students can also be seen, including infants.
- Health centers are open year round so children are able to receive treatment even when school is not in session.

JPS school-based health centers will manage approximately 40,000 visits in a fiscal year 2010, equaling healthier kids, healthier schools and healthier families.

Learn more about school-based centers in this two-minute video at
http://files.me.com/sregian/rjf729

Mr. PITTS. The chair recognizes the gentleman, Dr. Cassidy, for 5 minutes for questioning.

Mr. CASSIDY. I forego my questioning. I wasn't here to hear the testimony. And although I have a great interest in the topic, I don't want to just read something put in front of me. I would actually rather digest, and so if I could yield to anyone who wishes to have time yielded to them.

Mr. BURGESS. I would be happy to accept the time from the gentleman from Louisiana.

Dr. Goodman, we started just a moment ago when I had a few seconds yielded to me and we were talking about the costs of the subsidies. Now, we had multiple hearings leading up to the passage of PPACA a year ago, and one of the things that got me was, we never really focused on the cost of delivering care. Now, you have been a proponent of patient-powered, consumer-directed health plans. Governor Mitch Daniels in Indiana popularized the Healthy Indiana program and over the same period of time that Medicare and Medicaid expenses, PPO expenses grew by 7 or 8 percent, he saw an overall reduction in expenses for State employees of 11 percent over that same 2-year interval. Would you care to comment on the techniques used by Governor Daniels to hold down costs in his State for the State employees?

Mr. GOODMAN. Well, sure. Part of the approach is to empower patients and give them control over dollars, and that is the reason I said earlier, if low-income families could just stop by the minute clinic, get their immunization shot, get their flu shot, get a prescription filled, that probably is a better use of money than building a lot of buildings.

Mr. BURGESS. And what is the barrier to the patients doing that?

Mr. GOODMAN. The barrier is the government and bureaucracy's control of the money, and it is not patient friendly, and so the system is set up so that it is a relationship between the provider and the payer and the patient is just an excuse to bill, and if you want real change in the marketplace, then you have to have providers competing for patience based on price and on quality, and they are not going to do that unless the patient controls the money.

I wonder if I might respond to Congressman Engel's point about Massachusetts and the mandate there, if I may?

Mr. BURGESS. Please.

Mr. GOODMAN. Because I have talked to Governor Romney about this. They did it the wrong way in Massachusetts and we did it the wrong way in the Affordable Care Act, and if I could just choose a number, suppose we are willing to offer somebody a $2,500 subsidy to buy individual health insurance. The way to do it is to offer it as a refundable tax credit so that if he buys this insurance, he gets his $2,500 for the insurance. But if he doesn't buy the insurance, then the $2,500 needs to go over into the social safety net. So if he goes in for care, he doesn't have insurance, he is responsible for his bills. If he can't pay for his bills, we put money over there for him. But in doing it that way, you don't let people game the system. You let money follow people. We will never get all the people in the insurance system. But the way you make them pay their own way is, they pay higher taxes if they turn down your subsidy, and that is the right way to organize the system, and I can't

speak for Governor Romney but I think these days he is leaning more toward that approach than trying to force everybody to buy a plan that they don't really want to buy.

Mr. BURGESS. Thank you.

Mr. Istook, you were an appropriator during the years that the Medicare Modernization Act passed. Would you care to comment on some of the discussion we have heard today how the forward funding or advance appropriations occurred in the Medicare Modernization Act? I was too young to remember it or to acknowledge it at the time but you were there, a seasoned appropriator.

Mr. ISTOOK. It was not done the same way. What we have in Medicare, whether you are talking about Medicare Part D or any other Medicare, you have what is called a permanent appropriation. Now, that is a problem because rather than having a defined amount where we spend what we can afford to spend, it is an open-ended expenditure. So when Medicare Part D was created, it was simply changing the definitions of what is covered as opposed to providing new appropriations.

In the case of PPACA, Obamacare, there are a series, and Congressional Research Services devotes I think 16 pages to describing specific item after specific item after specific item after specific item where they make appropriations for the current fiscal year when it happened, fiscal year 2010, where they make appropriations that are explicit to fiscal year 2011, explicit appropriations for fiscal year 2012, and so forth all the way up to fiscal year 2019 scattered over a whole variety of different programs. So it is taking singular programs and a great number of them and creating annual appropriations for them not on a permanent basis but for a 10-year period not changing the definition of something that exists that also has permanent appropriations. It is a very different process and very unprecedented in my experience.

Mr. BURGESS. Thank you. And I will just point out in H.R. 3200 that passed this committee, the appropriations, the public health fund was subject to appropriations.

I thank the gentleman for yielding. I will yield back.

Mr. PITTS. The gentleman's time has expired. The chair recognizes the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you. First I wanted to clarify something about the school-based clinics. The grant application for the school-based clinics, which many schools are applying for, is very clear. They need to demonstrate that they have the funds to run the center but they don't have the funds to build the center. So this is a suggestion where denying construction funds actually would deny the clinic and they understand that they have to provide the money to run it.

Mr. Istook, we are kind of getting into the weeds here, but in general about this issue of secret funding, you said that FactCheck exonerated you but I wanted to just read a quote. You said that "it is within the range of fair comment and opinion for Congresswoman Bachmann to say that funding for these and other programs was a secret." So in a way, you are saying that this kind of we didn't know about it, nobody knew about it, this was snuck in there is a fair statement. Do you agree with that?

Mr. ISTOOK. Well, when the Speaker of the House told people that you had to pass the bill so that folks could find out what was in it, you know, I think that illustrates that we are finding out bit by bit is certainly within the realm of fair comment.

Ms. SCHAKOWSKY. So even though the debate was very clear, for example, on the CHIP program you say that there is something very different about the Medicare Prescription Drug Improvement and Modernization program which you voted for but in fact $40 billion of what is in the Affordable Care Act goes to the CHIP program just for 2 years, so isn't that exactly the same thing?

Mr. ISTOOK. Actually it goes for 2 years and those particular 2 years, if I recall correctly, are something like adding—what is it—2017 and 2019——

Ms. SCHAKOWSKY. No, 2014 and 2015, actually, and that is when the program goes into effect.

Mr. ISTOOK. There are other provisions that go up to 2017.

Ms. SCHAKOWSKY. Well, I wanted to ask you about something——

Mr. ISTOOK. So the point there is, if something is supposed to be subject to the annual appropriations process, why isn't it subjected to the annual appropriations process by the people——

Ms. SCHAKOWSKY. Well, that is what I want to ask you about. Funding for the State pharmaceutical assistance program into 2006, that was 3 years into the future. You voted for that, right?

Mr. ISTOOK. I am not sure what you are talking about.

Ms. SCHAKOWSKY. This is what was in the bill, a 3-year appropriation for the State pharmaceutical assistance program, and there was also funding for a pilot program for nursing home backgrounds. That was 4 years into the future, and of course, that was a good call. But you voted for that.

Mr. ISTOOK. Ma'am, one, if you have specific provisions you want to recite from that bill to see where they are parallel, I would be happy to look at that. But secondly, whether you are talking about the practice of advance appropriations for appropriations that occur 1 year or 2 years in the future, there is no comparison with a bill that seeks to make advance appropriations 10 years into the future which is what we are talking about with Obamacare.

Ms. SCHAKOWSKY. When you voted for the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, the welfare reform, did you know that that bill contained significant mandatory appropriations for abstinence education and childcare and development block grant?

Mr. ISTOOK. When you use the term "mandatory appropriations," it means different things. Does it have express line items for year by year for fiscal years? Do you have that information in front of you?

Ms. SCHAKOWSKY. Well, let us ask for the Deficit Reduction Act. You missed that vote. But all the Republicans on this committee supported it. It contained mandatory spending.

Mr. ISTOOK. Well, again, you see, the term "mandatory spending" is used to cover a lot of different definitions. I am talking about the practice of advance appropriations which are defined, and this is from OMB, which are defined as one made to become available 1 year or more beyond the year for which the appropriations act is

passed. That is not the same as other categories of so-called mandatory spending. It is certainly not the same as permanent appropriations as they are found, for example, in Medicare. So again, if you have something specific you would like me to look at, the line item of a legislation, but I find nothing that is comparable to what happens——

Ms. SCHAKOWSKY. Well, actually that is not true because the State pharmaceutical assistance program that you asked about, and I was listening to you while staff was telling me, that was unlimited 3 years into the future but absolutely unlimited. There was no dollar amount.

Mr. ISTOOK. If you can recite a—there is—well, then it is certainly not the same thing as what we are talking about if you say there was no dollar amount. If you have a citation to a specific section of a law that you want me to look at, I would be happy to look at that with you.

Ms. SCHAKOWSKY. And let us remember also that none of us this was paid for, period, that that legislation was not paid for at all, and the Affordable Care Act is.

Mr. PITTS. The gentlelady's time is expired. The chair recognizes the gentleman from Illinois, Mr. Shimkus, for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. Welcome to our panelists. I appreciate you coming. I am going to yield my time to Congressman Burgess for questions.

Mr. BURGESS. I thank the gentleman for yielding. You know, it is almost like a line from that Kevin Costner movie, if you build it, they will come, so OK, we are going to build the clinics. We are not going to fund the staffing but the requirement is that you have to staff the clinic if you are going to apply for the building fund, but what happens when the States get into a budget crunch. Who could believe that that would ever happen, but it could. The States get into a budget crunch and they can no longer afford that. The fact of the matter is, we are going to continue to build the clinics. That spending is required in the Patient Protection and Affordable Care Act. So it is duplicitous to say that hey, it is oK to pay to mandate the funding for the building of the clinics because people have to demonstrate an ability to staff. In fact, they don't. If they did, why have 4101(b) contained within the bill?

Again, I will accept Secretary Sebelius's assertion that she doesn't know why those two sections were put side by side, 4101(a) and 4101(b). I accept the fact that the bill was poorly crafted and poorly drafted. I accept the fact that even though I opposed H.R. 3200, it was an infinitely better crafted product than this thing that came out of the Senate on Christmas Eve. After all, 3200 had a severability clause. The bill that was signed in law contains no such clause and in fact if there were a severability clause, we might not be having the arguments that we are having down in Florida today.

Dr. Goodman, I wonder if you would—we heard it expressed again today that the Patient Protection and Affordable Care Act is going to save $142 billion over the lifetime of the bill. I think that is preposterous. But you started to talk about the cost of the subsidies for purchase of insurance in the exchange. We have already talked about the huge deficit for the month of February, the ex-

trapolated deficits into the future. What is going to happen to those projections when the subsidies for families earning up to $80,000 a year, what is going to happen when those subsidies kick in to the overall cost of this legislation?

Mr. GOODMAN. Well, it is going to soar, so we are sort of treading water right now. There are a few changes that have been made but really everything begins January 1, 2014. That is when the mandates become effective, the subsidies become effective. Overall on the employer side, I think companies like McDonald's and Burger King, who employ a lot of workers who only make $10, $15 an hour, they are not going to be able to afford family coverage that costs as much as $6 an hour, so they are going to have to find a way to get their workers over in the exchange, and I don't know how they will do that, maybe treat them all as independent contractors, but they are going to find a way or they won't survive, and then when they get over there, the taxpayer is going to pay for not just the premium but going to reimburse those workers for a lot of out-of-pocket costs.

The costs are going to be quite large. Remember, the only way we really are paying for most of this is by thinking we are going to cut Medicare, but when you all 3 years from now start getting calls from seniors saying we can't find a doctor who will see us, then you are going to be under enormous pressure to undo all of that spending that is in the bill and then you are going to find that you really haven't paid for this at all.

Mr. BURGESS. And of course, the Independent Payment Advisory Board is beyond our scope today, but it should be the subject of a future hearing but that actually has some pretty dire consequences, again, wasn't part of the House bill, 3200, but certainly as part of the bill that was signed into law. Have you had any thoughts looking ahead to that Independent Payment Advisory Board and how that is supposed to structurally pay for the expansion of all of this?

Mr. GOODMAN. Yes. And let me just say too that I think we do need to reform Medicare and there is a right way to reform it and the right way to reform it is to let doctors and hospitals come to Medicare and propose different ways of being paid. If they can save Medicare a dollar, you ought to be able to let them keep 50 cents or 25 cents, and if you did it that way, I think you would solve a lot of problems very quickly. But the only way this payment commission is going to be able to control cost is just by squeezing the providers. The only thing they know how to do is just squeeze down the doctor fees, hospital fees, and as the chief actuary of Medicare pointed out, the Medicare rates are going to be down here and everybody else's rates are going to be going like that, and the difference is going to grow wider and wider through time, and by the time we get to the end of the decade, doctors will prefer Medicaid patients to Medicare patients. The waiting lines are going to be long and seniors will be at the end of the line.

Mr. BURGESS. What is the implication for the average Member of Congress on that day?

Mr. GOODMAN. You are going to be hearing from a lot of older voters and they are not going to happy.

Mr. BURGESS. I was going to say, are they going to be happy or sad?

Mr. GOODMAN. They are going to be very sad.

Mr. BURGESS. I thank the gentleman for yielding his time, and I will back the 10 seconds.

Mr. PITTS. The chair thanks the gentleman. The gentleman's time is expired. The chair recognizes the ranking member of the full committee, Mr. Waxman, for 5 minutes for questioning.

Mr. WAXMAN. Thank you, Mr. Chairman. I would like to draw attention to a statement from Senator Harkin which I first of all ask unanimous consent to put into the record.

Mr. PITTS. Without objection.

[The information follows:]

Committee on Energy and Commerce
Subcommittee on Health
Setting Fiscal Priorities in Health Care Funding
Testimony by Senator Tom Harkin

On March 23 of last year, President Obama signed into law the most comprehensive and humane reform of our health care system since Medicare. The Affordable Care Act (ACA) will give 94% of Americans access to affordable health coverage that can never be taken away; protect consumers against insurance company abuses; make unprecedented investments in prevention, wellness, and quality of care; aggressively control runaway health care costs; and transform the health care delivery system.

For all the rhetoric about debt and government spending, the bill's opponents seek to dismantle our most effective deficit reduction tool. The nonpartisan Congressional Budget Office has certified that health reform reduces the deficit by $210 billion in the first decade and more than $1 trillion in the next. It achieves these reductions through commonsense reforms that Congress has been trying to effect for years – like reducing Medicare overpayments to private insurance companies and paying hospitals and doctors for how well they treat patients, rather than how often.

Over the last year, millions of Americans have seen the tangible benefits of health reform. Specifically, the Patients' Bill of Rights, effective in late September of last year, expands the quality and scope of health coverage for all Americans. Everyone who pays a health insurance premium is now protected against some of the most infamous and abusive practices of the insurance industry; put another way, because of reform, Americans now have protections that members of Congress have enjoyed for years.

To 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 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. The legislation being discussed in this Committee today is evidence of their determination. Let me assure you, these funding decisions were not taken lightly and involved careful consideration by representatives of the authorizing and appropriations committees, in conjunction with the Budget Committee. But let's be clear -- this debate is not really about the difference between mandatory and discretionary funding – it is about whether we are going to cut funding for the most important health care reforms since Medicare.

For example, the legislation the Committee is considering today would eliminate funding for one of the linchpins of the Affordable Care Act's coverage expansion – the American Health Benefit Exchanges. As a "one-stop shop" for health coverage, the exchange will give millions of individuals and small businesses currently locked out of the market access to affordable coverage. Qualifying individuals and small businesses will receive tax credits to make premiums affordable. Small businesses, whose premiums have increased 85% on average just in the last decade, will be able to give their employees unprecedented choice among plans. According to the nonpartisan Congressional Budget Office, small businesses coverage purchased through an exchange will "have lower administrative costs, on average, than the policies those firms would buy under current law, particularly for very small firms."

I have firsthand experience with standing up new programs, and I know how vital start-up capital is in the early years. The law requires exchanges to be financially self-sustaining by 2015, but also provides important seed funding so that states can build the infrastructure necessary for success. Careful investments are required so each exchange is specifically adapted to the state it serves. The exchanges, in many ways, give state authorities more power than they previously had to serve citizens' unique needs. To cite just one example, the Secretary has already awarded "Early Innovator" grants to seven states to develop innovative eligibility and enrollment systems for citizens entering the exchange. These systems will replace redundant and outmoded methods of enrollment, allowing the exchange to determine a person's eligibility for Medicaid or

exchange subsidies in real time and get them signed up quickly. The proposed legislation would require states to return these funds.

We can't afford to pull the rug out from under states just as they have begun such vital work. That's why mandatory funding that isn't subject to the vagaries of the budget cycle is so important. Without certainty of funding, states will not make the investments they need to ensure that exchanges are self-sustaining in four years.

In addition to these crucial grants, the proposed legislation would eliminate the Prevention and Public Health Fund, a component of the health reform law that is absolutely critical to the transformation of our Nation into a genuine wellness society. For the first time in history, we have decided not just to pay lip service to wellness and prevention, but actually to invest in these national priorities in a very robust way. Already, this commitment has provided essential resources to communities to prevent obesity, diabetes, heart disease, and other very costly conditions and diseases.

The Prevention Fund provides us not only with a tremendous opportunity to improve the health of the American people, but also to restrain health care spending. In a budget environment like the one we face today, we can't afford not to make this investment. Prior to the Prevention Fund, for every dollar spent on health care, 75 cents went to treating patients with chronic diseases, while only four cents were spent on prevention of those diseases. This t has had devastating consequences: chronic diseases are one of the main reasons why health care costs have increased so dramatically over the past several decades. Two thirds of the increase in health care spending between 1987 and 2000 was due to increased prevalence of chronic diseases. The Prevention Fund gives us an unprecedented opportunity to bend the cost curve: overall, the return on investment in community-based prevention interventions is six dollars for every dollar invested.

The provision creating the Fund was drafted with great care to guarantee funding while maintaining the decision-making authority of appropriators. Contrary to misperceptions that it evades the appropriations process, the Fund was established – in conjunction with all the relevant

committees, including the Budget Committee -- in such a way that appropriators direct how monies from the Fund are spent. The current misperception that the Fund is not subject to the appropriations process stems from the unfortunate reality that Congress has not been able to pass an appropriations bill this year, thus requiring the Administration to make these decisions. I can assure that this was not our intent; it is imperative that appropriators maintain this authority, as required by Affordable Care Act.

Finally, I would like to mention briefly the other provisions being examined by the Committee today. The proposed legislation would cut funding made available in health reform for the establishment of school-based health centers. These centers will play a critical role in providing access to school-aged children and their families once they receive quality, affordable health insurance, especially in medically underserved communities where it is difficult to find providers. The proposal would also eliminate funding for teaching health centers, a grant program that ensures continued training and development of providers, particularly in rural areas, to meet significant future demand.

Each of the Affordable Care Act provisions I have described was drafted in consultation with all relevant committees, each of whom concurred that the programs required mandatory appropriations to be sustainable. Today I am here to reaffirm this consensus: each of these programs, and their reliable funding streams, promote a healthier nation and ensure all Americans have access to key protections and crucial care. We must not deprive communities of the start-up funding they need to make get health reform off the ground. Millions of Americans who will benefit from this law are looking to us to move steadily ahead, not to pick apart the foundation we've already laid.

Mr. WAXMAN. He is chairman of both an authorizing committee and appropriations subcommittee, and he says, "I understand the implications of this guarantee that Congress should mandate appropriations for certain programs in the Affordable Care Act that are fundamental to its success." So I thought he has a lot to say from both sides of authorizing and appropriating.

The health insurance marketplace was broken, and reforming the health insurance market was imperative. We say this frequently, and I would like to ask rhetorically, what does it mean? It meant the number of uninsured Americans would have grown to 66 million by 2019. Those would be unhappy people as well. From 2004 to 2007, 12.6 million adults, 36 percent of those who actually tried to purchase insurance in the individual market, were denied coverage. They weren't happy about that. They were charged a higher premium rate or discriminated against because of preexisting conditions. Health insurance premiums more than doubled in the last decade and have risen three and a half times faster than wages during the same period, and at least 42 States, at least 75 percent of the insurance market was controlled by five or fewer insurance companies. This type of market concentration provides little leverage for consumers to fight insurance company abuses such as rescissions of health care coverage when someone gets sick or denials of medically necessary treatments are insisted on.

Now, I might just point out that those facts are I guess the Republican plan because they want to repeal the Affordable Care Act, which would leave us with the status quo. They would do nothing. The Affordable Care Act addressed these problems, and here are a few of the examples. They prohibit insurers from denying individuals insurance or charging people more because of preexisting health conditions from hangnails to heart disease. They limit out-of-pocket spending for health care benefits, prohibit annual and lifetime limits by insurance companies, significantly reduce red tape, invest in ways to reform the delivery system to provide better care at lower costs.

Senator Vitale, can you describe why health reform is so important, why repealing it would be disastrous for Americans, for the economy and for our health care system?

Mr. VITALE. Thank you, Mr. Waxman. You all have a very difficult time of it here and you made some very difficult decisions and very controversial decisions. I can speak from the experience of New Jersey and what it means to have a State with 1.3 million uninsured mostly working people who get up every day, put on their shoes and try to make a living and provide for their families. They work for small companies by and large who can't afford the cost of health insurance to provide to their employees, and if they can, the contribution by the employee is usually beyond what it is that they can afford. So the simple facts are, and setting aside all the controversy between what is mandatory and what is discretionary, the fact of the matter is that there are millions of New Jerseyans and millions of Americans who are suffering every day without an opportunity for what is reliable and dependable and affordable health care. PPACA provides that. It is an imperfect piece of legislation, and most legislative initiatives are, and I can speak for that firsthand in New Jersey.

Mr. WAXMAN. Now, if it weren't there, we would be back to the golden age of pre-Affordable Care Act, which I guess is what the Republicans would want.

Now, one of the things they attack in this proposal today are the teaching health centers. For years, we provided mandatory funding for hospitals under the Medicare program to train medical resident trainees. In 2009, we provided about $9.5 billion in mandatory funding to train medical residents. Multiple expert bodies including MedPAC, the Council on Graduate Medical Education and others have called for more training of primary care residents and more training in the community because that is where most physicians practice today. That is why the ACA provided $230 million over 5 years to directly fund community-based centers to train primary care.

Now, my colleagues on the other side of the aisle have repeatedly called for more workforce efforts. One of the witnesses, Dr. Goodman, has criticized the ACA for not providing enough funding to train physicians. Senator Vitale, can you tell us about the importance of funding to training primary care residents in your State?

Mr. VITALE. Three years ago, I attended a class and I spoke to a class at Rutgers Medical School, and there were about 60 students present and I asked by a show of hands how many were going forward to primary care. One person raised their hand. So the importance is of course—and thank you, Mr. Chairman. The importance is of course that we begin to develop this not just those who practice in primary care but also those who practice in advanced practice nursing.

Mr. WAXMAN. Well, I can think of no better use of mandatory funds than to provide funding for residents.

Mr. PITTS. The gentleman's time has expired. The chair recognizes the gentlelady from Tennessee, Ms. Blackburn, for 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman, and thank you to our witnesses for your patience today, and also for understanding that we have another hearing going on downstairs.

Mr. Vitale, I appreciate that you are here. I was a State senator in Tennessee before I came here, and I was a State senator during the TennCare era, which was the test case for public option health care. Now, I know in New Jersey you have guaranteed issue and I think it is 45 mandates—am I correct—that you all have to cover in that package? Which is pretty expensive. And the way TennCare is set up under an 1115 waiver with CMS, it was between the Governor's Office in Tennessee and CMS. So in New Jersey, do you all have any law on the books that allows the governor to spend State money without coming to the legislature?

Mr. VITALE. Well, there are elements in every—and we balance our budget every year by constitutional mandate. There are elements in the budget that is part of the governor's budget and so he is of course free to spend the dollars in his budget appropriation.

Mrs. BLACKBURN. OK. Let me ask you this, the 45 benefit mandates, that is a big number. Do you think as you are looking at the health care situation in your State and others and talking with us,

do you think that individuals should have access to health care with fewer mandated benefits, State or federal mandated benefits?

Mr. VITALE. I think we should all have the same benefits available to all of us.

Mrs. BLACKBURN. So you think one size fits all?

Mr. VITALE. In most cases, yes.

Mrs. BLACKBURN. I have to differ with you on that.

Mr. Istook, let me talk to you about the teaching centers. I found this very interesting. Section 5508 of Obamacare provides $230 million not simply an authorization but this is for the teaching study program yet the President's budget zeroes out funding for children's hospital graduate medical education. And you are a former appropriator so do you think that it is wise to make one program mandatory and beef up one and then completely cut out another one, especially when you are looking at children's health care?

Mr. ISTOOK. There is an unfortunate trend that we have seen in the President's budget proposals of substituting mandatory funding for discretionary funding, in other words, trying to remove things beyond the ability of Congress to control spending. Examples include not only what you cite but when the President says, for example, we are reducing discretionary spending, if you read the budget you find that one way is, you take Pell grants and say they are no longer discretionary, now they are mandatory. You take transportation funding and say it is no longer discretionary, now it is mandatory, and they then trumpet a claim that we have reduced discretionary spending. Well, you have done that by relabeling it as mandatory. There is no savings there and it is lousy practice as far as accountability.

Mrs. BLACKBURN. Dr. Goodman, if I could come to you on that very point, because the concern of moving things from discretionary to mandatory is of great concern to us. As you all have reviewed the bill, have you been able to articulate the number of times that this has happened in the Obamacare bill and to look at the estimated impact above what we know as the appropriated dollars for this one action?

Mr. GOODMAN. Well, not beyond what the Congressional Research Service report has stated. I just think there are, as my testimony indicated, fundamental flaws in this bill. And in response to Congressman Waxman's critique, behind every flaw that we discuss in this testimony, we said this is the alternative, this it the right way to do it as far as general concept is concerned, and if we don't do it the right way, then we are going to continue on a spending path that is simply unsustainable. There is nothing in the Affordable Care Act that fundamentally changes the way we are going to pay for health care. It is going to make all the perverse incentives that are now there worse than they were before, and the price we pay is going to be higher.

Mrs. BLACKBURN. I found it so interesting last week, and I discussed this with Secretary Sebelius last week. There was a Wall Street Journal editorial where you had Ms. Cutter and Ms. Daparel, the word was that they were telling people not to worry about all the numerous waivers that were there and not to worry about the duplications, that this is a way—giving the States a

waiver was a way to ease us more to a single payer system, and as we have looked at these programs, the personal responsibility education program, there is money for that that is made mandatory in the Obamacare program but yet the President's fiscal year budget, 2012 budget, includes $16 billion for programs that overlap. Are you all doing any research work on that? And I know my time is expired and I will yield back at the end of your response.

Mr. GOODMAN. Well, let us think about what those waivers are about. Two point seven million people have been granted a waiver. That contracts with 12,500 people who have the problem everybody is talking about, that they have been denied health insurance because of a preexisting condition. Twelve thousand five hundred people now have been signed up for insurance, paying the same premium healthy people pay. That problem is solved. The 2.7 million people are people like the workers at McDonald's who earn $10, $15 an hour. The insurance that they are going to have to buy for family coverage would be almost $6 an hour. They can't afford it. McDonald's can't afford it. That is why they were granted a waiver but at the end of the waiver period the problem is not going to go away.

Mr. PITTS. The gentlelady's time is expired, and the chair recognizes the gentlelady from Wisconsin, Ms. Baldwin, for 5 minutes for questions.

Ms. BALDWIN. Thank you, Mr. Chairman, and before I turn to the topic of the hearing, I do want to express my gratitude to you and members on both sides of the aisle for advancing H.R. 525 on public health veterinarians, which passed last night by the very comfortable margin of two votes. So mission accomplished with regard to that piece of important legislation, and I really do appreciate the efforts of members on both sides of the aisle.

Turning to the subject at hand, many are familiar with the expression "everyone is entitled to their own opinions but they are not entitled to their own facts," and I understand that my Republican colleagues may have differing opinions about the health care law that was signed into law last year but there should be no mistake about the facts. The five committee prints that we are looking at in this hearing put forth by the Majority will not create jobs. These proposals will not stimulate our struggling economy and these proposals will not put the middle class of America back to work.

The Republican Majority is playing what I would consider a dangerous game of bait and switch with the American people. Despite promises from the new Majority during the midterm elections that this Congress would be focusing on creating jobs and bolstering the economy, the legislative proposals and the committee prints that they have offered us today fail to deliver on this promise. In fact, not only do the Majority's legislative proposals do nothing to create jobs or bolster the economy, I think these proposals would actually exacerbate the problem by taking away new job opportunities.

With new investments in the health care law, we took tremendous strides towards expanding, for example, the primary care workforce, and we are on a path to train 16,000 new primary care providers in the United States. So far, my home State of Wisconsin has received $3.8 million for a primary care residency program,

and we know how important training primary care physicians is for our economy. I mean, these doctors serve as gatekeepers, keeping people out of emergency rooms and controlling health care costs. The Republican proposal to change the teaching centers development grants program places this investment at risk and could ultimately worsen the health care workforce shortage. I fail to see how taking away funding for critical jobs is going to help our economy.

Another proposal that we are looking at today would repeal funding for grants to States to establish exchanges. These exchanges are critical for ensuring that thousands of small businesses and 24 million Americans have access to new coverage options. The grants to States would provide States with the flexibility to create an exchange that meets each State's needs. Wisconsin has already received $38 million through an early innovator grant. This critical funding will spur job creation in my State and improve access to quality, low-cost health coverage.

This Republican proposal raises an important question: Are we going to ask cash-strapped States to return the money they have already been awarded? Will Wisconsin have to return the $38 million that Governor Walker has already accepted? And I fail to see how rescinding money that will create jobs is the right thing to do to get our economy back on track.

Mr. Chairman, the American people, the people of Wisconsin deserve better, and we should be focusing on the greatest need our country has right now, which is jobs, jobs and jobs. I would yield my remaining time to the gentleman from New York, Mr. Weiner.

Mr. WEINER. Thank you very much, and welcome, Congressman. It is nice to see you back. It is nice to see people who leave this place with marketable skills. I am glad at least you do.

I just want to ask a yes or no question, if I could, in the brief time that Congresswoman Baldwin has yielded to me. Congressman Istook, is Medicare a single-payer system?

Mr. ISTOOK. No.

Mr. WEINER. Dr. Goodman, is Medicare a single-payer system?

Mr. GOODMAN. No.

Mr. WEINER. Senator Vitale, is Medicare a single-payer system?

Mr. VITALE. I believe it is.

Mr. WEINER. It is single payer in the traditional way that it is used because there is one person writing the checks but that doesn't mean that—right? I mean, basically the Federal Government collects our money in our taxes, in our payroll taxes and then reimburses doctors, reimburses clinics, reimburses other—that is a single-payer system. It doesn't mean that Medicare employs the doctors, it doesn't mean they employ the clinics, it doesn't mean they employ the pharmaceutical companies. It is just who passes the money along. And in the one second I have left, do you know what the overhead and profits is of Medicare? One point zero three percent.

Mr. BURGESS. [Presiding] The gentleman's time is expired. The chair recognizes the gentleman from Georgia, Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you, and Representative Istook, let me associate myself with Representative Weiner in regard to his comments. Thank you for your service and happy to see you, and thank all three of the witnesses for your testimony today.

I want to start out by saying that the actions of this Administration and the Secretary of Health and Human Services I think border on deception and they leave me with very little confidence in both Obamacare and the Administration's ability to enact the law through regulation over these next 3 years. Just last week was the latest example. Secretary Sebelius right here in this committee told Congressman Shimkus that the Administration was confident that she could spend one pot of money, $500 billion worth of money, twice, both to pay for Obamacare and increase the solvency of Medicare. And then next the Secretary testified that she had used her powers as Secretary to slip in an end-of-life provider code into Medicare in the dark of night without allowing for public comment. And finally, she told our panel and a Senate Finance Committee panel a few weeks ago that a major long-term-care program created in Obamacare that she is in charge of was totally unsustainable but only after direct questioning. No previous announcement to the American people or to Congress, and of course, I am referring to the CLASS Act.

With these thoughts in mind, I wanted to ask you, Representative Istook, section 4002 of the Obamacare bill, or the Affordable Care Act, created a fund for prevention, wellness and public health activities. In the language of Obamacare, it says that these funds are for "sustained and national investment in prevention and public health programs." Are the words "prevention" and "public health programs" defined in section 4002?

Mr. ISTOOK. I am not aware of any definition. I think that is left to the sole discretion and judgment of the Secretary.

Mr. GINGREY. And so conceivably then Secretary Sebelius or any Secretary could use these funds for any purpose that they decide is prevention, correct?

Mr. ISTOOK. Oh, yes. They could be extremely broadly defined.

Mr. GINGREY. Wide, wide discretion on the part of the Secretary of HHS.

Mr. ISTOOK. Right.

Mr. GINGREY. Let me go to Mr. Goodman. You know, we all remember the Andy Griffith Medicare ads that the Secretary ran last year that looked a lot like to me political advertising for the Affordable Care Act, Obamacare. Is there anything that would prevent the Secretary from using these taxpayer dollars to pay for similar political advertising on provisions in Obamacare in a lead-up to the 2012 elections, as an example?

Mr. GOODMAN. I don't think so, and let me say, those Andy Griffith ads were extremely deceptive bordering on fraud because what he talked about were the benefits for seniors under the bill but didn't mention any of the costs, and for every $1 of new spending, there are $10 of reductions in spending for seniors. So on net, there is going to be a lot less spending on senior citizens. You know, that ad made it sound like boy, once seniors find out how this works, they are going to like it.

Mr. GINGREY. Well, I thank you for that response, and I wasn't going to use the word "fraud" but I guess "bordering on fraud" is acceptable language in your testimony, and I tend to agree with you on that.

Dr. Goodman, how much authority does Secretary Sebelius have over Obamacare now that it is being implemented by regulation?

Mr. GOODMAN. You know, I don't know but every time I learn about some new exercise of authority, I am shocked. I have never seen so much authority that has been given to a Secretary, nothing even close to it, and it bothers me because, you know, there are elections, Presidents come and go, Secretaries come and go, and if a Secretary has that much power, how do we know what is going to happen 8 years from now, 12 years from now? We are no longer a government of laws, we are government of people and discretion, whims.

Mr. GINGREY. Mr. Goodman, thank you.

In the few seconds I have got left, let me shift to Senator Vitale. Senator, in your written testimony and what you said to us here today, you kind of touted what New Jersey has done in regard to the CHIP program and the fact that you cover childless adults, and I realize this goes back to Governor Whitman but, you know, and you talk about the fact that charity care went way down because you expanded this cover, the CHIP program. I think it was, what, something like 400 percent of the federal poverty level in New Jersey. Are you aware of the fact that most of these hospitals that provide charity care are not-for-profit, and in that status as not-for-profit they get tremendous tax breaks, and it is their obligation to be designated as not-for-profit to provide this charity care?

Mr. VITALE. May I respond, Chairman? Thank you.

Well, you are right, but the fact of the matter is that the overwhelming amount of charity care has just really been debilitating for our State's hospitals. It is so overwhelming that they do meet their charitable obligation as not-for-profits but to the extent now that there are so many uninsured accessing health care in the worst and most expensive manner, in the emergency departments, has pushed a number of hospitals and into closure in our State, and those who are surviving are under increasing pressure from those who are uninsured.

Mr. GINGREY. Mr. Chairman, reclaiming—I realize my time is expired and I appreciate your indulgence. If you could just let me make this one comment? I mean, the point I am making is that these hospitals, they are designed not-for-profit, and it doesn't mean that these patients are going to the emergency room to get their care. Most of these hospitals have outpatient clinics and the ability to provide the same level of care that they would be getting if they were signed up for SCHIP or in one of these exchanges that the good senator is referring to, and I will yield back and I thank you for your indulgence.

Mr. BURGESS. Thank you. The gentleman from New York is recognized for 5 minutes.

Mr. WEINER. The problem is, they are not paid for. Ultimately, they have to pay for it. The bill fairy doesn't come in and say to any kind of hospital we are going to go pay your bills.

By the way, Dr. Goodman, calling Andy Griffith a fraud is outrageous. He is one of the most beloved Americans. I am just kidding.

Let me just, Senator Vitale, let me ask you a couple of questions. There has been a lot of discussion by the two gentlemen to your

right about the inflexibility and the Federal Government control that is being taken by this bill. Let me just ask you a couple of questions. State insurance commissioners were still kept in charge of State insurance policies in the 50 States. Is that correct?

Mr. VITALE. Yes.

Mr. WEINER. And didn't the Affordable Care Act not only do that but empower them with additional tools they didn't have before on behalf of the residents of the State? Is that correct?

Mr. VITALE. That is correct.

Mr. WEINER. Is it also correct that under the federal Affordable Care Act the exchanges if the States so choose are going to be set up as State-run, State-governed exchanges? Is that correct?

Mr. VITALE. That is correct.

Mr. WEINER. Isn't it also true that despite the efforts of many of my Republican friends and perhaps the gentlemen to your right, efforts to nationalize tort reform were resisted? Isn't tort reform still the purview of the States under this law?

Mr. VITALE. It is and always has been.

Mr. WEINER. Isn't it also true that the expansion of Medicaid between now and 2017 is entirely picked up by the Federal Government? Is that true?

Mr. VITALE. Yes.

Mr. WEINER. Isn't it also true that in 2018, 2019, 2020 and 2021, if there are fewer poor people, fewer people bankrupted by health care costs, for example, more people working, more people employed, the number of Medicare beneficiaries if your State is successful will go down, will it not?

Mr. VITALE. Yes, it will.

Mr. WEINER. And with it will be Medicaid expenses, will it not?

Mr. VITALE. Yes.

Mr. WEINER. So in fact, if you are a well-governed State and the economy does better, meaning less, God willing, 20 percent of the economy is health care, and people are employed more like they have been increasingly—more private sector jobs have been created under President Obama than under 8 years of President Bush—if it continues that way, Medicaid expenses could go down. Is that correct?

Mr. VITALE. That is correct.

Mr. WEINER. Now, if I can talk to you a little bit about some of the things that are required in here and just get your feedback on them. One is this notion of standards. The gentlewoman from Tennessee says oh, one size fits all, but let us assume for a moment the citizens of New Jersey through their State rights say that we are going to have certain health care standards that are robust, we want to make sure that our insurance actually covers people, and the State of Tennessee says no, we are going to have a scaled-down program that has virtually no benefits but lower cost, isn't it very likely that citizens of New Jersey, if they can go to that lower standard, the healthy ones will say, Wait a minute, I don't need a lot of insurance, I am going to go to the lower standards—won't there be a race to the bottom, less insurance and ultimately the same thing we have now, which is people who are underinsured? Wouldn't that be the effect?

Mr. VITALE. That will be the effect, yes.

Mr. WEINER. So the effect of having standards across State lines is to make sure there is fair competition between States.

Next is this notion of mandatory coverage that is enshrined in Romneycare. Are you aware that under the mandatory policies of Romneycare that with the subsidy, a very similar model that we set up, under Romneycare, a grand total of 0.67 percent chose not to take the subsidy and buy insurance? Are you aware of that?

Mr. VITALE. Yes.

Mr. WEINER. It is a very tiny number because actually this is going to come as a surprise, the American people when given a subsidy, they want the insurance.

Now I would like to talk a little bit about Dr. Goodman and Congressman Istook's solutions. They say why don't we look at what Walmart does and they are able to lower costs if we just give people money, they will go out and buy insurance. Well, if you don't believe in the laws of big markets and you don't believe in the laws of the economy that more people joining together can negotiate for lower prices, you can do something. Maybe my father when he retired at 61 with an incidence of prostate cancer was not yet eligible for Medicare, he went out as an individual and said I am going to try to buy insurance so the insurance company said one of two things: One, we don't want you, you are going to get sick, our business model is paying out as little as possible, or two, they said $17,000 to $20,000 a year from my retired father. And the reason is very simple. Under Dr. Goodman's model, we can all be given money to go out and spend and people like me and Congressman Istook, who is healthy as an ox, he will be able to get insurance, but what do you do with the people who the insurance company says I don't want it. Under Dr. Goodman's model, there are no standards, everyone just gets a check. What you are doing is deconstructing one of the most powerful models that Walmart uses, which is when you get large pools of people, you are able to hold costs down. If you don't believe me, look at how auto insurance works. It aggregates risk over the whole pool. You say to each and every citizen, go out and buy for yourself, you are resisting the ideas of a free marketplace and how it works and works best. And I have got news for you, Dr. Goodman. Do you know who is going to love your idea? Insurance companies. They love the idea of just give the money, we will get some people come in with the money but we will get to decide who we want and who we don't, and you ignore the idea that sometimes what you have got to say is you know what, let us pool people together, and for those of you who are wondering, the idea of expanding Medicare, the boogeyman of the single-payer system, is based on that model because we have all these citizens, we hold down costs and we aggregate everyone together. That is the way the system works correctly. I thank you.

Mr. PITTS. The gentleman's time has expired. The chair recognizes the ranking member for a unanimous consent request.

Mr. PALLONE. Mr. Chairman, I would ask unanimous consent to include the testimony of Jeff Levi of the Trust for America's Health and from Alan Weil of the National Academy for State Health Policy, and I would also like to add a facts sheet on your proposal, the chairman's proposal, to block mandatory funding in the Affordable

Care Act. This was prepared by Mr. Waxman, our ranking member. I believe you have all of these.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Written Statement for House Energy and Commerce Subcommittee on Health Hearing "Setting Fiscal Priorities in Health Care Funding" on behalf of Jeffrey Levi, PhD, Executive Director for Trust for America's Health

Thank you for this opportunity to submit written testimony to the Subcommittee on Health on the importance of the Prevention and Public Health Fund in assuring the future health of our nation. Trust for America's Health is an independent, non-profit and non-partisan advocacy organization committed to making prevention a national priority.

In this statement, TFAH would like to address four critical points:

- First, to show why prevention is so important to improving the health of the Nation, reducing health care costs, and restoring our economic competitiveness.
- Second, to show how the Prevention and Public Health Fund (Prevention Fund) is critical to achieving the health status of Americans regardless of one's position on the rest of the reforms contained in the Affordable Care Act.
- Third, to show why mandatory funding is needed for prevention and public health, to assure consistent and predictable investment levels in prevention so that we can achieve the intended outcome of improving the nation's health.
- Fourth, to show that even with a mandatory appropriation, the Affordable Care Act reserves for Congress the right to determine allocation of resources within the Prevention Fund.

Before addressing these points, it is important to note that the Prevention and Public Health Fund has very broad support in the health community. Over 530 organizations, including over 185 state and local organizations from your states alone, have joined together in support for retaining the Prevention Fund in its current form. A list of those organizations is appended to this testimony.

Why prevention?

It is no secret that the United States has some of the worst health outcomes of any country in the developed world. Average life expectancy in the United States is just over 78 years, according to the CIA Fact Book, number 50 among developed countries (**see figure 1**).

This is because we have focused on treating people when they get sick – at great cost – rather than focusing on keeping them healthy in the first place. We need to bring common sense into our health care system by helping people to stay healthy and not get sick in the first place. That's the role of the Prevention Fund: it will help Americans to make healthier choices and take personal responsibility for their own health and the health of their families and children.

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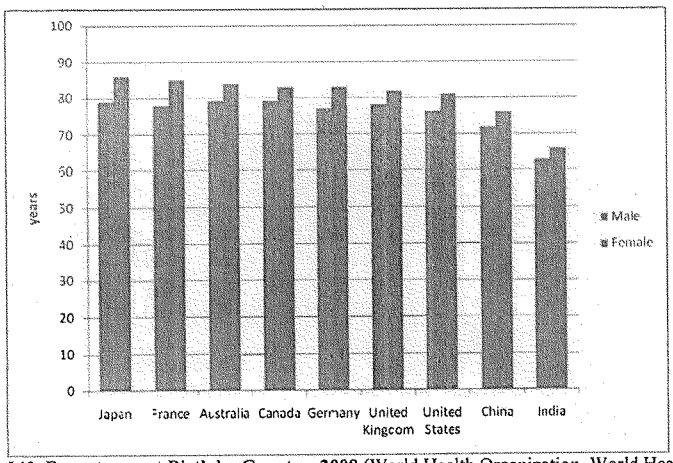

Figure 1 - Life Expectancy at Birth by Country, 2008 (World Health Organization, World Health Statistics, 2010. http://www.who.int/whosis/whostat/EN_WHS10_Part2.pdf)

We will never control health care costs until we improve the health of Americans by investing in prevention. The biggest cost drivers in the U.S. health care system today are chronic diseases – right now 75 percent of health care costs are associated with chronic diseases, many of which can be prevented and better managed by the kind of community based prevention programs supported by the Prevention Fund. That's the incredible value of the Prevention Fund: it is investing in measures that will keep people healthier and will help people already sick become healthier -- all through less costly interventions than traditional medical care.

Indeed, studies have shown that the type of prevention interventions supported by the fund can be cost-effective, saving the health care system money in the short and long term. For example:

- A report Trust for America's Health developed in conjunction with economists from the Urban Institute and colleagues from the New York Academy of Medicine and Prevention Institute, entitled *Prevention for a Healthier America* concluded that an investment of $10 per person per year in proven community-based programs to increase physical activity, improve nutrition, and prevent smoking and other tobacco use could save the country more than $16 billion annually within 5 years. This is a return of $5.60 for every $1.
- Several large research studies, including the U.S. Diabetes Prevention Program, have found that over half of new cases of type 2 diabetes could be prevented through evidence-driven, community-based prevention programs. An analysis by the Urban Institute estimates that a targeted national program modeled on the Diabetes

Prevention Program approach could result in total savings over 10 years of $191 billion – and 75 percent of this would be savings to Medicare or Medicaid.

- For every $1.00 spent on Diphtheria-Tetanus-acellular Pertussis (DTaP) vaccine saves $27.00; Measles, Mumps, and Rubella (MMR) vaccine saves $26.00; Perinatal Hepatitis B vaccine saves $14.70; Varicella vaccine saves $5.40; and Inactivated Polio (IPV) saves $5.45.
- According to the Pacific Institute for Research and Evaluation, there are significant cost savings for proven injury prevention strategies. Every $46 dollar child safety seat saves $1,900 in medical costs, future earnings and other resource costs, and quality of life costs. Similarly, a $33 smoke alarm provides cost savings of $940.

But prevention is not just about reducing health care costs. It's also about assuring that the American economy remains competitive. Poor health is putting the nation's economic security in jeopardy. The skyrocketing costs of health care threaten to bankrupt American businesses, causing some companies to send jobs to other countries where costs are lower. The indirect costs to employers of their employees' poor health can be 2-3 times the costs of direct medical expenses, including lower productivity, higher rates of disability, higher rates of injury, and more workers' compensation claims. Small businesses disproportionately feel the impact of an unhealthy workforce. When one person is out sick, has a chronic illness, or is less productive at work ("presenteeism"), the entire work operation suffers. Larger employers may be able to weather these losses more easily than a small business. Indeed, according to the U.S. Chamber of Commerce, investing in the health of Americans will improve the bottom line for businesses by lowering health care costs, reducing absenteeism, and improving productivity.

Finally, it is important to note that the American people understand the value of prevention. In a public opinion survey conducted in 2010, Trust for America's Health and the Robert Wood Johnson Foundation found that 71 percent of Americans favored an increased investment in community health and disease prevention. Indeed, our polling has shown that Americans of all political stripes believe prevention works, believe prevention can save money, and believe it is worth the investment even if it didn't save money because it will make us a healthier, more productive nation.

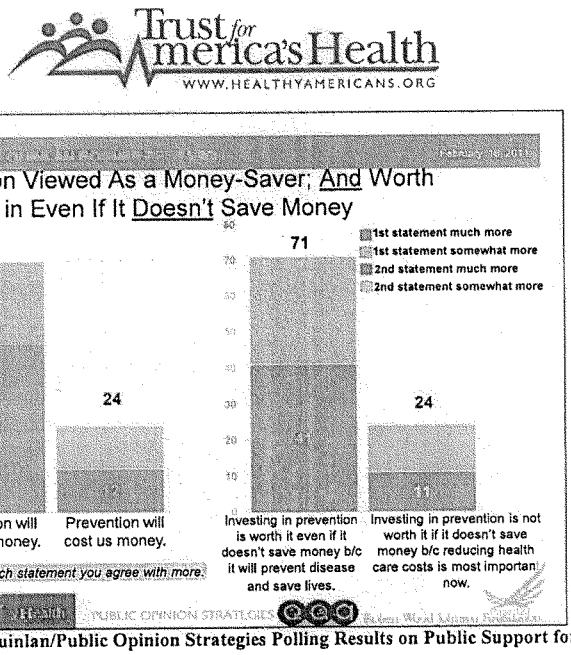

Figure 2 - Greenberg Quinlan/Public Opinion Strategies Polling Results on Public Support for Prevention

What is the Prevention and Public Health Fund doing now and what can it do in the future to improve the health of Americans?

The Prevention Fund is a vehicle for expanding our nation's capacity to assure access to critical preventive health services, such as immunizations, and to assuring that wherever we live, all Americans have the same opportunity to make healthier choices. The investments made by the Prevention Fund fall into three categories: (1) expanding clinical and community-based prevention programs; (2) improving and modernizing public health agencies across the country so they can provide 21st century protection for all Americans; and (3) building the evidence base for what works best in prevention and public health. All three elements are critical to our ability to improve the Nation's health, control health care costs, and improve our country's economic competitiveness.

Community and clinical prevention
Already in Fiscal Year 2010, we have seen the Prevention Fund invested in programs to promote tobacco control and implement tobacco cessation services and campaigns, as well as obesity prevention, better nutrition and physical activity, and HIV prevention. This is the core of what the Prevention Fund is about: giving the tools to communities to help make healthier choices the easy choices for Americans across the country. As the Fund grows in size, the geographic scope of these programs will increase.

It is important to note that as a condition of receiving these community prevention funds, the Centers for Disease Control and Prevention (CDC) is requiring that grantees adhere to

evidence-based approaches – approaches that have been proven to make a difference in healthy behaviors and health outcomes. We are not just throwing money into the field and hoping it will work: this is a focused, planned investment based on the best science available. Some examples of the kinds of projects supported in FY 2010 include:

- The state of Pennsylvania received $115,000 to build the nation's network of Quitlines, to help people quit tobacco use;
- Texas received nearly $2.4 million for HIV prevention including HIV testing, linking HIV-infected persons with appropriate services, and filling critical gaps in data and understanding of the HIV epidemic;
- Kentucky received over $600,000 to support recruitment and training of the public health workforce that serves Kentucky and Appalachia;
- Michigan was given nearly $500,000 to integrate primary and behavioral health services to try to address the fact that people with serious mental illness die on average 25 years sooner than the general population, largely due to extremely high rates of chronic disease.
- North Carolina received approximately $3.7 million to address obesity in two rural areas of the state by focusing on increasing access to healthy foods and encouraging physical activity. Other states, including Georgia ($2.35 million), Illinois ($5.8 million), California ($3.6 million), and Arkansas ($2.3 million), received funding to conduct similar obesity prevention activities.

Stronger, accountable health departments
In FY 2010, and going forward, the Prevention Fund will be investing in modernizing our nation's public health system. We rely on state, local, and tribal health departments to provide immunizations, protect our food and water supply, conduct surveillance, detect and monitor emerging infectious diseases, prevent disease, and prepare for and respond to disasters, acts of bioterrorism and other health emergencies. The Prevention Fund is providing desperately needed resources to assure that health departments have a 21st century capacity -- in terms of both equipment and workforce. For example, through the Prevention Fund all states are now supported to increase their quality improvement capacity and all states are receiving support to improve their epidemiology and laboratory capacity – critical functions of government public health.

Building the evidence base
The Fund will build upon what works, but also test new approaches to promoting prevention and wellness. The Fund will help ensure accountability by evaluating new programs that are funded and enable us to prioritize the best prevention approaches. This is reflected in FY 2010 and 2011 in investments in expanding the work of the Community Preventive Services Task Force, which assesses the evidence for approaches to prevention, and in a new investment in public health services and systems research, which helps us understand the most cost-effective ways of structuring and delivering public health.

Why a mandatory funding stream?

As important as the investments described above may be, the question remains: why can't they be funded through the regular appropriations process? Why is a mandatory funding stream so important?

A mandatory funding stream is necessary to ensure predictability in funding levels. Much of this funding is going out to state and local health departments which are expected to expand services, modernize technologies, train and recruit a public health workforce, or implement new community-based prevention programs with these grants. Unfortunately, our chronically underfunded public health system has failed to achieve nearly 70 percent of its top priority objectives aimed at reducing the main causes of death. Simply stated, the nation's public health is underfunded, understaffed and saddled with using out-of-date technologies to combat today's modern health threats. Achieving the outcomes envisioned for these investments -- of healthier choices for all Americans, of better access to clinical preventive services such as immunizations, and of health departments with a 21st century capacity in such areas as health information technology -- is a multi-year process and thus requires a multi-year investment.

Whether it is a state health department or a community based organization that is receiving these funds, committing to these outcomes can only be expected if there is predictability to funding. Relying on the annual appropriations process – with its unpredictability both in terms of timing and in terms of funding levels – would understandably make many leery of a long-term commitment to this process.

Can Congress determine how the Prevention Fund is spent?

That said, this is ***not*** a mandatory funding stream that disempowers Congress and in particular, the appropriations committees. Indeed, Section 4002 (d) of the Affordable Care Act states:

> (d) TRANSFER AUTHORITY.—The Committee on Appropriations of the Senate and the Committee on Appropriations of the House of Representatives may provide for the transfer of funds in the Fund to eligible activities under this section, subject to subsection(c).

Thus, Congress can use the regular appropriations process to influence how the Fund is invested.

Conclusion

When it comes to the health of our nation, we are at a critical decision point. Some experts fear that today's generation of children may not have as long and as healthy a life as their parents – because of the challenges of obesity and other chronic diseases. This is

a threat to the quality of life of Americans and to our economy because of potentially higher health costs and diminished competitiveness. This would be a tragic outcome if we didn't know what needed to be done to prevent it. But we have the tools – proven approaches to prevention and public health that can assure a better quality of life and lower health care costs – if only we will harness them. What could be a more important role of government than to provide all Americans the opportunity to be healthy – to give them the capacity to take responsibility for their health and make the healthier choices? That's what the Prevention and Public Health Fund is about. It would be a tragedy of monumental proportions if the political discord over the Affordable Care Act resulted in taking away this incredible opportunity that Americans overwhelmingly support and need.

On behalf of Trust for America's Health and our hundreds of colleague organizations who support the Prevention and Public Health Fund, we urge you to retain the Prevention and Public Health Fund in its current form.

Appendix 1 -

Groups Supporting the Prevention and Public Health Fund
Total count: 534 (as of March 7, 2011)

National Organizations:

317 Coalition
AARP
Advocates for Better Children's Diets
AIDS Alliance for Children Youth & Families
AIDS United
Alzheimer's Foundation of America
American Academy of HIV Medicine
American Academy of Pediatrics
American Academy of Physician Assistants
American Alliance for Health, Physical Education, Recreation, and Dance
American Association for Health Education
American Association for International Aging
American Association for the Study of Liver Diseases
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Association of People With Disabilities
American Association on Health and Disability
American Cancer Society Cancer Action Network
American College of Clinical Pharmacy
American College of Gastroenterology
American College of Occupational and Environmental Medicine

American College of Preventive Medicine
American Congress of Obstetricians and Gynecologists
American Counseling Association
American Dental Education Association
American Diabetes Association
American Dietetic Association
American Federation of State, County and Municipal Employees
American Foundation for Suicide Prevention
American Health Planning Association
American Heart Association
American Liver Foundation
American Lung Association
American Medical Student Association
American Muslim Health Professionals
American Nurses Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Social Health Association
American Society for Gastrointestinal Endoscopy
American Thoracic Society
amfAR, the Foundation for AIDS Research
Aniz, Inc.
Applied Research Center
Arthritis Foundation
Asian & Pacific Islander American Health Forum
Association for Prevention Teaching and Research
Association for Professionals in Infection Control and Epidemiology, Inc.
Association of American Medical Colleges
Association of Maternal and Child Health Programs
Association of Public Health Laboratories
Association of Schools of Public Health
Association of State & Territorial Health Officials
Association of State & Territorial Public Health Nutrition Directors
Association of State and Territorial Dental Directors
Association of State and Territorial Directors of Nursing
Association of State and Territorial Health Officials
Association of University Centers on Disabilities
Association of Women's Health, Obstetric and Neonatal Nurses
AVAC: Global Advocacy for HIV Prevention
Bazelon Center for Mental Health Law
Building Healthier America
C3: Colorectal Cancer Coalition
Campaign for Community Change
Campaign for Public Health

Campaign for Tobacco-Free Kids
Caring Ambassadors Program
C-Change
Center for Adolescent Health & the Law
Center for Biosecurity, University of Pittsburgh Medical Center
Center for Health Improvement
Center for Science in the Public Interest
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Children Now
Children's Dental Health Project
Children's Health Fund
Coalition for Health Funding
Coalition for Health Services Research
Colon Cancer Alliance
Commissioned Officers Association of the U.S. Public Health Service
CommonHealth ACTION
Community Access National Network
Community Action Partnership
Community Catalyst
Council of State and Territorial Epidemiologists
Crohn's and Colitis Foundation of America
Defeat Diabetes Foundation
Defeat Diabetes Fund
Digestive Disease National Coalition
Epilepsy Foundation
Faces & Voices of Recovery
Families USA
Family Violence Prevention Fund
Family Voices
Federation of Associations in Behavioral & Brain Sciences
Friends of AHRQ
Friends of NCHS
Friends of SAMHSA
Global AIDS Alliance
Grassroots Organizing
Health Care for America Now
Health Promotion Advocates
Health Rights Organizing Project
HealthHIV
Hep C Connection
Hepatitis B Foundation
Hepatitis Foundation International
HIV Medicine Association
HIV Prevention Justice Alliance
Home Safety Council

Infectious Diseases Society of America
Institute for Public Health Innovation
Integrated Healthcare Policy Consortium
International Certification and Reciprocity Consortium (IC&RC)
International Health, Racquet & Sportsclub Association
Interstitial Cystitis Association
Iron Disorders Institute
Laotian American National Alliance
League of United Latin American Citizens
Main Street Alliance
March of Dimes Foundation
Media Policy Center
MEND Foundation
Mended Little Hearts
Mental Health America
Mo Hepatitis C Alliance
National Alliance of Multi-ethnic Behavioral Health Associations
National Alliance of State and Territorial AIDS Directors
National Asian American Pacific Islander Mental Health Association
National Assembly on School-Based Health Care
National Assoc. of Area Agencies on Aging (n4a)
National Association for Public Health Statistics and Information Systems
National Association for Sport and Physical Education
National Association of Chain Drug Stores
National Association of Children's Hospitals
National Association of Chronic Disease Directors
National Association of Community Health Centers, Inc.
National Association of Counties
National Association of County and City Health Officials
National Association of Local Boards of Health
National Association of People with AIDS
National Association of Public Hospitals and Health Systems
National Association of School Nurses
National Association of State Alcohol and Drug Abuse Directors
National Association of State Mental Health Program Directors
National Athletic Trainers' Association
National Black Leadership Commission on AIDS
National Business Coalition on Health
National Center for Healthy Housing
National Coalition for LGBT Health
National Coalition for Promoting Physical Activity
National Coalition of STD Directors
National Council of Asian Pacific Islander Physicians
National Council of Jewish Women
National Council of La Raza

National Council on Aging
National Education Association
National Environmental Health Association
National Family Planning & Reproductive Health Association
National Federation of Families for Children's Mental Health
National Forum for Heart Disease and Stroke Prevention
National Health Council
National Health Equity Coalition
National Indian Project Center
National Initiative for Children's Healthcare Quality
National Kidney Foundation
National Korean American Service and Education Consortium
National Latino AIDS Action Network
National Minority AIDS Council
National Network of Public Health Institutes
National Nursing Centers Consortium
National Nursing Network Organization
National Patient Advocate Foundation
National Physicians Alliance
National REACH Coalition
National Recreation and Park Association
National Rural Health Association
National Viral Hepatitis Roundtable
National WIC Association
National Women and AIDS Collective (VT)
Nemours
North American Quitline Consortium
Northwest Federation of Community Organizations
Novo Nordisk
OCA
Out of Many, One
Partnership for Prevention
Pediatric Pharmacy Advocacy Group
Pew Children's Dental Campaign
Physician Assistant Education Association
Planned Parenthood Federation of America
PolicyLink
Prevent Blindness America
Prevention Institute
Preventive Cardiovascular Nurses Association
Professional Association of Social Workers in HIV and AIDS
Project Inform
Public Health Foundation
Public Health Institute
Public Health Law and Policy

Public Health Solutions
Pulmonary Hypertension Association
Rails-to-Trails Conservancy
Safe Routes to School National Partnership
Safe States Alliance
Samuels and Associates
Service Employees International Union
Sexuality Information and Education Council of the U.S.
Society Against STI's & HIV
Society for Adolescent Health and Medicine
Society for Advancement of Violence and Injury Research
Society for Healthcare Epidemiology of America
Society for Public Health Education
Society of General Internal Medicine
State and Territorial Injury Prevention Directors Association
Summit Health Institute for Research and Education, Inc.
Tethys Bioscience, Inc.
The AIDS Institute
The Center for HIV Law and Policy
The Corporate Hepatitis Alliance
The National Alliance to Advance Adolescent Health
The National LGBT Cancer Project - Out With Cancer
Treatment Access Expansion Project (MA)
Trust for America's Health
U.S. PIRG
United Fresh Produce Association
United Ostomy Associations of America
United Way Worldwide
Urban Coalition for HIV/AIDS Prevention Services
WomenHeart: The National Coalition for Women with Heart Disease
YMCA of the USA

State Organizations:

Alabama

Alabama Public Health Association
AIDS Alabama
Birmingham AIDS Outreach
Southern AIDS Coalition, Inc.

Arizona

Maricopa County Dept of Public Health

Arkansas

Community Health Centers of Arkansas, Arkansas Primary Care Association
The Living Affected Corporation
University of Arkansas for Medical Sciences

California

A World Fit for Kids!
ACCESS Women's Health Justice
AIDS Project Los Angeles
All Saints Home Care And Referral Services
Asian & Pacific Islander Wellness Center
Asian and Pacific AIDS Intervention Team
Association of Asian Pacific Community Health Organizations
Beach Cities Health District
Berkeley Media Studies Group
Bienestar Human Services
California Association of Alcohol and Drug Abuse Counselors
California Center for Public Health Advocacy
California Conference of Local Health Department Nursing Directors
California Conference of Local Health Officers
California Food Policy Advocates
California Foundation for the Advancement of Addiction Professionals
California Immigrant Policy Center
California Newsreel
California Pan-Ethnic Health Network
California Partnership
California Primary Care Association
California Public Health Association
California School Health Centers Association
Children's Hospital and Research Center Oakland
Coalition for Humane Immigrant Rights of LA
Community Health Councils
County Health Executives Association of California
County of Santa Clara, California
County of Sonoma, California
Desert AIDS Project
First Five
Having Our Say Coalition
Health Justice Network
Health Officers Association of California
Hep B Free Long Beach
JWCH Institute, Inc.
Korean Resource Center
Latino Coalition for a Healthy California
Libreria del Pueblo Inc.

North County Health Services
Prochilo Health, Inc.
Redwood AIDS Information Network & Services
South Bay Coalition
Special Services for Groups, Inc. - PALS for Health
STOP AIDS Project
Thai Health and Information Services, Inc.
The California Hepatitis Alliance
The Friends of AIDS Foundation
The Greenlining Institute
United Cambodian Community

Colorado

Colorado AIDS Project
Colorado Community Health Network
Colorado Progressive Coalition
Colorado Public Health Association
Community Health Association of Mountain/Plains States
Northern Colorado AIDS Project

Connecticut

Connecticut Association of Directors of Health
Connecticut Certification Board
Connecticut Citizen Action Group
United Action Connecticut
Khmer Health Advocates, Inc.

Delaware

Delaware Center for Health Promotion
Health Education Network of Delaware
The Ministry of Caring, Inc.

Florida

AIDS Service Association of Pinellas
ALERT Health, Inc.
DYNS Services, Inc.
Florida Public Health Association
ISAIAH
NOFLAweb.org
Okaloosa AIDS Support and Informational Services, Inc.

Riverfund, Inc. (The River Fund)
Youth Education Services

Georgia

Atlanta Regional Health Forum
Bryan County Health Department
Camden County Health Department
Center for Pan Asian Community Services, Inc
Chatham County Health Department
Effingham County Health Department
Georgia AIDS Coalition
Georgia Equality
Georgia Public Health Association
Glynn County Health Department
Grady Health System Infectious Disease Program
HIV Dental Alliance
Institute for Health and Productivity Studies, Rollins School of Public Health, Emory University
Institute of Public Health, Georgia State University
Long County Health Department
Liberty County Health Department
McIntosh County Health Department
The Youth Becoming Healthy Project, Inc.

Hawaii

Faith Action for Community Equity
Hawaii Island HIV/AIDS Foundation
Hawai'i Primary Care Association
Malama Pono Health Services
Papa Ola Lokahi

Idaho

Allies Linked for the Prevention of HIV & AIDS
Idaho Community Action Network

Illinois

AIDS Foundation of Chicago
Asian Health Coalition
Chicago House and Social Service Agency
Children's Heart Foundation
Cook County Department of Public Health

David Ostrow & Associates, LLC
Illinois Association of Public Health Administrators
Illinois Maternal and Child Health Coalition
Illinois Primary Health Care Association
Illinois Public Health Institute
Northern Illinois Public Health Consortium
Open Door Clinic
Project VIDA
Springfield Harm Reduction Initiative
The Phoenix Center
Total Health Awareness Team

Indiana

Indiana Association of Public Health Physicians and Local Health Departments Organization, Inc.
Indiana Primary Health Care Association
Indiana Public Health Association

Iowa

AIDS Project of Central Iowa
Community HIV/Hepatitis Advocates of Iowa Network
Iowa Public Health Association
Wilson Resource Center

Kansas

Kansas Association for the Medically Underserved
Kansas Association of Local Health Departments

Kentucky

AIDS Interfaith Ministries of Kentuckiana, Inc
Christian County Health Department
Kentucky Health Departments Association
Kentucky Public Health Association
Kentucky Voices for Health

Louisiana

Health Law Advocates of Louisiana, Inc.
Louisiana Primary Care Association

Louisiana Public Health Institute

Maine

Maine Primary Care Association
Maine Public Health Association
Maine People's Alliance

Maryland

AIDS Action Baltimore
CASA de Maryland
Johns Hopkins AIDS Education and Training Center
Maryland Association of County Health Officers
Maryland Partnership for Prevention
Moveable Feast
Older Women Embracing Life
South Asian Americans Leading Together
Trans-United

Massachusetts

Boston Public Health Commission
Health Resources in Action, Inc.
Immigrant Service Providers Group/Health
Massachusetts League of Community Health Centers
Massachusetts Public Health Association
Plymouth AIDS Support Services
Victory Programs, Inc.

Michigan

Huron County Health Department
Michigan Association for Local Public Health
Michigan Positive Action Coalition
Michigan Primary Care Association
Michigan Public Health Association
Monroe County Public Health Department
Public Health-Monroe County
Tuscola County Health Department
United Health Organization

Minnesota

Local Public Health Association of Minnesota

Minnesota AIDS Project
Minnesota Association of Community Health Center
TakeAction Minnesota

Mississippi

Mississippi Primary Health Care Association

Missouri

Doorways Interfaith Housing
Missouri Association of Local Public Health Agencies
Missouri Primary Care Association
Missouri Public Health Association

Montana

Indian People's Action
Montana Organizing Project
RiverStone Health

Nebraska

CityMatCH
Nebraska AIDS Project
Nebraska Appleseed
Nebraska Cancer Coalition
Nebraska Public Health Association
Nebraska State Association of County & City Health Officials
Nebraska Urban Indian Health Coalition
Public Health Association of Nebraska

Nevada

Nevada Public Health Association
Partners for a Healthy Nevada
Progressive Leadership Association of Nevada

New Hampshire

Bi-State Primary Care Association
Granite State Organizing Project
New Hampshire Public Health Association

New Jersey

Hyacinth AIDS Foundation
MAAT Center
New Jersey Association of County Health Officers
New Jersey Health Officers Association
New Jersey Primary Care Association
New Jersey Public Health Association
New Jersey Women and AIDS Network

New Mexico

First Nations Community HealthSource
New Mexico Hepatitis C Alliance Alliance
New Mexico Primary Care Association
New Mexico Public Health Association

New York

African Services Committee
Amethyst Women's Project
B Free CEED Coalition
Black Women's Blueprint
Brooklyn Perinatal Network, Inc.
CEO Services
Community Health Care Association of New York State
FamilyCook Productions
Gay Men of African Descent
HIV Law Project
Harm Reduction Coalition
Harlem United Community AIDS Center, Inc.
Liberty Research Group
Latino Commission on AIDS
Love Alive International
Lower East Side Harm Reduction Center
Make the Road New York
NYC Hepatitis B Coalition
New York Academy of Medicine
New York Harm Reduction Educators, Inc.
New York Immigration Coalition
New York Society for Gastrointestinal Endoscopy
New York State Association of County Health Officials
NYC Department of Health and Mental Hygiene
NYU Langone Medical Center

Status C Unknown
The Amos Project
The Community Heart Health Coalition of Ulster County
The Women's Center
Visual AIDS for the Arts, Inc

North Carolina

Nia's Ark
North Carolina Association of Local Health Directors
North Carolina Community Health Center Association
North Carolina Fair Share
North Carolina Harm Reduction Coalition
North Carolina Public Health Association

Ohio

Association of Nurses in AIDS Care
Association of Ohio Health Commissioners
Cerebral Palsy Association of Ohio
Mahoning Valley Organizing Collaborative
Miami Valley Positives for Positives
Northeast Ohio Alliance for Hope
Ohio AIDS Coalition
Ohio Alliance for Retired Americans
Ohio Association of Community Health Centers
Ohio Public Health Association
Progress Ohio
UHCAN Ohio
The MetroHealth System
Toledo Area Jobs with Justice

Oregon

Oregon Action
Oregon Primary Care Association
Oregon Public Health Association
Oregon Public Health Institute

Pennsylvania

Action AIDS
Adult Congenital Heart Association
Alder Health Services
City of Philadelphia Department of Public Health

OraSure Technologies, Inc.
Pennsylvania Public Health Association
Reading Risk Reduction

Rhode Island

Ocean State Action

South Carolina

Palmetto AIDS Life Support Services, Inc.
REACH U.S. Southeastern African American Center of Excellence in the Elimination of Disparities in Diabetes (REACH U.S. SEA-CEED)
South Carolina Eat Smart Move More Coalition
South Carolina Fair Share
South Carolina Primary Health Care Association
South Carolina Tobacco Collaborative

South Dakota

West South Dakota Native American Organizing Project

Tennessee

Nashville CARES
Positive East Tennesseans
Tennessee Association of People With AIDS

Texas

Healthy Family Initiatives
La Fe Policy Research and Education Center
Texas Association of Local Health Officials

Utah

Association for Utah Community Health

Vermont

Center for Health and Learning
Ottauquechee Community Partnership
Vermont Public Health Association

Virginia

K.I. Services, Inc.
Tenants and Workers United
Virginia Organizing Project

Washington

Childhood Obesity Prevention Coalition
Comprehensive Health Education Foundation
Public Health - Seattle and King County
Public Health-Seattle & King County
Snohomish Health District
Thurston County Board of Health
Washington Association of Local Public Health Officials
Washington Health Foundation- Healthiest State in the Nation Campaign
YWCA of Seattle – King County – Snohomish County, Seattle WA

West Virginia

Covenant House, Inc. West Virginia
West Virginia Primary Care Association

Wisconsin

Wisconsin Association of Local Health Departments and Boards
Wisconsin Primary Health Care Association
Wisconsin Public Health Association

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for STATE HEALTH POLICY

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Executive Director
Alan Weil

March 8, 2011

Hon. Frank Pallone, Jr.
House of Representatives
237 Cannon House Office Building
Washington, DC 20515

Dear Congressman Pallone:

Thank you for your inquiry regarding state roles and plans implementing the Affordable Care Act (ACA)as you prepare for the March 9, 2011, hearing of the Committee on Energy and Commerce, Subcommittee on Health titled "Setting Fiscal Priorities in Health Care Funding."

The National Academy for State Health Policy (NASHP) is an independent, non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice. We provide a forum for constructive, practical work across branches and agencies of state government on critical health issues facing states.

In our role, we have gathered a large number of state documents related to implementation of the Affordable Care Act. We currently have about 300 documents from 44 states covering topics including health insurance exchange legislation, state planning reports, and fiscal analyses. All of these documents are available at www.statereforum.org. From these documents it is clear that states are actively involved in implementation—despite the serious misgivings regarding the law political leaders in many of these states have.

States understand the complexity of implementation and have developed specific work plans that run from now until (and in some cases beyond) January 1, 2014, when many of the ACA's provisions take effect. States view implementation as a continuous activity that has already begun and must occur within specific, tight timelines, in order to meet their goals associated with effective implementation of the federal law.

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Much, but not all, of the state work thus far has focused on establishing health insurance exchanges. Other areas of focus include modernizing eligibility and enrollment systems, planning for the health care workforce necessary to cover those who will become eligible for coverage under the law, and revising insurance laws and regulations to conform to new federal standards.

While states vary significantly in their approach to implementation, the information we have collected indicates a significant amount of commonality in the issues they are facing and the areas where they are focusing their work. For the purposes of illustration, consider the activity in Maryland, South Carolina, and California.

Maryland appointed a Health Care Reform Coordinating Council that held meetings throughout 2010, culminating in a final report in January of this year that serves as an implementation plan and roadmap for the state. They have established specific goals for each year related to development of their health insurance exchange. In 2011, they plan to establish a governance structure, research exchange issues, complete an interim report, and appoint a board. In 2012, they will codify their regulations and make additional legislative changes if needed. In 2013, they plan to focus on implementation, education, and outreach. These steps are viewed as necessary in order for their exchange to be certified in 2013 and operational in 2014.

Maryland's implementation of the health insurance exchange is occurring in conjunction with an overhaul of the information technology systems the state uses for eligibility and enrollment. Maryland was recently rewarded an early innovator grant from HHS. Maryland's goal is to serve as a national model, and to develop their systems in partnership with other states. Maryland states that successful implementation will require effort on both immediate requirements and the longer-term transformative opportunities presented by reform. They believe that work must begin immediately given that the new systems will be a major departure from the current systems and thus will require significant time for planning, procurement, and implementation.

South Carolina is actively engaged in planning and developing an insurance exchange. A bill introduced in the House in late February would establish an insurance exchange within the Governor's office that is governed by a board of directors appointed by the Governor. With a planning grant they have received from the federal government, South Carolina plans to undertake many activities to better understand the needs of the state and how their health insurance exchange should be structured. During the background research and data collection phase they plan to determine the number of uninsured and the extent of coverage in the existing health insurance market, collect qualitative data from stakeholders on exchange design and operation, estimate the number of people eligible for coverage, and model and analyze exchange options. The state plans to assess program integration, resources and capabilities, governance models, finance, technical infrastructure, business operations, and funding. They will then design their exchange operations and governance

based on input from representatives from the legislative, insurance, health, and business communities.

California developed a Health Reform Implementation Task Force after enactment of the ACA. The Task Force oversees three activities they consider essential for successful implementation of the ACA: tracking and responding to federal grants and guidance, establishing and maintaining a centralized website that provides access to documents and developments related to implementation and serves as stakeholder outreach, and supporting key legislation needed for early implementation efforts. Governor Arnold Schwarzenegger signed seven laws into effect during the 2010 legislative session, including the first law in the nation to establish an insurance exchange that meets the requirements of the ACA. California relied upon its initial planning grant from HHS to develop appropriate work plans and timelines for exchange implementation, and define the additional infrastructure, resources, data and coordination activities that will be needed to make the exchange operational by 2014.

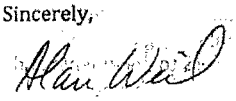
Our review of state implementation documents leads me to the following conclusions:

1. Each state is identifying its own priorities for emphasis in the implementation process. State choices derive from each state's own perspective on its goals for improving the health care system, the assets it has to address those goals, and the requirements and resources embodied in the ACA. States are integrating ACA implementation into a stream of health reform activities that have been underway since long before the federal law was enacted.
2. States are conducting their implementation activities with significant stakeholder involvement and support, including conducting focus groups and appointing planning committees with consumers, health care providers, business owners, insurance companies, and legislative branch representation.
3. States have developed specific implementation timelines that require continuous work over the next few years. Interruptions in that work would threaten their ability to achieve effective implementation.
4. Given state fiscal conditions, states are heavily reliant upon federal funds to support their implementation activities. Revocation or curtailment of those funds would yield missed deadlines and an inability of states to complete the work they feel they must do to be successful.

States 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 government—a decision most states would strongly prefer not to make.

As Congress considers changes to the financing of the ACA, I hope you will keep in mind the role states are playing in implementation and that you will avoid steps that diminish their ability to effectively implement the law.

Sincerely,



Alan Weil
Executive Director

March 2011

The Pitts Proposal to Block Mandatory Funding in the Affordable Care Act

Committee on Energy and Commerce, Democratic Staff
Henry A. Waxman, Ranking Member

Under the Affordable Care Act, Americans have more freedom and control over their health care choices. Already, millions of Americans across the country are experiencing the law's new consumer protections and benefits.

Opponents of the Affordable Care Act have tried unsuccessfully to date to repeal the law and defund it. Now, the Energy and Commerce Committee is considering a new approach to undermining the law: eliminating the mandatory funding provided to the Department of Health and Human Services to implement key parts of the law. Specifically, a new proposal by Subcommittee Chairman Joe Pitts would:

- **Take away funding to establish exchanges and modernize eligibility systems.** The law provides funding for states to conduct planning activities needed to develop a health insurance exchange, as well as funding through 2015 to establish the exchange. Blocking funding would prevent new exchanges from being established and the premium tax credit from being implemented, thereby preventing thousands of small businesses and 24 million Americans from accessing this new coverage.

- **Halt new prevention activities.** The Affordable Care Act creates a new Prevention and Public Health Fund to assist state and community efforts to prevent illness and promote health, so that all Americans can lead longer, more productive lives. The fund will help prevent disease, detect it early, and manage conditions before they become severe. By concentrating on the causes of chronic disease, the law helps move the nation from a focus on sickness and disease to one based on wellness and prevention. Taking away this critical new investment in prevention will be harmful to the health of Americans now and in the future.

- **Worsen the health care workforce shortage.** New investments in the law, along with those in the Recovery Act, provide an important platform for expanding the primary care workforce and creating more opportunities to prepare physicians to practice primary care in community-based settings, while ensuring primary care services are available to our nation's most underserved communities. Without this funding, we will no longer be on the path to train 16,000 primary care providers. Blocking funding would allow our workforce shortage to continue to grow, especially in communities that are already severely underserved.

- **Eliminate new investments in school-based health centers.** School-based health centers not only enable children with acute or chronic illnesses to attend school, but also improve the overall health and wellness of all children through health screenings, health promotion, and disease prevention activities. Taking away the funding for up to 400 school-based health centers that could benefit from this provision will weaken a vital piece of the children's health safety net that helps improve access to care for children and maximizes their potential to learn.

- **Eliminate new funding for personal responsibility education.** The law awards Personal Responsibility Education grants to states for programs to educate adolescents on both abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS.

The principal argument against these essential health care funds is that they are "mandatory appropriations," which Republican members have described as an unprecedented approach to legislating and a "gangster government."[1]

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.[2] 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 laws considered by the Energy and Commerce Committee when it was last under the control of Republicans in the 108th and 109th Congresses illustrate how Republicans used mandatory appropriations. These laws are the Medicare Prescription Drug Improvement and Modernization Act (P.L. No. 108-173) and the Deficit Reduction Act (P.L. No. 109-171). They contained billions of dollars of mandatory appropriations funding a wide array of government activities. Current Republican Members of the Energy and Commerce Committee voted for both bills unanimously, including 18 Republicans who were Members in 2006 and 17 who were Members in 2003.

The Medicare Prescription Drug Improvement and Modernization Act (P.L. No. 108-173) included specific mandatory appropriations, including an unlimited mandatory appropriation for a drug assistance program. Moreover, the new benefit added over $400 billion to the deficit. Mandatory appropriations in that legislation included:

- $410 billion in funding for prescription drug benefits under Medicare Part D (title I)
- An unlimited appropriation to fund the transitional drug assistance program (section 101)
- $125 million to fund coordination with state pharmaceutical assistance programs (section 101)
- $1.5 billion to fund start-up administrative costs for implementation (section 1015)
- $200 million to fund a health care infrastructure improvement program (section 1016)
- $100 million to fund a chronic care improvement program in Medicare (section 721).
- $1 billion to fund federal reimbursement of emergency health services furnished to undocumented individuals (section 1011)
- $25 million for a pilot program for background checks on workers at nursing homes (Section 307)

The Deficit Reduction Act (DRA; P.L. No. 109-171) also included a significant amount of mandatory appropriations both inside and outside of the jurisdiction of the Committee.

Mandatory appropriations within the Committee's jurisdiction included:

- $2 billion for Medicaid assistance for states affected by Hurricane Katrina (section 6201)
- $1.8 billion to fund the Money Follows the Person rebalancing demonstration program (section 6071)
- $1 billion for the Low-Income Home Energy Assistance program (section 9001)
- $730 million over the first 10 years, and $75 million each year thereafter, to fund the Medicaid Integrity Program (section 6034)

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[1] "Bachman Stands by Gangster Government," Roll Call (Mar. 6, 2011) (online at http://www.rollcall.com/news/-203887-1.html).

[2] Mandatory spending (also called direct spending) encompasses all spending not passed in the annual appropriations bills.

- $283 million to close state shortfalls in the CHIP program (section 6101)
- $218 million to fund demonstration projects regarding home and community-based alternatives to psychiatric residential treatment facilities for children (section 6063)
- $60 million to fund implementation of the Act (section 6203)

Programs outside the jurisdiction of the Committee also received significant mandatory appropriations in the bill, including:

- $750 million to fund grants for healthy marriage promotion and responsible fatherhood (section 7103)
- $4.53 billion to fund academic competitiveness grants (section 8003)
- $100 million to improve the collaboration between state courts and children's welfare agencies (section 7401).

Other mandatory appropriations enacted by Republicans when they last controlled the House include funding for "abstinence-only" education in Pub. L. No. 109-432, that was subsequently extended by Pub. L. No. 110-48 and Pub. L. No. 110-275.

Mr. PITTS. In conclusion, I would like to thank our witnesses, former Congressman Istook, Dr. Goodman, Senator Vitale, for their testimony. I would like to thank them and the members for participating in today's hearing. I remind the members that they have 10 business days to submit questions for the record, and I ask the witnesses to please respond promptly to the questions. Members should submit their questions by the close of business on March 23rd.

With that, this subcommittee hearing is adjourned.

[Whereupon, at 1:50 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Chairman Fred Upton
Subcommittee on Health Hearing
Setting Fiscal Priorities in Health Care Spending
March 9, 2011

Mr. Chairman, thank you for holding this hearing. Today, the subcommittee will examine a question of great importance that will dominate the time of this committee over the next two years: at a time of record deficits and when our nation's debt looms larger every day, what programs should we prioritize and what should we eliminate?

It is abundantly clear that rampant government spending is the cloud that hangs over job growth and economic prosperity. What was unimaginable only a few years ago has become the new normal in Washington.

We have had three straight years of trillion dollar plus deficits. The federal government is now borrowing 41 cents of every dollar it spends. We recently learned that the largest monthly deficit in our nation's history occurred in February – $223 billion.

For far too long, the issue of out-of-control government spending has been ignored. Congress has enjoyed spending taxpayer dollars on new programs, but failed to cut elsewhere. The math simply doesn't add up anymore. That will not be the practice of this committee going forward.

We have acknowledged the need to change our ways in Congress. Yet the White House is once again showing a failure to lead and acknowledge the obvious. The administration's latest budget will saddle the country with $13 trillion dollars in additional debt that will fuel the uncertainty holding our nation back from a stronger recovery.

Over the past few years, we have seen families and small businesses cut back and set priorities. Today, we will take steps to do the same. We will examine five provisions found in the Democrats' massive new health care law that blindly appropriate dollars without setting spending priorities.

I want to highlight one particular provision that I find personally disturbing, as should every member of Congress. Last week, the secretary of HHS testified in front of the Health Subcommittee on the president's new budget and implementation of the new health care law. The secretary confirmed our interpretation of Section 1311 of PPACA regarding the new health insurance exchanges.

In the rush to pass the massive health care bill, Congress gave the administration an unlimited appropriation to spend as much as it would like on state grants authorized by under the law. That's right: the Secretary of HHS was granted an unlimited tap into the Treasury by the health care law.

This is an unprecedented grant of power to a single administration official. This delegation of Congress' power of the purse is an absolutely breathtaking abdication of our role as stewards of taxpayer dollars. We have given the secretary someone else's credit card and the authority to spend an unlimited amount. Whether or not a member supported the health care law, no member should support this unprecedented authority to spend the taxpayer funds without limitation.

Congress needs to reassert its role and set spending priorities, rather than give the executive branch unfettered power to spend as much as it wishes. Today, our committee will start to do just that.

Mr. Chairman, I yield back the balance of my time.

Response to Questions for the Record
The Honorable Ernest Istook
Subcommittee on Health
Setting Fiscal Priorities in Health Care Funding
March 9, 2011

1. **Generally speaking in your experience as an appropriator how common was it to give the Administration unlimited access to the government's coffers and even more alarming provide access without any Congressional oversight?**

In my experience it is extremely uncommon and the scale of this in PPACA is unprecedented, involving as it does billions of dollars. It's an accurate truism that Congress best expresses its oversight through the power of the purse. No other system of enforcing oversight has the same effectiveness as reducing or denying funding for agencies and programs. There is an unfortunate trend to evade this enforcement through direct funding that bypasses the appropriations process. In addition to Obamacare (PPACA), another major abuse is the funding mechanism for the new Consumer Financial Protection Bureau, which is funded by intercepting money paid from the Federal Reserve and sending it directly to CFPB before it is deposited in the U.S. Treasury as it normally would have been.

a. **Aren't these types of mandatory spending provision examples of Congress abdicating its responsibility?**

You are absolutely right. Under Article 1, Section 8, Clause 7, "No money shall be drawn from the Treasury but in Consequence of Appropriations made by Law." Since each Congress lasts only two years before elections re-create the House and a third of the Senate, no Congress should be making appropriations decisions for future Congresses.

b. **And, as stewards of taxpayers' dollars don't we have an obligation to reign in this type of unilateral discretion.**

Yes, you do have this obligation. If Congress delegates its authority by granting virtually unlimited discretion for the Executive Branch to make spending and policy decisions, it thwarts both the separation of powers and the balance of powers that are fundamental to our Constitution.

John Goodman
National Center for Policy Analysis
Responses to Subcommittee Questions
House Energy & Commerce Subcommittee on Health
April 6, 2011

1) I believe the cost of the PPACA will be far higher than the $1 trillion price tag estimated by the CBO. To finance the expansion of Medicaid and new subsidies for low-and moderate-income families in the Exchange, the PPACA cuts $523 billion over 10 years from Medicare Advantage plans and Medicare providers. The Medicare Chief Actuary, Richard Foster, has explained that the draconian cuts to Medicare – if allowed to take place – will result in Medicare payments to providers falling behind Medicaid rates in this decade. As a result one out of seven hospitals will become insolvent and seniors will lose access to care. In response, Congress will be under enormous pressure to reverse these cuts. For this reason, Foster does not believe most of the Medicare cuts will occur.

In addition, far more people are likely to get subsidized coverage in the Exchange than the CBO estimates. According to the Census Bureau, approximately 110 million theoretically qualify for Exchange subsidies based on income. Yet the CBO only estimates that about 25 million people will get subsidized coverage in the Exchange. This is improbable. For low income families, the subsidies in the Exchange are five to seven times greater than what they would receive through an employer. I believe this will cause the labor market to segment into low-wage and high-wage firms. Low wage firms will dump their workers into the Exchange, possibly paying a fine.

2) In theory, if everyone has health coverage there is little need to provide additional subsidies to hospitals that treat a disproportionate share of indigent patients. The PPACA cuts about 25 percent of disproportionate share hospital (DSH) payments — with the largest cuts coming in the later years around 2019. The problem is that even under the PPACA, there will be about 23 million people who remain uninsured. Moreover, half of the newly insured will be covered by Medicaid – which pays reimbursements of only about 59 percent of the fees private insurers pay. Many of the uninsured will still seek care at safety net hospitals. Those covered by Medicaid will have a difficult time seeing doctors who will treat them for the low fees state Medicaid programs pay. They will likely seek care in hospital emergency rooms, especially of safety net hospitals. This will put an enormous financial strain on these facilities.

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