THE PRESIDENT'S FISCAL YEAR 2015 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

HEARING

BEFORE THE

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

ONE HUNDRED THIRTEENTH CONGRESS

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THE PRESIDENT'S FISCAL YEAR 2015 BUDGET PROPOSAL WITH U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES SECRETARY KATHLEEN SEBELIUS

WEDNESDAY, MARCH 12, 2014

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

The Committee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Dave Camp [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
Wednesday, March 5, 2014
No. FC–16

CONTACT: (202) 225–3625

Chairman Camp Announces Hearing on the President's Fiscal Year 2015 Budget Proposal with U.S. Department of Health and Human Services Secretary Kathleen Sebelius

House Ways and Means Committee Chairman Dave Camp (R–MI) today announced that the Committee on Ways and Means will hold a hearing on President Obama's budget proposals for the Department of Health and Human Services (HHS) for fiscal year 2015. **The hearing will take place on Wednesday, March 12, 2014, in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from the invited witness only. The sole witness will be the Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

On March 4, 2014, President Obama submitted his fiscal year 2015 budget proposal to Congress. The President's proposed budget contains his tax, spending and policy proposals for the coming fiscal year, including his proposed budget for the Department of Health and Human Services and the programs it oversees and operates. Many of the Department's programs such as Medicare, healthcare programs under the Affordable Care Act and Temporary Assistance for Needy Families are within the Committee's jurisdiction.

In announcing this hearing, Chairman Camp said, **"Reviewing the budget, I am troubled by the President's decision to ignore what he once saw as a crisis in our entitlement programs. By leaving out any real reforms to protect and preserve Medicare, the President has chosen to provide political cover in an election year when what this country needs most are solutions that protect both today's seniors and future generations.**

"We also must ask difficult questions about HHS' troubled efforts to implement the Affordable Care Act. Open enrollment is almost over, enrollment is behind schedule and the website is not completed. Most importantly, the American people are facing higher premiums, fewer healthcare choices and a loss of wages—the exact opposite of what they need in a tough economy. Administrative delays and exemptions cannot fix this law, and the Committee looks forward to hearing how Secretary Sebelius plans to work with Congress to solve this crisis.

"Members also look forward to reviewing the Administration's proposals affecting human services programs, including those that may help welfare recipients replace welfare checks with paychecks or assist youth in foster care become successful adults."

FOCUS OF THE HEARING:

U.S. Department of Health and Human Services Secretary Sebelius will discuss the details of the President's HHS FY15 budget proposals that are within the Committee's jurisdiction.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, March 19, 2014**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman CAMP. Good morning. The Committee will come to order.

Secretary Sebelius, thank you for joining us today for a discussion of the President's 2015 budget.

It has been 4 years since Obamacare became the law of the land, and it has been a bumpy road since then. Millions of Americans are paying more for health care as a result of the law.

The Committee will come to order. Please take your seats.

It has been 4 years since Obamacare became the law of the land, and it has been a bumpy road since then. Millions of Americans are paying more for health care as a result of the law, a trend which will only continue to spike as a result of the failed healthcare exchange launch. All across the country, low- and middle-class income Americans are seeing smaller paychecks and working less. Towns, schools, restaurants, and businesses are struggling to comply with the law, finding that they are forced to cut hours or hold off on hiring. Millions of Americans have discovered the plan they have and like has been canceled or they can no longer rely on the care from their local doctor or hospital.

I hear about how the healthcare law is affecting communities like my hometown of Midland, Michigan, and how families are dealing with the uncertainty this has brought them and their children.

Unfortunately, despite Republican attempts to provide Americans relief from the burdens of this law, it appears that this is a road map of what is to come. We now know, after the failed launch of the exchanges, that since the Administration was unable to meet their enrollment targets and failed to sign up enough young and healthy individuals, premiums will be higher next year. The Congressional Budget Office has also found that compared to initial estimates, fewer individuals will find healthcare coverage through the exchanges, Medicaid, or employer-sponsored insurance.

And while Democratic leaders promised that Obamacare would create 4 million jobs, 4,000 almost immediately, the CBO projects fewer Americans will be working as a result of Obamacare. In fact, the U.S. economy will see a decline in the number of full-time-equivalent workers of about 2 million in 2017, rising to about 2.5 million in 2024, according to CBO. CBO went on to emphasize this should mean, and I am quoting, "The largest declines in labor supply will probably occur among lower-wage workers."

Secretary Sebelius, you have stated that there is absolutely no evidence, and every economist will tell you this, that there is any job loss related to the Affordable Care Act. But the evidence is everywhere. We hear it from employers back home, from testimony in front of Congress, and we read about it in the papers weekly.

The law is not working as was promised, and yet the President's budget doubles down on this law and requests another $1.8 billion for its implementation. With so many unanswered questions, it is hard to understand how or why Congress would approve such a request. I am hopeful you will shed some light on those questions and provide some answers today, basic questions such as how much taxpayer money has been spent thus far and where did it come from, how much taxpayer money will be spent on subsidies for individuals outside of the exchange, how much did the failed launch of the exchange cost taxpayers, how many people have actually paid a premium, and how many previously uninsured Americans have signed up for Obamacare?

And increasingly, we must all ask the question, when is the next delay or next administrative change in the law coming? It seems not a holiday goes by without a new announcement from the Administration that delays some part of Obamacare.

Notably missing from this budget is any mention on how we can secure the promise of Medicare for seniors in the future. In just a few short years, Medicare will go broke. This Committee has released numerous discussion drafts, based on bipartisan ideas, to secure Medicare for current and future seniors, some of which were included in previous budgets from President Obama.

We have the opportunity now to work toward reforms that strengthen the program, and the longer we wait, the harder the choices we must make will be. We need to have an open dialogue between the Administration and Congress on this, and I am disappointed that the Administration has walked away from this commitment and seemingly provided political cover during an election year rather than offer solutions.

I appreciate your making the time to be here today, and I hope we can count on a more open, constructive dialogue between Congress and the Administration if we are going to make progress on resolving the law's failures and working toward solutions for our Nation's seniors.

Before I recognize Ranking Member Levin for the purpose of an opening statement, I ask unanimous consent that all Members' written statements be included in the record. And without objection, so ordered.

I now recognize Ranking Member Levin for his opening statement.

Mr. LEVIN. Thank you very much.

Madam Secretary, welcome. We really do welcome you here, a chance to have some dialogue. I hope that is what will occur. Instead of dialogue, what we have really had from the Republicans is diatribe. And we are going to see that further this week when there is an effort to take up our reform on SGR that is on a bipartisan basis and fund it with essentially the destruction of ACA.

The *New York Times* talks about today where the enrollment is. And it is interesting, the Republicans often used to talk about Part D and how it proceeded. The Energy and Commerce Committee is going to come out with a report this morning, and it is going to turn out that ACA enrollment as a percentage of projected enrollment is already better than Part D's voluntary enrollment. So I hope you will be able to set the record straight. As we know, it is short of the original goal. And I hope you will address that, where we are, what the figures really mean. And also you may want to comment that 3 million young adults have already gained access to health insurance through their parents' policies, which would not have happened if it weren't for ACA.

I just want to give one example of what this has meant for people in this country. A person from Brighton, Michigan, in her thirties, has lupus, a preexisting condition. She hasn't had insurance in 6 years because it was simply too expensive. She lived in constant fear of getting sick or injured, and she said, and I quote, "There are lots of things I haven't done. I used to like to ski and mountain bike, but I know that if I broke a wrist it would cost me $10,000. It is that constant worry of what happens if." And that uncertainty ended January 1, when her new insurance plan, costing $175 a month, took effect.

The real contrast is an ad that has been running in Michigan about a cancer patient, and I won't go into the details. But essentially, she said her policy was unaffordable through the marketplace. The ad has been funded over a million dollars by Americans for Prosperity. It turns out, according to the *Detroit News* and others, that that ad and that statement together are just false. It turns out that this person will save more than $1,000 a year.

So, Madam Secretary, I hope you will use your time to acknowledge the problems with the website at the beginning and put in perspective what has happened since then and where we are going, and indeed, to have a dialogue. What has been most short in the discussion of ACA has been dialogue. We welcome you here and look forward to your testimony.

Chairman CAMP. Well, thank you, Mr. Levin.

Again, I want to now welcome our witness, Secretary Kathleen Sebelius of the Department of Health and Human Services.

Again, thank you for being with us today. The Committee has received your written statement and testimony, and it will be made part of the formal hearing record. You are now recognized for 5 minutes for your oral remarks. Thank you.

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

Secretary SEBELIUS. Well, thank you, Chairman Camp, and Ranking Member Levin, and Members of the Committee.

In his State of the Union, President Obama laid out values that are the backbone of his 2015 budget: opportunity for all, economic growth, and security, the notion that if you work hard and take responsibility you should have the opportunity to succeed in America. Our budget will allow our Department to move this mission forward.

We start with the fact that every child deserves the opportunity for a healthy start and a high-quality learning environment. And as the President has said, research shows that one of the best investments we can make in a child's life is high-quality early education. Science has clearly demonstrated over and over that the return on early childhood investments is at least seven to one, far exceeding any investment in the stock market. And the fact of the matter is these investments are good for our kids, good for our economy, and good for a family's economic security.

In every State, currently the cost of child care for two children now exceeds the median annual rent. Our budget puts a special focus on birth to kindergarten. It brings the total investment in child care and development funds to $6.1 billion, so more of our children have access to quality care.

We also propose to expand early Head Start child care partnerships for more of our children. This allows us to build on the progress we are making in reforming Head Start. And by funding the President's Opportunity, Growth, and Security Initiative, we could provide an additional hundred thousand children with access to high-quality early learning.

Our global competitors have figured out that investing in early education makes good economic sense. China plans to increase the

preschool enrollment by 50 percent by 2020. And in Japan, virtually every 4-year-old attends preschool. So if we want our children to compete for the global jobs of the future, these investments really matter.

This budget also extends and expands voluntary home visitation so we can empower our children's first and best teachers, their parents.

The investments don't add a dime to the deficit. One of the ways they are paid for is through an increase to the tobacco tax, which we know encourages younger Americans from smoking. But here is the snapshot: Every day more than 3,000 children try their first cigarette, and nearly 1,000 a day become daily smokers. So the efforts to reduce their smoking habits are imperative.

These investments have broad bipartisan support from governors, from business, military, and law enforcement leaders, from parents and health providers, and can make a huge difference in our Nation's prosperity.

Of course no child can learn with a toothache that his or her family can't afford to have treated. No family can save for college when they are drowning in medical bills. This budget protects the progress we are making in helping more Americans obtain the opportunity of affordable health coverage. Yesterday, we announced that 4.2 million people had signed up through the end of February, which is an increase of 29 percent in the month of February in the number of signups. The number of people choosing a plan every day last month also increased from an average of 32,800 in January to 34,000 a day in February. We expect that number to rise by the March 31st deadline, as more Americans learn how affordable the marketplace coverage can be. We also know that we have had a total of 8.9 million people, as the last Medicaid report indicated, that have been determined eligible for either renewal or new Medicaid benefits.

Now, one of our best tools also for expanding access to health care are the community health centers, which are throughout our urban and rural areas. This budget invests to help them serve an additional 31 million Americans at new and existing sites. The budget also protects our seniors by increasing investments for elder justice to protect them from abuse, neglect, and exploitation. It protects consumers with additional resources to help the FDA oversee the safety of our food supply and pharmaceutical resources. It expands the efforts to protect hospital patients from healthcare-associated infection.

And because the opportunity, growth, and security mean very little when a family faces unemployment, the budget is a job creator. It invests in industries that drive our economy, innovation, science, and discovery. The investments fuel entrepreneurship and economic growth, while saving lives, the NIH-funded BRAIN Initiative, vaccine development, and other innovative products.

Through the Health Care Workforce Initiative, the budget expands the National Health Service Corps, enabling us to focus training dollars on the primary care workforce by expanding residency training opportunities. And for all these proposed investments, the budget makes tough, fiscally responsible choices. It will contribute a net $369 billion to our deficit reduction over the next

decade by incentivizing high-quality, efficient care, and by continuing to reduce healthcare cost growth, strengthen Medicare and Medicaid with $415 billion in net savings over 10 years.

We will also produce budget savings for taxpayers by continuing to crack down on waste, fraud, and abuse. Every dollar we invest in the Health Care Fraud and Abuse Control Initiative, for example, returns $8.10 in money we recover, which last year was a record-breaking $4.3 billion.

Now, in many ways the budget reflects the notion from the Book of Matthew that where your treasure is there also your heart will be. A budget is more than a ledger. It is a statement of a mission, intentions, and priorities. This budget succeeds in that mission by expanding opportunity, encouraging growth, and protecting both our families' economic security and our Nation's health security.

Thank you, Mr. Chairman, and I would be pleased to answer your questions.

[The prepared statement of Secretary Sebelius follows:]

STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

THE PRESIDENT'S FISCAL YEAR 2015 BUDGET

BEFORE THE

COMMITTEE ON WAYS AND MEANS

UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 12, 2014

Testimony of
Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
Before the
U. S. House of Representatives
Committee on Ways and Means
March 12, 2014

Chairman Camp, Ranking Member Levin, and Members of the Committee, thank you for the invitation to discuss the President's FY 2015 Budget for the Department of Health and Human Services (HHS).

This budget for the Department of Health and Human Services (HHS) improves the economic opportunity of all Americans by providing critical investments in scientific research, health care, disease prevention, social services, and children's well-being, to achieve healthier families, stronger communities, and a thriving America. While it invests in areas that are critical to our long-term prosperity, the budget also helps tackle our deficit with legislative proposals that would save an estimated net $356 billion over 10 years. The Budget totals $1.0 trillion in outlays and proposes $77.1 billion in discretionary budget authority, a reduction of $1.3 billion from FY 2014 enacted. With this funding HHS will continue to improve health care and expand coverage, create opportunity and give kids the chance to succeed, protect vulnerable populations, promote science and innovation, protect the nation's public health and national security, and focus on responsible stewardship of taxpayer dollars.

Strengthening Health Care and Continuing Effective Implementation of the Affordable Care Act

Expanding Health Insurance Coverage. As of January 1, 2014, millions of Americans gained access to new health insurance options previously not available to them. The Marketplaces provide improved access to insurance coverage, creating a new private health insurance market in which those in need of coverage are more easily able to purchase health insurance. As of February 25, 2014, the Marketplaces had enrolled 4 million individuals. New premium tax credits and rules ensuring fair premium rates are making private coverage more affordable for consumers. The Budget supports continued operations in the federally facilitated Marketplace, as well as oversight and assistance to state based and Partnership Marketplaces.

The Affordable Care Act provides full federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the federal poverty level for three years starting in 2014 and covers no less than 90 percent thereafter. The Affordable Care Act also simplified Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment processes and aligned them with Marketplaces. The Centers for Medicare & Medicaid Services (CMS) continues to work with states and other partners to advance state efforts that promote health, improve the quality of care, and lower health care costs.

Also beginning in 2014, consumers will benefit from a number of new protections in the private health insurance market. Non-grandfathered health plans will no longer be allowed to charge more or deny coverage to people because of pre-existing conditions. These new protections will also prohibit non-grandfathered plans from putting annual dollar limits on benefits and from varying premiums based on gender or any factor other than age, tobacco use, family size, or geography. In addition, new plans in the individual and small group market will

be required to cover a comprehensive package of items and services known as Essential Health Benefits, which must include items and services within ten benefit categories. Finally, many individuals will find it easier to participate in clinical trials because issuers will have to cover their routine patient costs and cannot deny their participation in trials. This protection applies to all clinical trials that treat cancer or other life threatening diseases.

Health Centers. Health centers will continue to be a vital source of primary care for uninsured and medically underserved patients seeking a quality source of care in FY 2015. The Budget requests $4.6 billion for health centers, $3.6 billion of which is funded by the Affordable Care Act's Community Health Center Fund, to serve approximately 31 million patients in FY 2015. These resources will support the establishment of 150 new health center sites as well as enhance quality, and support capital development and facility improvements at currently existing health centers.

Health Care Workforce. The Budget makes new and strategic investments in our nation's health care workforce to ensure rural communities and other underserved populations have access to doctors and other providers. In total, $14.6 billion will be invested in three key initiatives: $4.0 billion in expanded funding for the National Health Service Corps, $5.2 billion for a new Targeted Support for Graduate Medical Education program, and $5.4 billion for enhanced Medicaid reimbursements for primary care.

The $4.0 billion in new mandatory resources from FY 2015 through FY 2020 is in addition to $100 million in discretionary funding and $310 million in current law funding for FY 2015 for the National Health Service Corps. Corps clinicians serve in medical facilities in high-need areas of the country. This investment is projected to support 15,000 clinicians in FYs 2015-2020.HRSA will also invest in our nation's health workforce through the new Targeted Support for Graduate Medical Education program. Between FY 2015 and FY 2024, $5.2 billion in total mandatory funding is requested for this effort, to be distributed to teaching hospitals, children's hospitals, and to community-based consortia of teaching hospitals and/or other health care entities. The focus of the targeted support program will be to support ambulatory and preventive care, in order to advance the Administration's goals of higher value health care that reduces long-term costs. This investment will support 13,000 residents over ten years.

Concurrent with these efforts at HRSA, CMS will devote $5.4 billion to extend enhanced reimbursements to states for primary care through the end of calendar year 2015, expand eligibility for reimbursements to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care.

Protecting Vulnerable Populations

Elder Justice. The FY 2015 Budget proposes $25 million in the Administration for Community Living (ACL) to protect vulnerable older adults by combating the rising scourge of elder abuse, neglect, and exploitation in America. This effort builds on the findings and recommendations of the Elder Justice Coordinating Council, a consortium of federal partners which I lead that was established by the Elder Justice Act of 2009. In response to the recommendations of the Council, ACL will begin developing a national Adult Protective Services data system and provide funding for key research. This investment will help states improve the quality and consistency of their Adult Protective Services programs.

Advancing Scientific Knowledge and Innovation

Protect Patients from Healthcare-Associated Infections. The CDC estimates that one in 20 hospitalized patients acquires a healthcare-associated infection (HAI), and over one million HAIs occur across the healthcare spectrum each year at a cost of over $30 billion. HHS is committed to reducing the national rate of HAIs. The Budget includes $44 million for HAI prevention activities at CDC, which include identifying emerging threats and protecting patients through outbreak detection and control, laboratory testing of the health care environment and contaminated products, and guideline development.

Complementing CDC's efforts, the Agency for Healthcare Research and Quality (AHRQ) focuses on conducting research to develop new methods of preventing and reducing HAIs, and disseminates these research findings to clinicians. The request includes $34 million for AHRQ's efforts to protect patients from HAIs.

Improving Healthcare through Meaningful Use of Health IT. Health information technology is essential to improving our nation's health care by moving from a transaction based system to one that emphasizes quality and value. The Budget includes $75 million for the Office of the National Coordinator for Health IT (ONC) to coordinate and support investments in policies, standards, testing tools, and implementation guides that have dramatically accelerated the adoption and meaningful use of certified Electronic Health Record technologies. Within this total, ONC will begin to address HIT-related patient safety issues under the Health IT Safety Center through data collection and analysis on the types and frequencies of health IT related adverse events. ONC will work closely with AHRQ, Patient Safety Organizations, the Joint Commission, and FDA on this effort.

Supporting Families

Maternal and Child Health. The FY 2015 Budget requests $1.3 billion to improve the health of mothers and children, an increase of $129 million. This level includes $500 million in FY 2015 and $15 billion through FY 2024 to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program, through which states are implementing voluntary, evidence-based home visiting programs that enable nurses, social workers, and other professionals to meet with at-risk families and connect them to assistance to support the child's health, development, and ability to learn. These programs have been shown to improve maternal and child health and developmental outcomes, improve parenting skills and school readiness. The request also includes $634 million, the same as FY 2014, for the Maternal and Child Health Block Grant.

Early Head Start—Child Care Partnerships. The Budget proposes $650 million in FY 2015 for Early Head Start – Child Care Partnerships, an increase of $150 million above FY 2014. These funds will provide access to high-quality early learning programs for tens of thousands of infants and toddlers through competitive grants to new and existing Early Head Start programs that partner with child care providers, especially those receiving federal child care subsidies.

Child Support and Fatherhood Initiative. The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to Temporary Assistance for Needy Families (TANF) recipients. The proposal requires states to include provisions in initial child support orders addressing parenting time responsibilities, to increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and to implement domestic violence safeguards. The Budget also includes new enforcement mechanisms such as requiring states to implement electronic

income withholding orders that will enhance child support collections. The Budget proposes an investment of $1.8 billion over ten years for these initiatives.

Facilitating Transitions to Adulthood

Demonstration to Address the Over Prescription of Psychotropic Medications for Children in Foster Care. The Budget includes $500 million for a new Medicaid demonstration in partnership with ACF to provide performance-based incentive payments to states through Medicaid, coupled with $250 million in mandatory child welfare funding to support state infrastructure and capacity-building. This transformational approach will encourage the use of evidence based screening, assessment, and treatment of trauma and mental health disorders among children and youth in foster care in order to reduce the over prescription of psychotropic medications. This new investment and continued collaboration will improve the social and emotional outcomes for some of America's most vulnerable children.

Continuing Program Integrity and Oversight

Combating Fraud, Waste, and Abuse in Health Care. The FY 2015 Budget makes cutting fraud, waste, and abuse a top Administration priority. In addition to the base discretionary Health Care Fraud and Abuse Control (HCFAC) funding in FY 2015, the Budget seeks new mandatory funding. Starting in FY 2016, the Budget proposes that all new HCFAC investments be mandatory, consistent with levels in the Budget Control Act. This investment supports fraud prevention initiatives like the Fraud Prevention System; reducing improper payments in Medicare, Medicaid, and CHIP; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team initiatives, including the Fraud Prevention Partnership between the federal government, private insurers, and other key stakeholders. The Budget's 10 year investment in HCFAC yields a conservative estimate of $7.4 billion in Medicare and Medicaid savings.

To help ensure the prudent use of federal funds, the Budget also includes $25 million in discretionary HCFAC funding for program integrity activities in private insurance, including the Health Insurance Marketplaces.

The Budget includes $400 million in discretionary and mandatory funding for the Office of Inspector General (OIG), an increase of $105 million above FY 2014. This increase will enable OIG to expand CMS Program Integrity efforts for the Health Care Fraud Prevention and Enforcement Action Team and improper payments, and also enhance investigative efforts focused on civil fraud, oversight of grants and the operation of Affordable Care Act programs.

The Budget also includes $100 million for the Office of Medicare Hearings and Appeals (OMHA), an increase of $18 million above FY 2014. OMHA received over 600,000 claims in FY 2013 compared to 313,000 received in FY 2012. The Budget will support adjudicatory capacity and central operations case processing in order to address a critical backlog in the number of appeals and maintain the quality and accuracy of its decisions.

Medicaid Program Integrity. States have the primary responsibility for combating fraud and abuse in the Medicaid program. CMS supports this effort through technical assistance and by contracting with eligible entities to carry out reviews, audits, identification of overpayments, education activities, and technical support. Other key CMS efforts include measuring Medicaid improper payments and efforts to transform the Medicaid data enterprise through the Medicaid and CHIP Business Information and Solutions program to provide states, auditors, and reviewers

timely access to more complete encounter data and other claims information. The Budget includes an additional $25 million per year for the Medicaid Integrity Program.

Responsible Stewardship of Taxpayer Dollars

Contributing to Deficit Reductions while Maintaining Promises to all Americans. The FY 2015 Medicare and Medicaid legislative proposals seek to strengthen these programs through payment innovations and other reforms that encourage high quality and efficient care while continuing to reduce health care cost growth. Medicare savings would total $407 billion over 10 years by encouraging beneficiaries to seek value in their health care choices, strengthening provider payment incentives to promote high-value, efficient care, and lowering drug costs. The Budget includes $7.3 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable. Together, the FY 2015 legislative proposals allow HHS to support the Administration's complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Opportunity, Growth, and Security Initiative

The Budget proposes a $56 billion, government-wide initiative to support both domestic and security expenditures that reflect the President's priorities to grow the economy and create opportunities. Resources for the initiative would be offset with a balanced package of spending reductions and the closing of tax loopholes. Multiple, specific HHS programs would benefit from the initiative.

National Institutes of Health. An additional $970 million would be provided by the initiative to increase the NIH budget to $31.3 billion. Funds would be used to increase the number of new grants funded by 650, and provide additional resources for signature activities such as the BRAIN Initiative, improving the sharing and analysis of complex biomedical data sets, expanding research on Alzheimer's disease and vaccine development, further accelerating partnership efforts to identify and develop new therapeutic drug targets, and other innovative projects.

Head Start. The initiative would also provide an additional $800 million to further expand Early Head Start – Child Care Partnerships. This investment would bring total funding for Early Head Start – Child Care Partnerships to $1.5 billion in FY 2015, and provide access to high-quality early learning programs for a total of more than 100,000 children.

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

Chairman CAMP. Well, thank you, Madam Secretary.

The Secretary has a hard stop at 12:15. And in the interest of time, questions will be limited to 3 minutes. I am going to hold my questions to the end of my time and yield to the Health Subcommittee Chairman, Kevin Brady, to begin questioning. I will then recognize Health Subcommittee Ranking Member McDermott, and then we will start in reverse order of seniority. If we run out of time before I have an opportunity to ask questions, I will submit mine for the record, and would ask that I get a timely response to those.

The Committee still seeks some basic information about how many people have paid their premiums, how many uninsured are actually enrolled in the exchanges, how much the launch of exchanges has cost taxpayers, and what programs were cut to pay for the implementation that really didn't work. So if we can get answers to those questions during the hearing, I think that would be helpful.

Mr. Brady is now recognized.

Mr. BRADY. Thank you, Mr. Chairman.

Madam Secretary, you were before the Committee in April of last year. You assured us all there would be absolutely no more delays in the Affordable Care Act. We have seen eight delays since you gave us those assurances, bringing the total now to 35. So the question is, I think fairly for our families at home, what other delays should they expect? Are you going to delay the mandate that individuals have to buy government-approved health care or pay a tax?

Secretary SEBELIUS. No, sir.

Mr. BRADY. Are you going to delay the open enrollment beyond March 31st?

Secretary SEBELIUS. No, sir.

Mr. BRADY. Is it correct that you don't have the authority to extend that deadline? The position that the Centers for Medicare & Medicaid Services have made, you agree with that?

Secretary SEBELIUS. I haven't seen their statement, sir, but there is no delay beyond March 31st.

Mr. BRADY. Well, my question is, the law very clearly makes the case that tax credits are available only to individuals who are enrolled through the exchanges. Yet 2 weeks ago in regulation you deemed that individuals who haven't enrolled in the exchanges are eligible for those tax credits. My question is, what specific provision in the Affordable Care Act grants you that authority?

Secretary SEBELIUS. Well, sir, I can get you the specific cite, but the authority really comes from the law, which states if a person is eligible for the Affordable Care Act and in the exchange process, then they are eligible for a tax credit. We have made it clear that if through no fault of their own they were unable to enroll, that eligibility extends to a delayed enrollment period, and they will have a special enrollment period which we have the authority to grant.

Mr. BRADY. Madam Secretary, to be very clear, the law is very plain, only people enrolled in exchanges are eligible for tax credits. As the Committee that handles the tax credits, we know this section well. So maybe you could ask the folks who are here today.

Secretary SEBELIUS. Sir, I would be happy to get you the statutory authority.

Mr. BRADY. Your experts are behind you. If you would like to ask them, please do. But there is no provision there.

Secretary SEBELIUS. Sir, I will get you this in writing.

There is a provision that indicates that if a person is eligible, the eligibility—and in the enrollment process—we can grant a special enrollment period.

Mr. BRADY. I guarantee you, Madam Secretary, you won't be getting us back that provision because it is not there. And my point is, if you delayed this law because it is not workable for businesses, why aren't you delaying this law because it is not workable for our families? How is that fair?

Secretary SEBELIUS. I am sorry, sir?

Mr. BRADY. How is it fair that you delayed this law because it is unworkable for businesses of all sizes, but it is not workable for families? Why aren't they getting the same treatment?

Secretary SEBELIUS. Well, sir, we haven't delayed the law's implementation across the board.

Mr. BRADY. Not across the board, but for businesses, large businesses, medium and small.

Secretary SEBELIUS. Ninety-four percent of business owners are less than 50, and the law has never applied to them. There are 2 percent of business owners who are in the above 100 percent. They have an additional year to fill out paperwork. Another 2 percent——

Mr. BRADY. Madam Secretary, it is just not fair.

Chairman CAMP. Time has expired.

Mr. McDermott.

Mr. MCDERMOTT. Wow. Take a breath.

Your budget contains several proposals for structural reforms to Medicare, all of which will increase the cost on beneficiaries. What I don't see in your budget is Medicare reforms that ask providers and pharmaceutical companies to share in the pain. Frankly, that concerns me. I think there ought to be a sharing of the pain among the providers and those who benefit from Medicare.

As you know, Medicare beneficiaries already spend a disproportionate share of their income on health care compared to those under age 65, and upper-income Medicare patients pay more.

Now, I understand these proposals, while they concern me, were put into the budget as a part of a so-called big, bold, balanced budget deficit reduction plan, one that calls for shared sacrifice among working and retired Americans, wealthy or not.

So let me ask this question. The notion that completely seems to be around here is much different that you can cherry pick those Medicare reforms here and one there, sort of low-hanging fruit as a way to offset or to pay for the SGR. Our Republican colleagues have been talking about doing this. And I think that it is hard for that to actually occur, because SGR needs to be fixed. There is not actually a documented access problem throughout the program. And it seems unconscionable to ask those with household incomes averaging $23,000 a year to pay more in order to increase payments to doctors.

My question is this: Does the Administration support cherry picking structural reforms which would increase costs for Medicare beneficiaries, or are those reforms solely intended as a part of a substantial deficit reduction package with shared sacrifice for all Americans?

Secretary SEBELIUS. Well, Congressman, as you know, the President has said for a number of years that he remains hopeful for a big deal, tax reform, entitlement reform package that would put us on the path to multiyear fiscal solvency. And so I think in the context of those reforms, that is why these proposals continue to be made in the budget, but it is in the context of a major effort. Entitlement reform is a piece of the puzzle, but only a piece of the puzzle if there is additional tax reform and revenue sharing that, as you say, involves everyone.

Mr. MCDERMOTT. So the White House doesn't support selecting out pieces to pay for SGR.

Secretary SEBELIUS. Well, I think the budget is a package that moves forward, and the cherry picking of one piece or another gives, as you say, undue burden on seniors.

Chairman CAMP. All right. Thank you.

Mr. Renacci is recognized.

Mr. RENACCI. Thank you, Mr. Chairman, for holding this hearing on the President's budget.

Chairman CAMP. I think you need to lean into the microphone.

Mr. RENACCI. It is not working.

Mr. CROWLEY. These aren't working. Are you pulling an Issa on us? This isn't an Issa, is it? Just making sure.

Chairman CAMP. There we go. Mr. Renacci is recognized.

Mr. RENACCI. Thank you, Mr. Chairman, for holding this very important hearing on the President's budget and allowing us the opportunity to question the Administration on behalf of our constituents.

Secretary Sebelius, welcome back, and thank you for taking the time to speak with us today.

Madam Secretary, Obamacare was sold to the American people as a bill that would make health care more affordable. In my State of Ohio, it has become clear this is not the case, as premiums, deductibles, and out-of-pocket costs have increased for a significant number of Americans, causing working-class families and young individuals to spend more of their hard-earned pay on healthcare expenses. In fact, I have had many individuals in my district who are now covered who can't afford their deductibles now questioning me as to what they are supposed to do to access health care.

Mr. Chairman, I would like to submit for the record a transcript of an interview between *NBC News* and Secretary Sebelius on September 30, 2013.

Chairman CAMP. Without objection.

Mr. RENACCI. Madam Secretary, in an interview on September 30, 2013, you said, when asked regarding Obamacare, what success would look like. Your answer, and I quote, was, "I think success looks like at least 7 million people signed up by the end of March 2014." Open enrollment ends this month, and you are well short of that target. Based on your own standards, Obamacare will not be successful at the end of March 2014. What do you now call success?

Secretary SEBELIUS. Well, Congressman, I think that in answer to your initial question, I don't know the constituents you are speaking to, but I can give you a national snapshot where private insurance rates in the 10 years before Obamacare were running about 8.6——

Mr. RENACCI. Madam Secretary, can I get you to answer that question on what is now success because I only have 3 minutes?

Secretary SEBELIUS. Well, success looks like millions of people with affordable health coverage, which we will have by the end of March, in the private marketplace, in Medicaid, young adults on their family plan. So we will have I think a successful program. We have a market, we have competition. We have for the first time self-employed individuals who don't have affordable care through their worksite getting affordable coverage.

Mr. RENACCI. So you are changing your standard of 7 million by the end of March 31st.

Secretary SEBELIUS. I said success looks like millions of people having affordable health care.

Mr. RENACCI. Actually, you said 7 million. I have one other question. In that interview, you also talked about deductibles, and your answer was, "Well, I think families can make a choice. It isn't something they can pay for. A lot of people couldn't pay their out-of-pocket, they will want a lower deductible." Can you answer the question as to how about those people in my district who can't afford a lower deductible? What should they be doing?

Secretary SEBELIUS. Again, sir, I think that the range of plans in the marketplace is more robust than the range of plans ever has been in the individual marketplace or in the small group marketplace. Some, as you know, have lower premiums in exchange for higher deductibles, some have lower deductibles and higher premiums. But that range has never been there, nor have the millions of Americans who now qualify for some financial help to get into the marketplace to have that benefit. So I meet people every day who are actually having affordable health care for the first time. They have never had employer-based health care, and they have an opportunity for health security for themselves and their families.

Chairman CAMP. All right. Thank you.

Ms. Sanchez is recognized.

Ms. SANCHEZ. Okay. My mike is working. Thank you, Mr. Chairman.

And, Madam Secretary, I want to thank you for taking the time to appear before the Committee today to discuss the Administration's fiscal year 2015 budget.

I continue to believe that budgets are a reflection of what our priorities are in this country, and our priorities should be pretty clear: creating an environment for good-paying jobs that allow workers to support a family, properly funding health care for all, and protecting benefits for those who have earned them. Those should be the focus. And I am happy to see that the President's budget does reflect some of these goals.

Specifically, just some things I wanted to point out, the proposed 2015 budget gets rid of a misguided approach to chained CPI, to change the chained CPI balanced on the backs of our seniors. It expands HIV/AIDS treatment and care through investments in the

Ryan White HIV/AIDS program and CDC activities. It funds the National Institutes of Health at $30.2 billion, and provides $140 million in services for victims of domestic violence.

As one of the few women who sit on this Committee, I think I would be remiss if I didn't spend at least a few moments on issues that are specific to women's health care. I want to talk about Title X. It is the only Federal program exclusively dedicated to family planning and reproductive health services. Publicly funded family planning services have helped reduce the rates of unintended pregnancy and abortion in the United States. And in fact the CDC has included family planning on its list of the top 10 most valuable public health achievements of the 20th century, along with things like childhood vaccinations and fluoridation of drinking water.

I was pleased to see that the President's budget calls for a slight increase in Title X funding. And I was wondering, Madam Secretary, if you agree that the investment in family planning services is a valuable one that reduces government healthcare expenditures in the long run.

Secretary SEBELIUS. Well, I think it has been shown, Congresswoman, that family planning and having families be able to make choices about the timing of children and the timing of pregnancy is a huge health issue and a huge family security issue, and we have made some significant strides.

I would also point out that as part of the Affordable Care Act, insurance policies now will cover a full range of health services for women, which was not necessarily the case. They will not be allowed to charge women more than men, which was typically a feature in the individual market, and for the first time have a focus on women's health issues, including family planning issues.

Ms. SANCHEZ. And do you think that the increased access to affordable birth control will affect healthcare costs overall under the Affordable Care Act?

Secretary SEBELIUS. Well, what we have seen, actuaries of private insurance companies will tell you that actually having contraception services as part of their package decreases costs because they pay for fewer unintended pregnancies and sometimes pregnancies that could result in very high birth and followup costs. So as an actuarial point of view, it is actually a net gain in terms of overall health costs. But more importantly, it allows families to make their own choices about families and timing, and the health of the mother and the health of the child are often significantly improved by that timing.

Ms. SANCHEZ. Thank you, Madam Secretary, and I yield back.

Chairman CAMP. Thank you.

Mr. Griffin.

Mr. GRIFFIN. Thank you, Mr. Chairman. Apparently it is not working now.

Secretary SEBELIUS. It is just when you try to use it that it doesn't work.

Chairman CAMP. Right. Why don't you come up.

Mr. GRIFFIN. I think a website manufacturer and website developer has been working on our mike system.

Thank you for coming. I appreciate it. What I would like to talk with you a little bit about is the issue of investments. You men-

tioned investments. Almost every constituent that comes to see me in my office talks about the need for additional funding, for example, for the NIH, for Alzheimer's research, for cancer research, MS, diabetes. They may talk about education, they may talk about some other program that is funded by discretionary spending. And a lot of times when people mention investments, that is what they are talking about.

I have supported increasing NIH research funding. I wish we had the money to increase it drastically. But the reality is that that funding is getting pressured or squeezed out by the growth of entitlement spending. If you could look, I have a slide here.

[Slide]

So this is something that President Obama said in 2011. "If you look at the numbers, Medicare in particular will run out of money, and we will not be able to sustain that program no matter how much taxes go up. I mean, it is not an option for us to just sit by and do nothing."

Next slide.

[Slide]

This is what I call the Pac-Man problem. I use this to explain to folks who come to visit me why the funding that they are in favor of, which often I favor, NIH funding, for example, why it is under pressure. And it is under pressure because the yellow part, which we recognize as Pac-Man, is continuing to close its mouth on all the stuff that you refer to as investments. And HHS Secretary after HHS Secretary, I have talked to both Administrations, Republican and Democrat, praise their budget as fixing the problem. But the problem persists.

And I just invite you to work with us for real reform on Medicaid and Medicare to fix this. And I would welcome your comments on how your budget will address this problem.

Secretary SEBELIUS. Well, sir, I would welcome the opportunity to work on a serious, big budget deal, including entitlement reform, but also including tax reform and revenue sharing, and spread that equally across the board.

I would say that the passage of the Affordable Care Act was one of the most significant issues of late to increase the solvency of the Medicare Trust Fund. The trustees put that passage at about a 12-year additional solvency. This budget adds an additional 5 years. So when this President came into office Medicare was likely to go broke in 2017. That window has now been significantly extended. And this Committee has voted 50 times to repeal those very——

Mr. GRIFFIN. But you are robbing Peter to pay Paul, and the seniors are bearing that burden.

Chairman CAMP. All right. Time has expired.

Mr. Crowley.

Mr. CROWLEY. Thank you, Mr. Chairman.

Madam Secretary, thanks so much for being here once again today. I am up here now. They moved me. Madam Secretary, they moved me up here. I am sorry. I know. Musical chairs. It is going to take a long time for me to get up here normally speaking. I thank the Chairman for this opportunity.

Secretary SEBELIUS. Just don't give it up.

Chairman CAMP. Don't get used to that seat.

Mr. CROWLEY. I am not getting used to it. I am enjoying my time here. I have very little time.

The Affordable Care Act has made great strides in improving access to quality health care, such as by closing the prescription drug coverage gap, strengthening the Medicare program, and establishing competitive marketplaces for working families to purchase insurance, for many people for the first time. I am glad that the budget sustains and builds upon these successes.

I am also pleased to see that this budget looks toward the future on improving our healthcare system, such as through the new physician workforce proposal growing the need for more doctors at the same time. Projections show that by 2020 the United States will face a physician shortage of more than 91,000 physicians, growing to over 130,000 physicians by 2025, not that long from now. That is both primary care physicians and specialists.

So clearly there is a need for continued Federal investment in doctor training. Yet I am concerned that some of the proposals in this budget would fundamentally change this longstanding contract on how doctor training is supported in our country. Our Nation has long recognized the need for doctor training to be a shared investment between our medical schools, residency training programs, and the Federal Government. Medical schools have increased graduating classes, and teaching hospitals are training residents above and beyond what Medicare supports.

In my home State of New York, there are almost 840 residents currently being supported by hospitals alone because Medicare can't fund these positions. Nearly 10,000 residents nationwide are in a similar situation. There is a clear and obvious demand for more residency slots even within the Medicare program, demonstrating that this is not the time to be drawing teaching dollars away from Medicare to other programs.

I have introduced legislation, the Resident Physician Shortage Reduction Act, to meet the real need of adding additional residency spots in these specialties, as well as in the primary care area. If you could, please comment in terms of the budget itself and the effect that this will have on teaching hospitals. I don't think this is the time to be taking away those moneys. We need to be adding money to produce the number of physicians we will need in lieu of the Affordable Care Act.

Secretary SEBELIUS. Well, Congressman, I think the President definitely shares your view that the healthcare workforce is of enormous importance. And we certainly have been focusing on that since the beginning of this Administration.

I would say there are three major components of a significant, $14.62 billion workforce initiative over the next 10 years. Increasing the size of the National Health Service Corps, which goes a long way to putting doctors, nurses, mental health techs, dentists in underserved communities, growing that force to about 15,000 from its current 8,800 and keeping it there.

Second, to focus on the targeted support for graduate medical education, really again driving not only the primary care workforce, but specific underserved specialty areas. Currently, hospitals kind of pick and choose which residencies they will slot. And we think at this point it is more helpful to really focus on the great need for

primary care, preventive care, community-based care, nurse practitioners, so that the growing population of elderly and others, who hopefully will stay out of the hospital, will have that kind of care.

And third, to continue the increase that was passed in the Affordable Care Act for primary care doctors who take Medicaid patients. And I think those three initiatives combined will really do a significant amount to increase the primary care workforce, but also to make sure that primary care docs and nurses are in the right places in the most underserved areas.

Chairman CAMP. All right. Thank you.

Mr. Kelly is recognized.

Mr. KELLY. I thank the Chairman.

Madam Secretary, thanks for being here today. I just want to get directly to the budget, because on page 33 of the budget it highlights or alludes to a potential large tax increase that is not defined. Now, reading from page 33, this is what it says: "Even with reforms to Medicare and other entitlements and tough choices, we will need additional revenue to maintain our commitments to seniors."

Now, as I read this, it looks like an open-ended discussion, but with no real specifics. What specifically are we going to do? Because we are past the rug-cutting time. Where do we go? Where do we go to get this revenue? What taxes are going to have to come about?

Secretary SEBELIUS. Well, I think, Congressman, as you know, there have been discussions over the last several years. The President has proposed a number of tax loopholes being closed.

Mr. KELLY. And I understand. I don't want to cut you short. I have a very short period of time.

Listen, we are playing ring around the rosy with this. There is no way that we can look at the metrics of this and say this is going to work. My question is, because the real choice right here is between entitlement reform or going to some other type of a tax, which I think a lot of people on the right and left are saying we are going to have to have a European-style VAT tax. This is going to put a tremendous burden on the middle-income folks, the lower-middle-income folks, and the lower-income folks because it hits every one of them hard, hard. Nobody walks away from this. Forget all the subsidies and everything else.

I want to know where are you going to get the money? Show me the money. If there is not going to be reform, show me the money. Where is the revenue going to come from? Because we know in this model you tax it, you fine it, it is through taxes, fines, fees, or borrowing, or God forbid just printing our way out of it. So where is the money going to come from?

Secretary SEBELIUS. Well, sir, nobody, as you know, in this Administration has ever suggested a VAT tax. I think what we are eager to do——

Mr. KELLY. Not yet. Not yet.

Secretary SEBELIUS [continuing]. Is work with Congress on a comprehensive program which shares the burden, not taking it out of the backs of seniors, of the backs of the poorest Americans.

Mr. KELLY. No, no, no, no, no. Listen, listen.

Secretary SEBELIUS. That has always been the proposal in the past.

Mr. KELLY. Madam Secretary, we agree, we agree violently on that. It comes down to dollars and cents. You can't wave a magic wand and make this money appear. You can't do it. If we are not going to have serious entitlement reform, where is it going to come from? It is simple math. The President says it all the time. Just do the arithmetic. It doesn't float.

Secretary SEBELIUS. Well, I would say some of the most serious entitlement reform is underway right now under this Administration. We have cut in half the cost trajectory of Medicare year in and year out. We are seeing the slowest growth in 50 years in the program. Plus more Medicare beneficiaries coming in and more benefits. So I would say that it is underway.

Mr. KELLY. I understand that. But sometimes it is much easier to talk the talk than it is to walk the walk. We heard this wouldn't cost us anything, and now we are finding out it is trillions more than we thought. It is just not working. I am looking at this, and the reform is absolutely necessary. I just don't see anybody walking that plank.

And I don't see any specifics of this. We can talk in flowery terms about what we want, what our hearts are willing to do, but what our wallets can't provide. The question is, how do you pay for it? It has to be tax increases. It can't come from anyplace else. I wish it was, just tap a magic wand and the money just magically appears. It doesn't. We are on a heck of a trajectory right here, and there is no way out of this absent real reform or huge tax increases. There is just no other way to do it.

Chairman CAMP. All right. The time has expired. We will try the mikes again.

So, Mr. Pascrell, you are recognized.

Mr. PASCRELL. Thank you, Mr. Chairman.

Madam Secretary, I am glad that we are now all talking about middle-income people. Well, we have come a long way in 3 years. That is good. I think we are on the right trail.

But let's change the pace a little bit. The commitment that the President has made to expanding educational opportunities and the investments in research and science within this budget are things I strongly support. The BRAIN Initiative is one of the investments that I think is particularly worthwhile. Today, we are celebrating what we have done for the past 14 years in the Rayburn Building, all the research that is being done both in the military and the civilian on traumatic brain injury, post-traumatic stress disorder, which has now helped in many, many ways to help our kids in making sport decisions.

The BRAIN Initiative is one of the investments that I think is worthwhile. As cochair of the Traumatic Brain Injury Task Force, along with Congressman Rooney of Pennsylvania, I am well aware of the advances that we have made in research in the brain in recent years and how much we have learned and continue to learn.

Your presence here today is very timely. As I said, the Congressional Brain Injury Awareness Day is evident on Capitol Hill, and a number of your offices are participating. The Centers for Disease Control and the CDC estimates that 2.4 million TBIs occur each

year and that 5.3 million Americans live with a lifelong disability as a result of TBI.

Beyond those numbers, TBI has become the signature wound in Iraq, as well as in Afghanistan. Twenty percent of our soldiers deployed are estimated to have experienced brain injury. This is serious. What is even more serious is how many have fallen through the cracks.

It is because of this Congress and the last three Presidents that we finally have come to the point of recognizing it and have stopped sweeping it under the rug, and we have insisted on it in a bipartisan way. Brain injuries can impact anyone at any time.

I know this $200 million commitment, which is double the investment in last year's budget, is not just coming from your Department. But can you speak to the goals of the BRAIN Initiative and how important it is that we pay attention to what is going on in that research? Very briefly, if you would.

Chairman CAMP. Okay. Time has expired. But if you will respond briefly. And if you want to supplement in writing a longer response, that would be fine.

Secretary SEBELIUS. I would be glad to, Mr. Chairman. I would say that Dr. Collins, the head of the National Institutes of Health, has identified the BRAIN Initiative as one of his signature efforts going forward. He has assembled what he would call the dream team of top-notch researchers from a variety of institutions and mapped out really a very aggressive strategy, multi-year strategy.

But the private sector will be intimately involved in this. Some of the key drug companies are at the table. There is an effort underway in the drug front to also get them involved in accelerating cures. So I would say it is a multifaceted project, and I would be glad to get you some more information.

Chairman CAMP. All right. Thank you very much.

Mr. Young is recognized.

Mr. YOUNG. Madam Secretary, thanks for being here today. I am going to start on a couple of words of encouragement and appreciation. First, coming from the State of Indiana, know that our delegation, our Governor and the people of our State really appreciate your consideration of allowing the Healthy Indiana Plan, which covers 40,000 low-income Hoosiers, to play an important role in terms of our Medicaid expansion in our State. HIP is the first consumer-directed plan for Medicaid recipients in the country, and thank you for that.

We also appreciate internally within HHS, and I know this is a priority for OMB, increasing the evaluation of the existing government programs so that we are focusing more on outcomes as opposed to inputs. I would love to work with you on that evidence-based approach in the future.

One of the biggest concerns related to this healthcare law, of course, is its impact on jobs and wages. The CBO has indicated that the Affordable Care Act will shrink the workforce by the equivalent of 2.3 million full-time jobs. Teamsters President James Hoffa has said the law, quote, "destroys the foundation of the 40-hour workweek that is the backbone of the American middle class." UNITE HERE is a union representing 265,000 casino, hotel, and food service and warehouse workers. And they recently published

a new report, "The Irony of Obamacare: Making Income Inequality Worse." And I would like to submit this report for the record.

Chairman CAMP. Without objection.

Mr. YOUNG. UNITE HERE supported what the President calls Obamacare, but they don't anymore. The report says, "Without smart fixes, the ACA threatens the middle class with higher premiums, loss of hours, and a shift to part-time work and less comprehensive coverage." You have indicated, as reported in the press, "There is absolutely no evidence, and every economist will tell you this, that there is any job loss related to the Affordable Care Act."

Based on the growing body of evidence, including this report, have you rethought whether or not the Affordable Care Act might in fact adversely impact wages, hours, and jobs for in particular low-income Americans?

Secretary SEBELIUS. Congressman, I have had some great meetings with Governor Pence and look forward to continuing those around Healthy Indiana and the expansion. I would say that, unfortunately, the Congressional Budget Office report I think has been mischaracterized. It does not say that the passage of this healthcare law will lead to 2 million fewer jobs. It does indicate that people will have some choices that they don't have today. They won't have job lock until they get to 65, where they have healthcare guarantees with Medicare. They can choose to stay at home. A lot of farm families will have the choice of not having to have an off-farm job to get health insurance for the family.

So there is an average that they give, and they say you could have an average number of hours worked less, or they say you could have an average number of hours worked more.

Mr. YOUNG. I see our time has expired. I guess we could lower the definition of full-time employment to 20 hours, giving employees more flexibility under your analysis of the CBO report. But thanks so much for entertaining my questions.

I yield back.

Chairman CAMP. Mr. Kind is recognized.

Mr. KIND. Thank you, Mr. Chairman.

And, Madam Secretary, thanks for being here, and thanks again for your service to our Nation. I know this hasn't been the easiest time, the rollout of the ACA. We didn't think it would be easy, but it is worth trying to do.

First a comment and then a question for you. My comment, coming from a very large rural congressional district, just keep an eye on those critical access hospitals. They face some unique challenges as far as recruitment, retention, and access issues. And I know we have had budget discussions about that in the past.

The question is one of the great stories in recent years, the last few years, has been the trajectory of healthcare spending, costs per beneficiary, which has never been lower in the last 50 years. I wonder if you could just take a moment to tell us what you are seeing in regards to the health system that is leading to these cost reductions.

Obviously, part of the Affordable Care Act is to reform not only the way health care is being delivered so it is more integrated and coordinated and patient-centered, but changing the financial incentives so it is more value and quality driven. But if you could take

a moment and just let us know what you are seeing as far as costs and whether these reports are sustainable in the future.

Secretary SEBELIUS. Well, Congressman, you and a number of the House delegation were instrumental in making sure that the sort of quality and value pieces were added to the Affordable Care Act, that that became a fundamental piece of this. And I would say that the framework of having for the first time real tools within the Medicare system to look at aligning value with payment is significant. And we are already seeing the first real reduction in preventable hospital readmissions, a very dramatic change in hospital infection rates. Good for patients, good for the bottom line.

In terms of overall expenditures, the 10 years before the Affordable Care Act, Medicare cost growth was on average 6 percent a year, year in and year out. Since the passage of the Act, 2010 to 2012, it was 1.6 percent, a dramatic drop. Last year, 0.7 percent. As you say, the lowest cost increases in history. And Medicare beneficiaries have more benefits, lower prescription drugs, additional costs. Private insurance costs have been cut in half during that same period of time. Overall health expenditures in the United States per capita were raising at about 6 percent a year. They now are at 3 percent a year, again cut in half. And Medicaid expenditures, again, are seeing the lowest cost increases.

But in part, it is because I think some of the fundamental structure of looking at ways to deliver more effective preventive care, earlier intervention with very high-cost patients, some of the pieces you put in place with the dual eligibles, a very expensive population, only about 10 million individuals, but people who spend over a third of both the Medicare and Medicaid budgets, that work with the States is very much underway. So there are some very promising trends I think on the horizon.

Mr. KIND. All right. Thank you.

Chairman CAMP. Mr. Reed, and then we will go to Mr. Blumenauer. And then we will begin two to one.

Mr. Reed.

Mr. REED. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here today.

I wanted to join with my colleague Mr. Kind to bring a message to you. Representing a rural district in western New York, I can tell you the Medicare and Medicaid reimbursement cuts that your proposals have done and implemented are seriously jeopardizing our critical access hospitals, our low-volume Medicare-dependent hospitals. I am dealing with two right now, St. James Hospital and Lake Shore Hospital. Lake Shore is actually going through a closure. St. James is going through a rebuild.

On the front line, in particular on rural hospitals, these cuts are causing significant problems for access to care for our people. So I am delivering to you some information, and join my colleague in highlighting that need.

Now, what I wanted to talk to you today about is we just had an election in Florida last night. The Democratic opponent was talking a lot about ways to fix the Affordable Care Act. And what I wanted to get from you is that the Administration has had 37 significant changes in the Affordable Care Act that it has put forward by Executive order and other amendments. And what I am looking

for from you, if you have any suggestions, have you supplied to Congress, to us, in areas that you want to fix the Affordable Care Act? Has there been any legislation sent from the Administration up to Congress in regards to those fixes?

Secretary SEBELIUS. I have not sent legislation to Congress, no, sir.

Mr. REED. Yeah, because the answer is zero. I knew the answer to that question. I just wanted to see exactly where you were coming at. So is the Administration's position that the Affordable Care Act is not fixable, therefore there is no need for any legislative fixes?

Secretary SEBELIUS. No, sir, I don't think that is the case.

Mr. REED. Okay. So it is fixable. There are areas that you want to fix. Could you state for the record what areas of the Affordable Care Act does the Administration want to work with us in order to fix?

Secretary SEBELIUS. Sir, we have said from the outset, from the passage of the law in March of 2010, if there are suggestions or ways that we——

Mr. REED. So the White House has no suggestions or ideas on how to fix it.

Secretary SEBELIUS. We have implemented a number of changes in the way the law was written to ease the transition into the marketplace.

Mr. REED. I appreciate that because we have had the same thing up here on the Hill with the employer mandate delay, that we passed legislation and then the White House vetoed that, or threatened to veto it, and then by Executive order implemented it.

Secretary SEBELIUS. No legislation has passed the Congress.

Mr. REED. So if we pass that you will say you will sign that?

Secretary SEBELIUS. I don't sign legislation.

Mr. REED. Well, the White House. What is the White House's position on that?

Secretary SEBELIUS. The White House made their position clear. But no legislation has passed the Congress in the 3½ years that the law has been implemented. And the House has voted 50 times to repeal the Act.

Mr. REED. Yeah. So when we pass a bill in the House and the White House issues a veto threat to it, that is an indication that the White House wants to work with us on policies that it is by Executive order implementing? I mean, we have the employer mandate delay. You have the health insurance plan, that you can keep if you like it. We get threats of veto from the White House on things that you are doing by Executive order over there. See, that doesn't make sense to us. Can you explain to the American people why that makes sense?

Secretary SEBELIUS. Sir, I think that the issue is the breadth of some of the legislation. We believe strongly that having a transition for people who are already insured gradually into ACA-compliant plans makes sense. The measure considered by the House of Representatives was considerably broader than that. It would have basically destroyed the new marketplaces. So that was a very different piece of legislation.

Mr. REED. That is not true. That is just not true.

Chairman CAMP. All right. Time has expired.

Mr. REED. Thank you.

Thank you, Madam Secretary.

Chairman CAMP. Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman.

Madam Secretary, thank you again for being here. We appreciate your tenacity and your patience. I would like to just shift something that doesn't bear directly on the Affordable Care Act.

I worked very hard on the House version, and it passed this Committee unanimously, provisions that would have provided reimbursement for voluntary consultation for patients who are facing difficult end-of-life circumstances. It stayed in the bill, but because of the reconciliation process it dropped out.

Since then, the evidence is even more compelling for the need for this service. I would just cite Reverend Billy Graham's most recent book talking about the need for families to approach this, or as former Majority Leader Bill Frist, in one of the op-eds on Capitol Hill, pointed out that because of a lack of this planning and assistance, quote, "patients are more likely to receive medical interventions that can actually prolong or worsen their suffering and will certainly increase the expense of their loved ones."

Yesterday, I joined with the American Association of Clinical Oncology, who had just a great report about this, and included a provision that I think is very compelling that they have research that shows, if you do this right, if you work with patients, you can actually, by adding palliative care, people will actually live up to 3 months longer while they get chemotherapy.

Well, in November 2010, CMS released a final payment rule that would have reimbursed Medicare doctors to have conversations with their patients on options for end-of-life care. This provision would have given people more control. And it speaks to much of the legislation, bipartisan legislation cosponsored by a number of people on this Committee, that Dr. Roe and I have introduced. Yet just days after that final rule went into effect, the Administration reversed course, pulled it back, and it has been 4 years, because of some sort of procedural something.

Is there some way that we can work with you and our legislation so that we can give people, at no cost to the Federal Government, something that 92 percent of the American public thinks they want? Is there a way that this Administration can work with this Committee on a bipartisan basis to solve this problem?

Secretary SEBELIUS. Yes, Congressman, I would welcome that opportunity. I can tell you it is a personal passion of mine. My mother spent her last 10 weeks in three different hospitals with dozens of procedures, and basically I would see it as being tortured to death. So I welcome the chance to look at how families and patients and providers can have more control over those end-of-life decisions.

I also think that—two things I would point out. One is that you did add to the Medicare benefits a wellness visit, a yearly wellness visit, which gives patients and doctors an opportunity to have conversations about health plans and potentially, you know, have a conversation about issues that arise in critical care. But, also, we

are very much working with revisions in the hospice benefit area, and we hope soon to——

Mr. BLUMENAUER. It is very important. I see my time has expired——

Chairman CAMP. Thank you.

Mr. BLUMENAUER [continuing]. But I would hope after 4 years that you could revisit the rule or that you support our bipartisan legislation so we can solve this.

Chairman CAMP. All right.

Mr. BLUMENAUER. Thank you very much.

Chairman CAMP. Ms. Black and then Mr. Marchant. Ms. Black is recognized.

Mrs. BLACK. Thank you, Mr. Chairman.

And, Madam Secretary, thank you for being here. I think that this dialogue is so important for us to have because these are big issues that directly impact individuals and their lives.

So my first question for you is, do you believe that the individual mandate tax penalty is an essential component of the implementation of Obamacare?

Secretary SEBELIUS. Congresswoman, I think that the mandate issue came from, I think, originally the Heritage Foundation and some other legislative analysis that ties it to getting rid of the pre-existing-condition barrier for insurance companies.

Mrs. BLACK. So you do believe that it is an important component?

Secretary SEBELIUS. You need to apply them together. Yes, ma'am.

Mrs. BLACK. You do believe.

So I ask this question because in the *Wall Street Journal* editorial today, it was exposed that a rule released last week quietly excused millions of people from the requirement to purchase insurance or else pay a tax. And the rule actually allows Americans whose coverage was cancelled to opt out of the mandate altogether.

Now all you need to do, according to this, is fill out a form attesting that your plan was cancelled and that you believe that your plan options available in the Obamacare mandates in your area are more expensive than what was cancelled or that you consider other available policies unaffordable.

Further, there is also a provision that says people can also qualify for hardship for the unspecified non-reason, and I quote, you experience another hardship in obtaining health insurance, which only requires documentation if possible. And yet another waiver is available to those who said they are merely unable to afford coverage regardless of their prior insurance.

In a word, these shifting legal benchmarks offer an exemption to anyone who conceivably wants one. Keep in mind, though, that the White House actually argued at the Supreme Court that the individual mandate to buy insurance was indispensable to the law's success.

So my question for you is: It just seems to me that only the people who might be subject to this individual tax are those who were never insured. Because these are the people that were insured and then for whatever reason—do you think that this is fair?

Secretary SEBELIUS. Well, Congresswoman, I did not read the *Wall Street Journal* editorial. I will read that later today. But I can tell you the description that you have just made is not accurate.

The hardship exemption was part of the law from the outset. There were some very specific rationale there, and it starts with the notion that if you can't afford coverage, you are not obligated to buy coverage. And that has always been a framework. What this says is, if your plan is unaffordable, you can file a hardship exemption. That was the part of the rule that was also included.

Mrs. BLACK. So if your plan is unaffordable——

Secretary SEBELIUS. It has always been based on affordability of coverage.

Mrs. BLACK. And if you feel your plan is unaffordable, you sign a form to say, attestation, my plans—I can't find a plan that is affordable for me, you just sign a document——

Secretary SEBELIUS. That is what the hardship exemption has always been based on, unaffordability of insurance. It has a measure in it——

Mrs. BLACK. So all of these——

Secretary SEBELIUS [continuing]. About income, that if you are offered employer coverage, but it has always been in——

Mrs. BLACK. Madam Secretary, all of these provisions that came out in this rule that was sort of hidden, not very much exposed, you feel that was already in the law previously and this is not a new piece.

Secretary SEBELIUS. What this allowed—the new piece is not the hardship exemption, which has always been part of the law.

Mrs. BLACK. Okay.

Secretary SEBELIUS. It allowed people who could not find an affordable option to also have the option of purchasing a catastrophic policy. That is the new piece, but it is not to get the exemption. The exemption has always been based on a hardship exemption. That has always been part of the law.

Mrs. BLACK. I can tell you, with 37 different changes in this law, my folks are really confused about what this law does and doesn't do and what applies to them.

Chairman CAMP. All right.

Mr. Marchant.

Mr. MARCHANT. Thank you, Mr. Chairman.

Secretary Sebelius, I have been hearing from the seniors in my district who rely on Medicare Advantage plans to fund their health care. They are very concerned as they are seeing their benefit reductions increase and the result of the recent cuts to the program.

It may come as a surprise to many seniors that only a small percentage of the cuts resulting from Obamacare have actually gone into effect. The vast majority of mandated Medicare Advantage cuts have not yet gone into effect and are backloaded in the Affordable Healthcare Act.

Can you please tell the seniors in my district that depend every day on their Medicare Advantage plans what to expect in the coming years once the Obamacare Medicare cuts are fully imposed?

Secretary SEBELIUS. Congressman, I think there is a very good story to tell on Medicare Advantage.

Seniors are benefiting from what has happened since 2010 in a number of ways. The premiums in Medicare Advantage have fallen by 10 percent since 2010. The enrollment has increased to nearly 33 percent—has increased 33 percent to nearly 30 percent of Medicare beneficiaries choosing Medicare Advantage plans. Quality has improved, with our five-star quality rating system. And taxpayers and other Medicare beneficiaries who were subsidizing the overpayment to insurance companies are now again seeing the benefits of that.

So enrollment is higher, premiums are lower, quality is better. We have many more plan sponsors in the market. There is 99.6 percent of Medicare beneficiaries who have Medicare Advantage choices. And I think we are seeing an even stronger program for the future.

Mr. MARCHANT. The Administration has issued countless waivers, modifications, and forms of release for business and others affected by Obamacare.

Forty percent of the enrollees in Medicare Advantage earn less than $20,000 a year. Many of these individuals will have a significant problem in dealing with the premiums and in the cuts that they are experiencing in their future.

Can you guarantee that they will receive the same level of benefits and the same access to their doctors? Because this is their biggest fear.

Secretary SEBELIUS. Well, sir, I can't guarantee the benefits that are outside of the Medicare benefit package. Insurance companies pick and choose. Some offer free gym memberships, some offer free eyeglasses. I can't guarantee that.

What I can say is that seniors have more choices than they have ever had. They have lower premiums in Medicare Advantage plans than they have ever had. And they have higher quality. More Medicare beneficiaries are choosing higher-quality plans. And I think that is all very good news.

Medicare Advantage plans are still being paid over 100 percent of the costs of fee-for-service. And that is what is gradually coming down, but there is no evidence—in 2010, it was stated unequivocally that these cuts in Medicare Advantage plans would destroy Medicare Advantage, that seniors would have no choice. That was just flat-out wrong. And I think there is very good news for the seniors now who are choosing Medicare Advantage plans. They are paying less and having higher quality.

Chairman CAMP. All right. Thank you.

Mr. Larson.

Mr. LARSON. Thank you, Mr. Chairman.

Thank you, Secretary Sebelius, for your dedication and hard work, and we deeply appreciate it, and also your willingness to come before this Committee and others and focus on what has been a frustrating rollout but something that is vitally important to the American people, our economy, and, most importantly, to the wellbeing of our citizens.

You know, this is an issue that has been debated for the last 4 years. I was impressed with something that John McCain had to say, and I want to submit that for the record.

But to summarize, in talking about the Finance Committee and what went on and the kind of debate that was taking place in the Senate and actually took place here on the floor, what Mr. McCain said: The Finance Committee submitted 564 amendments. One hundred thirty-five amendments were considered. Seventy-nine roll-call votes were taken. Forty-one amendments were adopted. Then the Senate Health, Education, Labor, and Pension Committee approved the Affordable Care Act by a 13-to-10 vote. Five hundred amendments were considered. More than 160 Republican amendments were accepted.

It is that kind of framework, even though Senator McCain disagreed and wanted to see the bill—didn't vote for the bill. And what he said at the end of the day and I think what the American people expect is us to work together to improve the bill.

What we see politically has been an attempt to total repeal to the far extreme, saying every single letter of the bill ought to be repealed, including preexisting conditions, including the great disparity that existed, especially for women, as it relates to health care.

There are a lot of positive, straightforward, pragmatic, programmatic reforms that have been made and are extraordinarily helpful to the American people. It is appalling to the American public—I come from a State where this is working extraordinarily well, where people are able to get insurance when they didn't have it before, where what was called the insurance capital of the world is now embracing and changing and meeting these reforms, where genomic projects in the biosciences are moving forward in an area that is going to be helpful.

And the only thing that drags the country down is this endless, mindless debate instead of constructive criticism about how we can work together to improve the health and wellbeing of the American citizens.

Thank you for your service.

Secretary SEBELIUS. Amen.

Chairman CAMP. Thank you.

Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman.

And, Madam Secretary, thanks for being here.

You know, Americans needed real healthcare reform before the President signed the new healthcare law, and the fact is they still need it today. The more we learn about the President's new healthcare law, I think the more the facts show it is hurting more people than it is actually helping.

I am hearing from constituents on a fairly regular basis right now who are genuinely concerned. Many are upset, many are confused because of the different delays in parts of the law. And they are fearful; they are fearful about the cost to their pocketbooks for increased healthcare costs for themselves and their families.

And instead of getting what the President I think promised when it was rolled out, for having lower premiums and lower costs, many are now paying more for health care—significantly higher deductibles, more expensive premiums. Many have lost their insurance, the plans that they liked or the plans that they had. Many have fewer choices now for doctors and for their plans.

And there is no doubt that some companies have been forced to scale back hours with more part-time jobs and less full-time jobs, and so those employees that had good full-time jobs now have part-time jobs. And there are jobs that are being lost. I know the medical device tax was a central component for the revenue stream of the Affordable Care Act, but we have 33,000 jobs now that have been estimated to have been lost in this industry. And this is one of our best American success stories; this is where health innovations come from to help patients.

And I have 51,000 seniors in my district that are part of that Medicare Advantage population. And some of the past cuts in the MA program and some of the proposed cuts are certainly giving them concern for losing benefits or maybe even losing some of their plans.

And I think, Madam Secretary, the irony in all this is that in Minnesota, a State like Minnesota, where we had one of the lowest uninsured rates before the law was put into place, we are actually likely to see an increase in the uninsured number now because the law eliminated a lot of the reforms successfully that had been implemented in a State like Minnesota.

So my question, Madam Secretary, is: Why should the Administration as a part of your budget request get another $1.8 billion for the exchanges and for all the other programs that are associated with the rollout of Obamacare?

Secretary SEBELIUS. Well, again, Congressman, I think that the evidence out with the recent health survey in the last 2 days indicates that the overall uninsured rate in this country is actually going down. So more people have insurance coverage, according to the survey, than did before this law was passed. So the evidence says that this actually is making an impact, and a positive impact.

I would also say that the vast majority of Americans have coverage through their workplaces, and that coverage over the last 3 years has gotten stronger. There are more consumer protections, so they don't have an annual cap anymore and they can't run out of treatment during chemotherapy, they have some features that——

Mr. PAULSEN. But, Madam Secretary——

Secretary SEBELIUS [continuing]. They didn't have before. But that is in place.

Mr. PAULSEN. But——

Secretary SEBELIUS. Medicare has gotten stronger with this plan. There are additional people who now——

Mr. PAULSEN. Madam Secretary——

Secretary SEBELIUS [continuing]. Have Medicaid benefits. And the individual market——

Mr. PAULSEN. I don't mean to interrupt, but can I just ask one more question? Do you expect healthcare premiums to increase again next year, on average? Will they go up? Because they certainly went up for a lot of folks this year, but do you expect that trend to continue next year again?

Secretary SEBELIUS. I think premiums are likely to go up, but go up at a smaller pace. And what we have seen since 2010, the increases are far less significant than they were prior to the passage of the Affordable Care Act. Yes, sir.

Chairman CAMP. All right.

Ms. Jenkins.

Ms. JENKINS. Thank you, Mr. Chairman.

Thank you, Madam Secretary, for being here. Greetings from Kansas.

Secretary SEBELIUS. Thank you.

Ms. JENKINS. I wanted to visit with you about the President's healthcare law and the costs associated with it. The American taxpayer, it has been estimated, will be billed nearly $2 trillion over the budget window. And the costs continue to mount. A Government Accountability Office, GAO, report issued last year says that the law will increase the Federal deficit $6.2 trillion in the long run.

The cost of this law seems to be rising every time we turn around. In the budget proposal that you are here to discuss with us today, the President is requesting another nearly $2 trillion for the healthcare exchanges.

And after all of the broken promises—like if you like what you have, you can keep it; if you like your doctor, you can keep it; premiums will go down by $2,500—I am wondering if you can tell us all today what happened to the President's promise. And I will quote him. He said, "I will not sign a plan that adds one dime to our deficits, either now or in the future." This is what he told us in a joint session of Congress in September of 2009. "I will not sign it if it adds one dime to the deficit now or in the future, period."

So given that the President's budget that you are here to defend today never, ever balances, can't ever point to a time in this Nation's future that you will stop spending more money than we take in, I am just wondering how you can explain his promise to us, first off.

Secretary SEBELIUS. Well, Congresswoman, greetings back to Kansas.

And the Congressional Budget Office, which I think you all rely on for scoring various pieces of legislation, when the Affordable Care Act was passed, said that the passage of the Act would save about $100 billion in the first 10 years and then closer to $1.1 trillion in the second decade. They updated that score and made it even more generous when cost trends began coming down.

That is what the Congressional Budget Office said. They have scored that again. Every time there is a vote on repeal and questions are asked, they continue to say repealing the Affordable Care Act would actually add to the deficit, not that it would subtract from the deficit.

So that, I think, is exactly what the President was talking about when he said he wouldn't sign a bill. Unlike the Medicare Part D, which was paid for on some credit card and added enormously to the deficit and still was never paid for, the Affordable Care Act was fully paid for within the scope of the law and was——

Ms. JENKINS. But, Madam Secretary, it is not fully——

Secretary SEBELIUS [continuing]. Scored as detracting from the deficit, so——

Ms. JENKINS [continuing]. It is not fully paid for. How can you explain—and now that you have the data that indicates this will add over $6 trillion to our national debt, what have you proposed that is going to bring that into line?

Secretary SEBELIUS. I have to tell you, Congresswoman, I would be happy to try to answer that. I have no idea what the $6 trillion to the national debt is based on, so I would love to——

Ms. JENKINS. But you do know what the Government Accountability Office is. And are you questioning their——

Secretary SEBELIUS. I have never seen the study that you are talking about. Yes, I——

Chairman CAMP. All right.

Secretary SEBELIUS [continuing]. Do know what the Government Accountability Office is. Thank you. But I will be happy to look up the study. I am not aware of that.

I do know the scoring on the Affordable Care Act by the Congressional Budget Office, and it continues to be updated. And I would be happy to provide that to you.

Chairman CAMP. All right.

Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

Madam Secretary, thank you very much for being here and for your tireless effort to ensure that people have access to quality, affordable health care.

I would like to ask you questions about two things that are in the budget, and I will just ask the questions and give you time to respond.

When is the new GME program? I think this is an issue. Ms. McMorris Rodgers and I have a bill that would hopefully provide more opportunity to train physicians. And, as you know, folks tend to practice where they train, and in especially rural and underserved areas, this is huge.

The Administration has a targeted support program, and I am just interested in what sort of assurance we will have that they will provide training outside of hospitals and in community-based settings and what the certainty is going to be in this program. Because you know the residency programs take a long time, and I want to make sure that the program is in place so folks have a certainty.

And then, second, on the administrative law judge appeals funding, the Administration has put $100 million in for Medicare hearings and appeals. And I know that is a little more than was in last year, but I question whether or not it is enough. And what are you going to do until the proper funding level is reached to make sure that our constituents don't get hung up in this void?

Secretary SEBELIUS. Congressman, the training grants will be consistent with the workforce goals, which include targeting more physicians to primary care and understaffed specialties, encouraging the practice in rural and underserved areas, and encouraging training in some of the key competencies for delivery system reform.

So I think it is very consistent with the outline that you have made about your goals in the workforce. And I think that HRSA, the Health Resources Services Administration, who would be administering these training dollars, has the expertise in identifying the underserved areas throughout the country and the whole workforce capacity issue. And that is why I think this program is really on target to try to not only train the providers that we are missing

but making sure, connecting them to the areas that are the most underserved.

In terms of—what was your second? Oh, yes, the administrative appeals. We are doing two things simultaneously, and we would welcome the opportunity to work with Congress. We don't want to recede from what are appropriate examinations of overcoding and overbilling and fraudulent activities; on the other hand, I think there are some system changes we can put in place.

But we share your concern that beneficiaries should not be in some queue waiting for appeals to be made, and we are trying to triage the system. But we would love to work with you on it.

Chairman CAMP. All right. Thank you.

Mr. Smith.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you, Madam Secretary, for taking time to have a conversation with us today. Obviously, the issues are very important. I am concerned that some of the policies enacted out of Washington, D.C. are actually hurting the very people, individuals they were intending to help.

If you could elaborate or reflect a bit on critical access hospitals. We know that that is a singular designation for a number of different approaches in various parts of the country. And, obviously, I represent a large number of critical access hospitals in rural Nebraska. I am sure you are probably familiar with facilities in Kansas.

The treatment of these hospitals, with kind of a cookie-cutter, one-size-fits-all approach, whether it is the 96-hour rule or whether it is the physician supervision, these are very cumbersome and burdensome. I have tried to find out exactly how and why they were adopted or proposed, even from HHS and CMS.

Have those saved money? I mean, can you point to the effectiveness of these things? Because it seems to me that the very professionals who are trained to make healthcare decisions find Washington, D.C. meddling and standing between a patient and their provider.

Secretary SEBELIUS. Congressman, I certainly share your concern about the important nature of critical access hospitals. And, as you say, coming from the State of Kansas, where vast territory is rural and closing a hospital often means closing a community, I know how essential a hospital presence is.

I think that what the administrators at CMS are trying to do is find the appropriate balance. As you know, critical access hospitals are still paid more than 100 percent of Medicare reimbursement. There is evidence that the proximity of one hospital to another, kind of, belies the definition of critical access——

Mr. SMITH. But that doesn't lead to—these arbitrary regulations, say, physician supervision, for example, you know, requiring a physician to be on the premises, on the same floor of the premises, when a phlebotomist might draw blood in order to be reimbursed, it seems to me that that would actually drive up the cost of the delivery of care rather than find an efficiency.

Secretary SEBELIUS. Well, again, I would be happy to take the specifics back and try to find the evidence behind why specific recommendations were made. I can assure you that at least the staff

that is looking at these situations is very concerned that patients not be jeopardized by the care and trying to not add administrative burden.

But I would be happy to, if you could give me some specifics——

Mr. SMITH. Absolutely.

Secretary SEBELIUS [continuing]. Get the evidence back to you.

Mr. SMITH. Thank you. And, again, I think these are examples that I hope we can avoid of the Federal Government standing between a patient and his or her provider.

Thank you. I yield back.

Chairman CAMP. Thank you.

Mr. Buchanan.

Mr. BUCHANAN. Madam Secretary, thanks for being here today.

I want to touch on the biggest issue in our area, employer mandates. A lot of people are concerned. I am looking at a *New York Times* article. It is about 2 weeks old; I would be glad to give it to you. But it says cities, counties, public schools, community colleges around the country are being limited or reducing hours in terms of part-time employees to avoid paying healthcare insurance under the ACA. And this is coming from State and national leaders from around the country.

Are you aware of this? And do you have any sense of the impact that this is having on communities? And I can tell you in our community, in Sarasota-Bradenton, Florida, it is a gigantic issue.

Secretary SEBELIUS. I have heard, Congressman, certainly, conversations about the 30-hour, kind of, cliff: that more than 30, people would be required to provide health coverage for those employees; less than 30, they would not. Again, I think there is disputing evidence of what is happening with that, but we are watching it very closely——

Mr. BUCHANAN. I would just ask you to take a look at it. We need to clearly—because this is—I know we are trying to get more health care out there, but everybody is taking, in a sense, a 25-percent pay cut.

I also want to mention something you said earlier, about the fact that it only affects 2 percent of the businesses. Do you have any idea—it is one way to spin it or present it, but do you have any idea what the 2 percent make up in terms of the number of jobs, the impact in the country? Do you have any sense of what that 2 percent is?

And I will say that because I have one employer in my area, they have over 1,000 employees. They are moving most of their employees from 40 hours to 29, and they are part of the 2 percent. But I think you are looking at 20, 30 percent of the jobs across the country are going to be impacted by these mandates. And even though you are pushing the mandates off, people are making those adjustments in the public sector and the private sector today. So we are very concerned about that.

But I would like to have you get back to me on what that 2 percent makes up.

One other thing I want to just mention, in terms of the taxes and revenues. Part of the reason we are having a record surplus this year—not a surplus, but record revenues this year is because we

did increase taxes 25 percent. We went from 35 to 44. That is what the passthrough entities are paying that create a lot of the jobs in the country. And if you look at the taxes for State and Federal, the average across the country is 49.6.

So I don't know how much more burden we can put on our employers across the country, as we, as you have mentioned, we need additional revenues. I hope you are not considering going after more passthrough entities that are the job creators of America.

Secretary SEBELIUS. Congressman, one thing I would point out is that the recently released rules by the Treasury Department did look at the 30-hour employee and particularly the, kind of, mixed work group where you have part-time and full-time, and indicated that employers, if they offer coverage to 70 percent of their employees, would meet the criteria.

I would tell you that the 30-hour definition came out of the offerings in the private-sector marketplace prior to the Affordable Care Act. That is what employers chose to do, that people who were working more than 30 hours were defined as full-time employees, people who were working less—so as the Congress looked across the country, that is where that hour rate came from.

But we are watching, as I say, that very closely.

Chairman CAMP. All right. Thank you.

Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman.

Madam Secretary, so much of the original promise of the Affordable Healthcare Act has been undermined by faulty implementation that has sometimes been indifferent to local concerns. Last month, the Congressional Budget Office, as you know, concluded that faulty implementation of the healthcare law, quote, "impeded so many people's enrollment in exchanges that 1 million fewer people will actually obtain exchange coverage this year than they had previously projected."

From your testimony this morning, it is clear we will not have 7 million or even 6 million. And, of course, the number that is really important is not how many people have enrolled, but how many people have paid their premiums and are actually getting exchange-based coverage, a number we have never been given.

As you are aware, since last August, I have been voicing concerns to your office about implementation in Texas. At best, less than 10 percent of exchange-eligible Texans have selected a plan. In other words, more than 90 percent of the people whom we wrote this law to get exchange coverage for have not been covered.

To meet your projections, we would need to enroll and have premiums paid for as many people this month as have been enrolled since the beginning in October to yesterday, or last week.

This is much more than a website problem, though I believe that the individual assistance program there has been handled with about the efficacy of the original website rollout. I have been unable to get straight answers about even who is responsible for coordinating in-person assistance in Texas—a place where we have multiple assisters in some areas and none in many others.

I have sought to get even just a dedicated line so that the certified counselor, who yesterday had put in 10 hours trying to help one person, would be able to call a line dedicated to assistance

counselors to be able to get prompt assistance and help people get enrolled in this. But there has been no response from HHS or CMS about that.

It seems to me that we are to a point where, instead of just circling the wagons against all the political arrows that are shot against this plan, we need a little more accountability, and we need to ensure that the next enrollment period is not handled as poorly as the last one.

I am very interested in answers to the questions that the Chairman raised at the beginning of this hearing. We haven't gotten them yet, and I hope that we do get them.

We come at this from a different perspective, but taxpayers deserve to get their money's worth. And I think much of the focus as it relates to in-person assistance needs to be to find out—and I assume, Mr. Chairman, that some of these questions I have been raising since last fall can be submitted by you with your questions for prompt answers, such as how much it costs us per person who is actually insured through the exchange for some of these contractors that have been providing these services. Two Washington Beltway contractors have been paid $9 million for in-person assistance in Texas. I have been unable to find out what it costs per enrollee for those persons.

And so I think that, while our goal should be to try to improve and strengthen this Act, if it is to perform any better in the next enrollment period than it has in this one, we need answers to these questions to get the taxpayer their money's worth and to get the promise of this Act fulfilled.

And I yield back.

Chairman CAMP. All right.

At this time, Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman.

Welcome, Madam Secretary, back to the Committee.

I think you sense a growing lack of trust that we reflect from our constituents. Americans have a growing lack of trust in their own Federal Government. I think there is no doubt about that. And I would suggest that Obamacare is really the poster child for one of the reasons that exists or that is increasing because word isn't matching deed. Promises have been made and absolutely broken.

And as a former practicing physician, it is distressing because we are not talking about just some nebulous program now; we are talking about real people's lives. And in so many ways, some of the stories that you have heard here, real people are getting harmed.

In spite of that, you have the Senate Majority Leader, Harry Reid, taking to the floor of the Senate and saying any story that decries a problem with Obamacare, all of them are lies. Do you agree that all of these stories that have been raised are lies?

Secretary SEBELIUS. Congressman, I did not hear what Senator Reid said. And, of course, there are lots of anecdotes of lots of people and——

Mr. PRICE. If you were to——

Secretary SEBELIUS [continuing]. Lots of success stories.

Mr. PRICE. If you were to have heard the Senate Majority Leader say all the stories——

Secretary SEBELIUS. Yeah, I——

Mr. PRICE [continuing]. About ACA are lies——

Secretary SEBELIUS [continuing]. I really don't want to comment on his comments. I didn't hear them.

Mr. PRICE. Again, it is—and that is the kind of trust that is lacking, because it begs for——

Secretary SEBELIUS. I just said clearly there are lots of people and lots of real stories. I don't assume that people are lying, no.

Mr. PRICE. Let me go to some specific questions. You mentioned in your opening remarks 4.2 million people have signed up on the exchange, and I want to get to some of the concerns that others have.

How many of those that have signed up, that have enrolled in Obamacare, have paid their premium?

Secretary SEBELIUS. I can't tell you that, sir, because I don't know that.

Mr. PRICE. How can it be that HHS, in charge of this program, cites a number, 4.2 million people signed up, but has no idea how many people have paid?

Secretary SEBELIUS. Because the consumers don't pay us; they pay their insurance company. We can tell you who has enrolled——

Mr. PRICE. You can get information from the insurers?

Secretary SEBELIUS. We get information now in aggregate form of the customers who qualify for——

Mr. PRICE. Let me ask another question.

Secretary SEBELIUS [continuing]. A tax credit. Not all their customers do, and——

Mr. PRICE. How many of those, of the 4.2 million, were previously insured?

Secretary SEBELIUS. I do not know that, sir.

Mr. PRICE. Isn't it true that many Members of Congress are in that 4.2 million? We had insurance before; we were forced off that insurance——

Secretary SEBELIUS. I assume if you have signed up on the exchange, you are in that number, yes, sir.

Mr. PRICE. McKinsey did a recent survey that said 27 percent of those joining the exchanges were previously uninsured. And that is a low number compared to what you all projected. Is that consistent with your information?

Secretary SEBELIUS. Again, we don't collect information on the previously insured. I think these questions would be—we would be happy to give answers to you as soon as we have accurate information. In the meantime, insurers have this information about their customers, because that is who is being paid and that is who is enrolling.

Mr. PRICE. It begs credulity, Madam Secretary, that you don't know the answers to these——

Secretary SEBELIUS. These are private insurance plans, and customers are——

Mr. PRICE. You all are charged with running the program.

Secretary SEBELIUS [continuing]. Buying a private product from a private insurance plan. We qualify them, we get their tax information to make sure they qualify, and then send them to their company——

Mr. PRICE. The American people trust that you——

Secretary SEBELIUS [continuing]. And they enroll with the company.

Mr. PRICE [continuing]. Know what you are doing, and you are not fulfilling the bill.

Chairman CAMP. All right.

Secretary SEBELIUS. This is not Medicare or Medicaid, sir. It is a private plan in the private market. It is not government insurance, in spite of the fact that it has been characterized that way. People are buying a product in the private market.

As soon as we have accurate information, we will give it to you, but we do not currently have information about how many people have paid.

Mr. PRICE. Sounds like last fall, Mr. Chairman.

Chairman CAMP. All right.

Mr. Gerlach.

Mr. GERLACH. Thank you, Mr. Chairman.

Madam Secretary, there is a section in the ACA on a reinsurance tax; is that correct?

Secretary SEBELIUS. Yes.

Mr. GERLACH. What is the purpose of that reinsurance tax, the proceeds from that tax?

Secretary SEBELIUS. Well, there actually are three components of risk corridors, reinsurance tax, and risk adjustment. A 3-year program that, again, is paid for by the insurance companies——

Mr. GERLACH. Right.

Secretary SEBELIUS [continuing]. Operating in the market, and it is to really balance the risk pool. It is exactly the same as the risk program——

Mr. GERLACH. Does the reinsurance tax——

Secretary SEBELIUS [continuing]. In Part D when Part D started——

Mr. GERLACH. I am focused on the reinsurance tax, in particular. Are the revenues to be used to fund other portions of the Act, including exchanges?

Secretary SEBELIUS. The revenues will be used to balance the marketplace.

Mr. GERLACH. How much is expected to be raised in the reinsurance tax this year?

Secretary SEBELIUS. I was just told that figure is $10 billion for this year.

Mr. GERLACH. Okay. But there is also a proposal out there to provide waivers to some of those that are right now under the law to pay that reinsurance tax; is that correct? In particular, unions?

Secretary SEBELIUS. Oh, yes, this is the—I am sorry—the rule that if you are self-administered and a self-funded plan, you do not pay the tax, and that is not exclusive to unions. There are a lot of self-administered, self-funded plans that are not paying the tax.

Mr. GERLACH. Okay. So how much relief under this waiver will unions receive as a result of this rule?

Secretary SEBELIUS. I could get you that information in writing.

Mr. GERLACH. Could you give me a ballpark right now?

Secretary SEBELIUS. I can't.

Mr. GERLACH. Okay. Well, I find it curious that—the reinsurance tax section of ACA is very clear as to who is to pay that tax. It is to be used, then, to help fund aspects of the ACA, including exchanges. And yet the President is requesting an additional $1.8 billion in his budget request for program management to continue to build and operate exchanges.

So what it seems to me is, you are providing a waiver to perhaps what would be termed "political friends" not to pay what the law requires them to pay, but then coming back to the taxpayers and asking them for more money to help fund the exchanges.

Secretary SEBELIUS. Well, sir, the statutory language talks about issuers or those who operate plans with third-party administrators. And the self-funded, self-administered plans, which are a much broader category than you have just described, are not in the statutory configuration of the law.

In addition——

Mr. GERLACH. Okay. Just so——

Secretary SEBELIUS [continuing]. The 1.8——

Mr. GERLACH [continuing]. I am clear on what you are saying, Madam Secretary, just make sure I understand what you are saying, it is your determination that those that are being granted this waiver are not covered by the language of the Act, and therefore——

Secretary SEBELIUS. They are not——

Mr. GERLACH [continuing]. You are granting that waiver.

Secretary SEBELIUS [continuing]. An issuer, nor do they operate with a third-party administrator, yes. Self-funded, self-administered plans—again, much broader than the category of unions; there are many who operate that way—are not specified in the statutory language.

Mr. GERLACH. Then why were unions jumping up and down asking for this relief if they weren't covered by the tax to begin with?

Secretary SEBELIUS. I can just tell you that is what the statutory language says. That was our interpretation of the statutory language. That is the rule we put out. The $1.8 billion that you suggest, 1.2 of that will be paid for by user fees. Six hundred million dollars is the request for appropriation.

Chairman CAMP. All right.

Mr. GERLACH. Thank you.

Chairman CAMP. Mr. Becerra.

Mr. BECERRA. Thank you, Mr. Chairman.

Madam Secretary, great to have you with us.

Actually, before I go to some of the questions about the Affordable Care Act, I wanted to check in with you regarding the financial alignment demonstration project being carried out in California, called the Dual Eligible program, for beneficiaries who receive both Medicare and Medicaid.

We share the goal of ensuring that everyone who transitions into this program will have uninterrupted, quality health care that they can count on. And I was just wondering, will you and CMS Administrator Tavenner keep us informed as you continue the rollout so we can make sure that there is a successful implementation of that program?

Secretary SEBELIUS. Yes, sir, we will.

Mr. BECERRA. Appreciate that.

Now, I know that, even today, if anyone is watching, there is no reason why folks should not be left with some sense of misunderstanding about what is going on. The disinformation and scare tactics that have been used over and over again have been difficult to combat. But I wanted to just make sure about something.

As I read the facts, since the passage of the Affordable Care Act, you mentioned that several million people have now become insured. In fact, I think you mentioned that over 4 million people now have private health insurance.

Did you mention the 3-or-so million young Americans who have insurance as a result of the Affordable Care Act, that now they can stay on their parents' insurance policy?

Secretary SEBELIUS. I did not mention that.

Mr. BECERRA. And that is about 3 million or so?

Secretary SEBELIUS. Yes, sir.

Mr. BECERRA. And we have some——

Secretary SEBELIUS. Three million previously uninsured. Far more young adults are on their parents' plan, but 3 million previously uninsured young adults.

Mr. BECERRA. Got it.

And we have some 4 million or more individuals who now have health coverage as a result of Medicaid?

Secretary SEBELIUS. Closer to 8.9 million in the Medicaid. Some of those are renewals; some of them are newly eligible in States that chose to expand their Medicaid program.

Mr. BECERRA. Right. So the 8-million-plus number includes people who probably qualified before but had—or who just transitioned from current Medicaid, what they had before to what they have now.

Secretary SEBELIUS. Some States require yearly renewals, and they are included in that, but there are close to 9 million people who will have Medicaid coverage. A number of those are newly insured.

Mr. BECERRA. So if I do the quick math, 9 million under Medicaid, 4 million with the private insurance under the marketplace, 3 million young adults, that is about 16 million Americans who have health security today that they might not have had before.

Secretary SEBELIUS. That is accurate.

Mr. BECERRA. My understanding, as well, looking at the job numbers, that since the Affordable Care Act passed, more than 8 million jobs have been created in this country, not lost. And, in fact, if you look just at the—I looked at just the healthcare sector, and in the healthcare sector, since the passage of the Affordable Care Act, we have seen over a million jobs created, just in the healthcare sector.

So as we continue to hear folks talk about job loss, that the Affordable Care Act will result in job loss, just the opposite is occurring. And, of course, we are also finding that we have seen a decrease in the rate of increase of the cost of health care, which I would think you would agree is a good sign.

Secretary SEBELIUS. I think that is a good sign.

And on the job front, we also see that the number of people working part-time hours is decreasing, the number of full-time workers is increasing.

Mr. BECERRA. Mr. Chairman, if I could just add to the record—ask unanimous consent to submit into the record the CBO's updated estimates that deal with job loss and the issues of employment and job creation.

Chairman CAMP. Yeah, without objection.

Mr. Roskam.

Mr. ROSKAM. Thank you, Mr. Chairman.

Madam Secretary, we just heard from Mr. Becerra, who criticized critics, characterizing it as disinformation and scare tactics, and yet that wasn't what we heard from Mr. Doggett. Mr. Doggett was essentially admonishing the Department for a lack of information and a lack of accountability.

So I want to associate myself with the spirit of Mr. Doggett and also bring in one of the themes that Dr. Price was trying to articulate, and that is this: Wouldn't it be great, Madam Secretary, if Dr. Price, in the question that he asked, if you were able to say, here is the answer, here is the answer, when he made the inquiry and you said, you know what, I don't have that information, I am just the Secretary of Health and Human Services, that is what the private insurance company—that was your answer a minute ago. Wouldn't it be a great thing if you were to say, here is the information and here is the answer?

And the problem is, at least as far as the construction of the Affordable Care Act, as it is currently constructed, some of this information you may not know, some of it you may, but it is because of the limitations of the Act itself.

So we have an inspector general, and your own inspector general is only able, Madam Secretary, to go and ask inquiries of Health and Human Services. That inspector general who reports to you cannot go and make any inquiries to the Treasury.

One of your earlier answers, you cited tax credits. Well, when it comes down to it, the HHS Secretary has no jurisdiction over tax credits. You don't know what is happening in that other department.

Wouldn't it be a good thing if we were to amend the law and you had that information and there were a special inspector general that had broad jurisdiction? Wouldn't that be a good thing?

Secretary SEBELIUS. I don't think that is necessary, and I think that is additional expenditure.

I will give you the information as soon as we have it. And we will have it——

Mr. ROSKAM. Yeah, but by your own admission——

Secretary SEBELIUS [continuing]. From insurance companies, but we do not have it now.

Mr. ROSKAM [continuing]. You don't know it.

So why is it a good idea to have a Special Inspector General for Iraq Reconstruction? Why is it a good idea to have a Special Inspector General for Afghanistan Reconstruction? Why is it a good idea to have a Special Inspector General for TARP oversight? Cumulatively, all of these have literally saved billions of dollars.

The Affordable Care Act, according to the Congressional Budget Office, is a $1.8-trillion expenditure. What is it that is sacrosanct that says that this should not be subject to that broad jurisdiction?

By your own admission, you don't know the answers to these questions, do you?

Secretary SEBELIUS. I could not answer Dr. Price's question because I don't have the information from the insurance companies yet.

Mr. ROSKAM. Right, because you can't——

Secretary SEBELIUS. We will have it, and I will——

Mr. ROSKAM [continuing]. Reach out.

Secretary SEBELIUS. This is in the private sector. This is not Treasury. This is private insurance companies——

Mr. ROSKAM. Right. That even begs the question——

Secretary SEBELIUS [continuing]. Three hundred of whom are selling policies in the marketplace.

Mr. ROSKAM. You can't get to it. Your inspector general can't get to it.

Secretary SEBELIUS. This is not an inspector general issue. It is private insurers who are selling plans to their customers. They can tell——

Mr. ROSKAM. That is even worse.

Secretary SEBELIUS [continuing]. You know how many of their customers have——

Mr. ROSKAM. It is ongoing——

Secretary SEBELIUS [continuing]. Paid their bills.

Mr. ROSKAM [continuing]. And you don't have the information, and you don't have the capacity to have the information.

Chairman CAMP. All right. I would just say, Madam Secretary, part of the frustration is that you did have the answer to the number of insured children, and that is also private-sector information, but yet, when we are trying to get further information, we don't——

Secretary SEBELIUS. That came directly, Mr. Chairman, from the insurers. And I am telling you, as soon as we have this information from the insurers—we don't collect it. We didn't have it. They turned that in to us.

Chairman CAMP. All right.

Dr. Boustany.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Madam Secretary, one of the glaring omissions in ACA was addressing the flawed physician payment formula under Medicare, SGR, the sustainable growth rate formula. A lot of work has been done. It has been a thorny problem facing Congress for quite a while, and over the past few years, we have actually gotten to an agreement on a policy—bicameral, bipartisan.

So first question: Does the Administration agree with this policy, and will the Administration support this policy?

Secretary SEBELIUS. Well, as you know, Congressman, the President has supported a long-term fix of the SGR long before the Affordable Care Act was signed into law. He has included it in every budget. And, yes, we do support the bicameral position.

Mr. BOUSTANY. Okay.

The other issue is going to be paying for this. And this will be a difficult fight, obviously, and it certainly can become a partisan fight. But in the interest of trying to get something done, will the Administration come forward and work with Congress, work with the Senate, to try to get to a solution on this?

Secretary SEBELIUS. We would be eager to do that. The first couple of budgets that the President put forward had specific pay-fors. Those were rejected. He does assume that the SGR is fixed; we have put that in our baseline for the next 10 years. We would be happy to work with Congress.

Mr. BOUSTANY. And pursuant to that same question, the President, in the past, put on the table some Medicare reforms that would help, I think, improve the outlook of Medicare over the long haul, one being combining Medicare Part A and Part B into a single structure, making it work more like a modern insurance type program. Second was limited means-testing.

Does the President still support these?

Secretary SEBELIUS. I think, as you know, Congressman, that was put on the table as part of a global package of both entitlement and structural spending reforms. And we would be eager to talk about those issues in that, kind of, global package.

Mr. BOUSTANY. But not within the context of reforming SGR, which is a pretty big piece.

Secretary SEBELIUS. Well, the SGR does impact, certainly, Medicare physicians. It is probably the single biggest threat to Medicare's future in terms of beneficiary service, the looming cuts.

Mr. BOUSTANY. It is a threat to access.

Secretary SEBELIUS. So we are eager to talk about pay-fors, but I think having a more global discussion about entitlement reform, tax reform, and revenues is also something we would be eager to——

Mr. BOUSTANY. And, finally, is the Administration willing to put forth the capital to try to solve this before the end of March so that we can avoid another patch, which will be expensive?

Secretary SEBELIUS. Put forward the capital—again, we would be happy to have the discussion with Members of Congress about what the pay-fors might look like.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Chairman CAMP. Thank you.

Mr. Neal.

Mr. NEAL. Thank you, Mr. Chairman.

Madam Secretary, I want to come back to you in a few moments about you as the trustee of Medicare and Social Security, but just a reminder here that the Democratic minority vigorously opposed the original Part D prescription drug benefit plan offered by the Bush Administration because we did not think it had gone far enough. Upon ascending to the majority right after, we took the role not to undo what had been done but instead to work hard to improve it, and closing the donut hole was a pretty masterful piece of work. And now there is broad acceptance of the whole notion of the Part D benefit. Now, I wish that that would have been the model that we would have adopted in Congress for working with ACA.

But let me draw your attention specifically to a couple of issues: graduate medical education and the role of Medicare in financing our hospitals across the country. As you know, in Massachusetts, our hospitals would be the equivalent of what Boeing perhaps means to the Pacific Northwest. I think that is a reasonable description in terms of not only the success that they have but the employment opportunities that they present.

You, I think, by law, have to sign every year a document certifying as to the longevity of Medicare. Is that correct?

Secretary SEBELIUS. Yes, sir.

Mr. NEAL. Would you talk a little bit about what ACA has done to that signing?

Secretary SEBELIUS. Yes.

The first year I was a Medicare trustee in 2009, the anticipation was—the actuarial projection was that Medicare would begin to be insolvent—not that they wouldn't have any money, but they would have about 70 cents on the dollar—by 2017. So, in 2009, it was a 2017 cliff.

The passage of the ACA added years to that solvency, according to the actuary who looked at the law and the impact over time, and subsequent budgets have also added years. So we are now, the 2015 budget, according to the actuarial projection, would add an additional 5 years to the solvency of the Medicare Trust Fund.

So during this Administration, I would say significant solvency years have been added.

Mr. NEAL. Are there Republican trustees?

Secretary SEBELIUS. Yes.

Mr. NEAL. Do they sign the document?

Secretary SEBELIUS. Yes, they do.

Mr. NEAL. And did they sign?

Secretary SEBELIUS. Yes.

Mr. NEAL. Okay.

My point is that, here is an example, again, of a very good story, much like the one that Secretary Lew presented about deficits in his appearance before the Committee recently, and it is frequently underreported in terms of the good news, because the emphasis remains on the conflict of the story as opposed to the substance of the story.

So I would hope that you use the opportunity, with Medicare solvency, graduate medical education, to promote the notion that this is a widespread success story on that basis.

Secretary SEBELIUS. Thank you.

Chairman CAMP. All right. Thank you.

Mr. Reichert.

Mr. REICHERT. Thank you, Mr. Chairman.

Madam Secretary, in response to Mr. Reed's question regarding legislation, your answer was that there was no legislation that has passed Congress. Are you aware that there are actually eight pieces of legislation that have passed Congress and have been signed by the President in regard to the Affordable Care Act?

There are eight pieces of legislation passed by Congress and actually signed into law by the President. So there is another—I think you ought to go back and review the laws that have been passed that affect the law that you are trying to implement.

I want to go back real quick. It has been 4 years since passage of the healthcare law, nearly 6 months since the exchanges opened for business. So let's look back at the 4 years.

In January 2010, the President spoke at the White House Republican Retreat and acknowledged that some stray cats and dogs were added to the healthcare bill and that some of the provisions that got snuck in the law might have violated the pledge that, if you like your health care, you can keep it; if you like your doctor, you might be able to keep your doctor.

In February 2011, during your testimony and my questioning, you said, in response to whether or not you can keep your doctor or your health care, you said, "I don't think there is any language in the bill that interferes with the current system." Again, you were wrong.

Again, in February 2012, when I raised these same concerns, you said, "The notion that somehow companies in grandfathered plans will not be able to keep their grandfathered plan is really not accurate." Again, you were wrong.

Yet, due to the law's many mandates and the regulations put out by HHS under your leadership, as many as 5 million Americans have lost their existing healthcare plans. The law has created so many disruptions that the President announced, perhaps illegally we think, that States and insurers can begin to ignore the law.

In fact, as Mr. Reed said, there are 37 changes to the law. September 24th, September 26th, October 23rd, November 14th, there were seven more changes to the law. On November 21st, November 22nd, January 1st, November 27th, and 30th of November, December 12th, December 19th, December 23rd.

And then, Secretary Sebelius, you were on Fox News and assured the American people who were watching Fox News at that time that there would be no more delays. Yet, on January 10th of this year, another delay; January 14th, another delay; and then February 10th, another delay.

Are there any further delays? Can you make a promise to the American people today, another promise, Madam Secretary, that there will be no more delays to the so-called Affordable Healthcare Act?

Secretary SEBELIUS. We will continue to put out regulations——

Mr. REICHERT. Do you make a promise to the American——

Secretary SEBELIUS [continuing]. And policies as we go through this Act.

And, sir, I would like an opportunity to correct some of the, I think, misstatements.

Mr. REICHERT. Will there be——

Secretary SEBELIUS. There is nothing in the law that would stop insurance companies——

Mr. REICHERT. Will there be further delays, Madam Secretary?

Secretary SEBELIUS. There are no planned delays in the law that——

Mr. REICHERT. Do you consult with HHS when you—or, pardon me. Do you consult with the Treasury Department before announcing any delays and changes?

Secretary SEBELIUS. Sir, most——

Mr. REICHERT. Do you consult with——

Secretary SEBELIUS [continuing]. Of the regulations that we——

Mr. REICHERT [continuing]. The Department of Treasury——

Secretary SEBELIUS. Most of the regulations that are written are written——

Mr. REICHERT. Do you consult with the Department of Treasury, yes or no?

Secretary SEBELIUS. Sir, the regulations require three agencies' participation: Treasury, Labor, and HHS. So there is broad consultation.

Mr. REICHERT. Okay. Thank you.

Chairman CAMP. Mr. Ryan is recognized.

Mr. RYAN. Thank you.

I would just quickly say to my friend from Massachusetts, he should look at the unprecedented original appendix of the trustees' report that talks about the double counting that occurred. And the putting Part D on the credit card, the Democratic proposal was more than double the credit card bill.

Here is what I want to ask, Madam Secretary. We keep this list here in the Ways and Means Committee about all the delays. We have 23 so far. One I want to ask you about is IPAB, the Independent Payment Advisory Board.

In your Table S–9 of your budget, last year you claimed in your budget you are going to save $4 billion from IPAB's recommendations. This year, you tripled that to $12.9 billion for IPAB's recommendations. This is above and beyond all the provider cuts that are in the ACA to pay for the ACA.

So here is my question: Where are we with IPAB? They have given us their last April report. I assume another one is forthcoming from the actuary. But where is IPAB itself? When are you going to submit the names?

If you don't do that, as you know, the law lets you, one person, submit the plan to save the $12.9 billion. So what is happening with that? And if you are going to do it, how do you come up with the $12.9 billion? Where is that savings coming from?

Secretary SEBELIUS. Well, Congressman, the President has not yet sent to Congress names for the nominees of IPAB. But, as you may know, the law is constructed in a way that IPAB wouldn't trigger any recommendations unless there is a gap between what the trajectory——

Mr. RYAN. I realize that, and you are claiming $12.9 billion.

Secretary SEBELIUS. So they would not have any recommendations to make in the foreseeable future. Nor would I take any action in the foreseeable future——

Mr. RYAN. Okay, so how——

Secretary SEBELIUS [continuing]. As long as the cost trajectory is——

Mr. RYAN. So are we to ignore the fact that you are claiming $12.9 billion in savings from IPAB?

Secretary SEBELIUS. I think the President intends to submit names to Congress as we watch the cost trajectory—if the cost trajectory changes, the IPAB will be in full effect. And those rec-

ommendations are presented to Congress, as you know, not to me. They come to Congress.

Mr. RYAN. No, I realize that.

Secretary SEBELIUS. And if Congress doesn't change them, then they go into effect.

Mr. RYAN. Or you just recommend them, if there is no IPAB at the time.

Secretary SEBELIUS. If there is no IPAB, that is correct.

Mr. RYAN. So you have no answer to where the $12.9 billion is going to come from?

Secretary SEBELIUS. We are optimistic that the current trajectory of Medicare costs would actually negate any impact of IPAB or me taking any kind of action in the foreseeable future.

Mr. RYAN. That is another way of saying, ignore our budget because it is not real.

Secretary SEBELIUS. I think the IPAB recommendations are based on an actuarial——

Mr. RYAN. No, I understand.

Secretary SEBELIUS [continuing]. Of out-year costs——

Mr. RYAN. You go from GDP of 1 to GDP of 5, I get all that. You did that last year; you went to GDP .5 last year. And you still had $4 billion. Now you triple your savings to 12.

And the question is, where is it coming from? What are those justifications? What is the assumption you are using to claim this savings to show how your budget is put together?

Secretary SEBELIUS. I think the actuarial projection is that outyear Medicare costs will rise again.

Mr. RYAN. Right.

Secretary SEBELIUS. So far, they have been incorrect about those increases. We are hoping that they continue to be incorrect. And so, if the IPAB indeed does rise—I mean, I am sorry——

Mr. RYAN. Yeah, the—I understand.

Secretary SEBELIUS [continuing]. The trajectory rises, IPAB would kick into gear, and we will make recommendations through the IPAB to Congress about those specifics.

Mr. RYAN. Okay. So you are saying, though, just so you know, in your own budget, it is going to triple from this year to last year. That is coming. It is above projection. You have it in your budget. But you are telling me you have no idea where in Medicare you are going to cut to get that, is basically what you are saying.

Secretary SEBELIUS. It is based, again, on what the actuary, the independent actuary——

Mr. RYAN. I understand that.

Secretary SEBELIUS [continuing]. Says will happen in outyears. Currently, we have not made specific recommendations about any cost cuts because none of that is actually happening right now.

Mr. RYAN. Okay. I know time is out. When are we going to see the names? What are we going to see IPAB——

Secretary SEBELIUS. I can't tell you. They come from the President.

Mr. RYAN. All right.

Secretary SEBELIUS. I don't know when you will see them.

Chairman CAMP. All right.

Mr. Davis.

Mr. DAVIS. Thank you, Mr. Chairman.

Madam Secretary, thank you very much for being here. But, also, I want to thank you for the Medicaid waiver for Cook County in the State of Illinois. As a result of that action, the Governor's expansion of Medicaid, and a lot of hard work on the part of a lot of people, Illinois is doing much better in signups for the Affordable Care Act than many other States. And for that, we are indeed grateful.

I am a big fan of home-visiting programs and community health centers, and I am pleased to note that both are included in the budget. As a matter of fact, I get my personal care at one of these centers in Chicago at the Mile Square.

Could you elaborate on the value and effectiveness of these two programs that relates to providing health care for especially low-income people?

Secretary SEBELIUS. Well, Congressman, I share your high regard for both programs. I think that there is no question the community health centers are the backbone of primary-care delivery in this country in rural and urban areas. They are proven time and time again to deliver lower-cost, high-value primary care.

And thanks to both investments from the Recovery Act and ongoing investments through the Affordable Care Act, the footprint of health centers is spreading, increasing services and increasing clients. And we are now going to be able to serve about 31 million people, including yourself. And I think they are an incredibly important—play an incredibly important role, particularly in underserved communities.

In terms of the home-visiting program, again, there is lots of very strong scientific evidence that it makes a huge difference to help give parents the tools to be the best parent they can be, that having a professional encounter with young parents is often extremely beneficial as a pathway to an early strong start in learning.

So the President's budget, as you say, both increases the voluntary home-visiting program as well as continues to expand the footprint, both new sites and additional services at sites, for the community health center program.

Mr. DAVIS. Thank you very much.

And I would like to just point out that our experiences in Illinois with the Affordable Care Act have not been automatic, but our experiences have come as a result of a large number of people believing in the program, believing that it will work, and then working to make sure that it does work.

So I thank you very much and——

Secretary SEBELIUS. Well——

Mr. DAVIS [continuing]. I yield back.

Chairman CAMP. Thank you.

Secretary SEBELIUS [continuing]. I don't think it comes as a surprise that in States where the Governor is very supportive, where there are delegation members, providers, others reaching out, there is a more positive experience than—Congressman Doggett has mentioned Texas, where there are not only barriers but significant laws that have been passed which make it very difficult

for a lot of the outreach people to even do the job they were contemplated to do.

Chairman CAMP. All right. Thank you.

Mr. Tiberi.

Mr. TIBERI. Madam Secretary, Mr. Young submitted for the report this report, "The Irony of Obamacare: Making Inequality Worse." I would like to read the conclusion, which says, "For two years, labor unions, employer partners have patiently explained to the Obama Administration and Congress the potential damage that the ACA poses to these unique successful nonprofit plans.

"Having already made efforts to accommodate businesses, churches, congressional staff, it is ironic the Administration is now highlighting issues of economic inequality without acting to preserve health plans that have been achieving the goals of ACA for decades. Without a smart fix, the ACA will heighten the inequality that the Administration seeks to reduce.

"We take seriously the promise that if you liked your health plan you can keep it, period. UNITE HERE members like their health plans. UNITE HERE members' plans are ready to compete with the corporate giants of the healthcare industry if Washington will simply create a level playing field."

There were three articles in local papers in my district I would like to submit for the record, Mr. Chairman, that highlight this very issue.

Chairman CAMP. Without objection.

Mr. TIBERI. The *Mansfield Journal* reported on Monday that only six of the Obamacare exchange plans in Richland County include the only hospital in the county, MedCentral, in-network. The *Marion Star* reported on Monday only 6 of the 26 Obamacare plans in Marion County have Marion General Hospital, again, the only hospital in Marion County, in-network. And, finally, the *Newark Advocate* reported only 6 of the 26 Obamacare exchange plans in Licking County consider the only hospital in Licking County, Licking Memorial, to be in-network.

That means that three-quarters of the exchange insurance plans in these counties don't give access to county residents to the only hospital and hundreds of doctors in-network. And because many of my constituents now are facing the choice of being in-network and having to travel out of the county maybe 100 miles to a hospital and are now losing doctors that they had—and these were people who had insurance and now have been forced to go into the exchanges. And in the county in which they reside, they can't even go to their hospital. This is a problem just beginning.

We spoke to a lady in the office yesterday, a central Ohioan, who wanted me to give you her name. Her name is Colleen. She had health care; now she is one of the 4 million in the exchange. And she has a plan that she is paying more for, that she doesn't like, with which she actually lost her doctor. She liked what she had, she couldn't keep it, and now she can't even keep the doctor that she had.

So the articles aren't misinformation or disinformation. The union report—not supportive of Republicans, by the way—is not disinformation. And yet there seems to be a disinformation campaign within the Administration that this is all just make-believe.

Madam Secretary, please help us reassure our constituents that the Administration is going to deal with the reality that is hitting the ground, and that is people are losing their doctor and now they are losing their hospital.

Chairman CAMP. All right. Thank you.

Mr. Schock.

Mr. SCHOCK. Thank you, Mr. Chairman.

Welcome, Madam Secretary.

Yesterday, the House of Representatives passed a bill dealing with the Affordable Care Act that clarifies the religious exemption clause for a small segment of the population who, on their annual tax return, will have to basically verify that their religious conscience prohibits them from participating in traditional health care here in our country.

This is modeled after a law that the State of Massachusetts put into effect. In the State of Massachusetts, since 2006, only 6,000 residents have taken advantage of it, primarily Christian Scientists and others.

The bill passed out of the House yesterday unanimously. It is now headed to the Senate, where it enjoys bipartisan support—Senators Ayotte, Schatz, Durbin, Bernie Sanders.

And I am just wondering if you could speak to whether or not you support this clarification in the religious exemption clause?

Secretary SEBELIUS. Congressman, I haven't read the language, but I will take a strong look at it. And I do know that it passed yesterday, but I haven't read the bill.

Mr. SCHOCK. Will you get back to us with your opinion on it?

Secretary SEBELIUS. Sure.

Mr. SCHOCK. Okay. Thank you.

My second question has to do with the Administration's change in, or HHS's change in how you are handling the appeals process for Medicare providers. The Office of Medicare Hearings and Appeals has recently taken the unprecedented and unorthodox step in no longer accepting Medicare appeals for processing at the administrative law judge level.

Obviously, I am concerned about the current healthcare providers and current seniors who could be denied reimbursement, what effect that will have downstream, if you will, if they are not allowed their due process.

And then, of course, if we fast-forward into the implementation of the Affordable Care Act, if we set the precedent that HHS says we are not going to allow due process for current Medicare recipients, one would then assume perhaps that would be a practice that the agency would do for folks on the ACA.

Are you working through that? Do you see the Administration standing firm in not allowing due process on the appeals?

Secretary SEBELIUS. Congressman, this is a major problem and issue. And I know that our head of the Office of Medicare Appeals has been here on the Hill briefing, in a bipartisan nature, both the House and the Senate just on what has happened over the last couple of years.

It is my understanding—and I don't want to misspeak, but I will tell you what my understanding is, and if it is incorrect, I will correct it immediately—that their initial decision to suspend hearings

was not for beneficiaries but for hospitals and providers. So they were very concerned that beneficiaries not get caught in this——

Mr. SCHOCK. Right.

Secretary SEBELIUS [continuing]. Huge queue and go to the back of the line.

In the meantime, they are looking at the whole array of systems which could alleviate the queue. The volume has about tripled over the last couple of years. We need to do some system changes. We need to work carefully with Congress. Because the last thing we want to do is have anybody give up their due process rights.

Chairman CAMP. All right. Thank you.

Mr. SCHOCK. Thank you.

Chairman CAMP. Mr. Rangel.

Mr. RANGEL. Thank you.

Madam Secretary, I am convinced that when the final pages of history are written, that your name will be included among the courageous pioneers that have brought health care to all Americans.

There seems to be some concern about the delay in the program. Do you recall when last we had a program for the Nation where all people would have access to health care?

Secretary SEBELIUS. No, sir.

Mr. RANGEL. So that is since the beginning of the Republic?

Secretary SEBELIUS. Yes.

Mr. RANGEL. And so this is the first time.

When we had Social Security, were there delays and legislation necessary to improve it?

Secretary SEBELIUS. Well, I would say both Social Security and Medicare certainly has transformed over time since they have been in place.

Mr. RANGEL. So I understand that the enrollments are going up and that people young and old are applying?

Secretary SEBELIUS. That is correct. We put out information yesterday that, as of the end of February, about 4.2 million people had enrolled in the private market, another almost 9 million have qualified to be Medicaid-eligible, and 3 million young adults got their coverage earlier in the program thanks to their parents' plan.

Mr. RANGEL. And that is young and healthier people, to bring the balance that we need.

Secretary SEBELIUS. Yes, sir.

Mr. RANGEL. Is there any indication that they are all Democrats?

Secretary SEBELIUS. We don't have that information currently.

Mr. RANGEL. Well, is there any reason to believe that Republicans are not in need of health insurance or they don't have preconditions or that they all are insured? Is there any evidence that Republicans will not receive the benefits of the Affordable Care Act?

Secretary SEBELIUS. No, sir.

Mr. RANGEL. Well, in the 50 attempts to derail or to repeal the Affordable Care Act, which has passed the House, the Senate, and has been approved by the Supreme Court, is there any indication from the President if, by some stretch of our imagination, the re-

peal goes through the Senate as to what the President would be inclined to do?

Secretary SEBELIUS. I think he has indicated he would veto a repeal of the Act.

Mr. RANGEL. And so, has there been any suggestions, then, from the Republican leadership, since this is the law of the land and is universal and bipartisan as it relates to the beneficiary, have there been any suggestions from the Republicans as to how we can improve upon this bill—that is, the provision to provide health care for everyone? Have they suggested to you anything that makes sense?

Secretary SEBELIUS. Well, there have been a number of conversations, and I would say some productive conversations. Unfortunately, I think the suggestions of how to improve are often tied to suggestions of——

Mr. RANGEL. Well, Madam Secretary——

Secretary SEBELIUS [continuing]. How to repeal.

Chairman CAMP. All right. Time has expired. And I would just say——

Mr. RANGEL. Oh, that is terrible——

Chairman CAMP [continuing]. There have been suggestions——

Mr. RANGEL [continuing]. Because I wanted to congratulate the Chair, and I will insist on congratulating him, as being a part of that Republican Party that has tried to be constructive on legislation. And I thank you——

Chairman CAMP. Well, thank you.

Mr. RANGEL [continuing]. For your courtesy.

Chairman CAMP. There is always time for that.

We are just down to Mr. Levin and myself. And I just want to return to this issue about how many individuals have paid their first month's premiums. And I realize that you have repeatedly said under questioning that you don't have that information yet.

But I just want to make the point that we are 2 weeks away from the end of the 6-month open enrollment. And, you know, I know there has been—you know, HHS has spent $2 billion building these exchanges. And your own budget document states, and I quote, "CMS administers the insurance affordability programs on behalf of all marketplaces. This process involves receiving enrollment information from marketplaces, including the level of APTC selected to calculate and distribute monthly aggregate payments to issuers for APTC and CSR owed."

But given all the time and the critical need that your own department has for this basic information, I think it is just absolutely critical that we find a way to get this information.

And there are reports that up to 20 percent of individuals who have selected plans have not actually paid their premiums. And I don't know if this is in line with what you are seeing. Do you have any information along that line about, is the 20 percent in line with what you have been finding out?

Secretary SEBELIUS. I think, again, Mr. Chairman, the 20-percent number came from insurance companies, if I recall, about the first of the year, where they were heartened by the fact that, even though the deadline for payment of the first month's premium—and many people, if you will, enrolled for the first time in Decem-

ber, and we have had, kind of, 3 months of strong enrollment—they were heartened by the fact that they had about an 80-percent payment rate.

But, again, that did not come from us. We will eventually, when the fully automated financial system is in place, have that information and be glad to share it with the Committee on a real-time basis. We just don't have it right now.

Chairman CAMP. Well, and I think there is such an interest in this for one reason, that we know that at least one and—that you have made at least one, and you are about to make the second payment to insurers for the premium tax credits and cost-sharing subsidies.

Secretary SEBELIUS. Yes, sir.

Chairman CAMP. And so these payments reflect what insurers are telling you about how many people have paid their premiums.

Secretary SEBELIUS. They are an aggregate number based on only those customers who would be qualified for either cost-sharing or APTC. And that is not at all the entire look of the marketplace.

So we don't even have any information at this point, even in aggregate. We don't have individual information about the group that is premium tax credit. And the insurance companies, to get paid month two, just restated the first month, as an indication that they did not have the full information.

So we are getting aggregate data about a portion of the marketplace and not individual data about customers.

Chairman CAMP. Well, unless they have paid their first month's premium, they can't get a premium tax credit.

Secretary SEBELIUS. That is correct.

Chairman CAMP. And so, obviously, that is in the jurisdiction of this Committee. We are very interested to make sure that that is being used. And my——

Secretary SEBELIUS. And we are, too. And we will be trueing up with insurance companies a person at a time. We just don't have that at this particular point.

Chairman CAMP. Have you asked the insurers for this information?

Secretary SEBELIUS. We have. We are working, Mr. Chairman, on the automated system, which, at the end of the day, the 834, which is the process by which we send to the insurance company from the website Chairman Camp's name and that he wants to enroll in Blue Cross of Michigan, and there will be a process where they will send back the confirmed 834 that Chairman Camp paid his premium, and that will be the end of the loop. Currently, that part of the process is not in place.

Chairman CAMP. Is there a coordination between the agencies on this? Because, obviously, some of this is administered between IRS and Treasury. Are you coordinating? I know in answer to some other questions you mentioned that some of this is involving more than one agency. So are IRS and Treasury——

Secretary SEBELIUS. Well, as in most bills, Treasury basically pays the bills. And they pay them based on a system of our presenting them with information, much the way Medicare bills are paid.

Chairman CAMP. All right.

Mr. Levin, and then we will conclude.

Mr. LEVIN. Thank you.

Well, welcome.

I just want to ask that there be entered into the record, Mr. Chairman, three documents relating to the Medicare Advantage rates: one from the Secretary to the Speaker, one an article from the *New York Times*, and one a letter from beneficiary groups.

Chairman CAMP. Without objection, they will be entered into the record.

Mr. LEVIN. And I also ask that the CBO table on 4015 that will be coming up in the next couple days, with your amendment, showing that about 13 million people more would be uninsured, I ask that be entered into the record also.

Chairman CAMP. Without objection, as well.

Mr. LEVIN. Thank you.

Chairman CAMP. Well, with that, again, I thank you for your time this morning and——

Secretary SEBELIUS. Yes, sir.

Chairman CAMP [continuing]. Appreciate that.

With that, this hearing is now adjourned.

[Whereupon, at 12:25 p.m., the Committee was adjourned.]

[Submissions for the Record follow:]

DHHS Secretary- "We Bear Part of the Responsibility" for Health Care Confusion
BRIAN WILLIAMS, anchor:
Now to the other big story of the day the other big deadline at midnight, the new health care law at the center of the showdown in Congress. A big part of that law will start to take effect tomorrow when people without health insurance can sign up to buy coverage. But our new poll with the Kaiser Family Foundation shows 70% say they are very or somewhat worried. They'll have to pay more for their health care or health insurance. And 62% of those without insurance say they are confused about this new law. Our Chief Medical Editor Doctor Nancy Snyderman sat down for an exclusive interview with the woman in charge today, Health and Human Services Secretary Kathleen Sebelius.
DOCTOR NANCY SNYDERMAN, reporting:
With all the run-up time to the eve of this, why the confusion today and why not more enthusiasm?
KATHLEEN SEBELIUS (Health and Human Services Secretary): Well, I think it still isn't real for a lot of people. And there is a lot of confusion about it.
DR. SNYDERMAN: Is that your fault?
SEBELIUS: I think we bear part of the responsibility of-- of not being able to get through a lot of the noise.
DR. SNYDERMAN: One of the big concerns is that as the numbers have been tossed out there. And we really don't know how things are going to fall and that the middle class may really take out it on the chin.
SEBELIUS: The middle class I would say depending on where that middle-class employee worked has been taking it on the chin.
DR. SNYDERMAN: But when the President says this is the cost of your cable bill or your cell phone bill. That's not quite true.
SEBELIUS: Well, six out of 10 people will have the choice if they choose to make it, the choice of a policy for under $100.
DR. SNYDERMAN: But the backend hurts.
SEBELIUS: It's a debate. Do you want to have protection for basically every check-up, every visit, everything that you do or do you have a situation where you are making a determination where you and your family don't use medical services that much and you want to make sure you have protection if something really goes terribly wrong.
DR. SNYDERMAN: But is it conceivable to you that the number of a 5,000 under $6,000 deductible for a middle class family is a reasonable feasible number?
SEBELIUS: Well, I think that families can make a budget choice. If that isn't something that clearly they can pay for and a lot of people couldn't pay for that out of pocket. They will want a lower deductible.
DR. SNYDERMAN: What does success look like?
SEBELIUS: Well, I think success looks like at least seven million people having signed up by the end of March 2014.
DR. SNYDERMAN: This is coming tomorrow. People without insurance can start signing up to buy it. Tomorrow, October 1st, the benefits then will kick in January 1st 2014. And you will have until March 31st of next year to enroll. I think a lot of people will start to look-- start looking at healthcare.gov where you can look at the

marketplace in your own state and then explore your options for your own coverage. There are a lot of options out there. I think people are going to be a little overwhelmed, Brian, when they start to see what this new marketplace looks like.
WILLIAMS: What a time beginning with this 24 hour period. Doctor Nancy Snyderman, thank you as always.
DR. SNYDERMAN: You bet.

The Irony of ObamaCare:

Making Inequality Worse

UNITEHERE!

The Irony of ObamaCare: Making Inequality Worse

The promise of Obamacare was the right one and the hope for extending healthcare coverage to the un-and under-insured a step in the right direction. Yet the unintended consequences will hit the average, hard-working American where it hurts: in the wallet. Currently a national dialogue is emerging by all political parties on the issue of income inequality. That is a debate worth having. The White House and Congressional Democrats are "resetting" the domestic agenda following the negative fallout from the rollout of the ACA. They plan to shift focus from health care to bread and butter issues of income inequality that have eroded the American paycheck for decades.

> Obama Presses Case for Health Law and Wage Increase
>
> —*New York Times,* December 4, 2013

Ironically, the Administration's own signature healthcare victory poses one of the most immediate challenges to redressing inequality. Yes, the Affordable Care Act will help many more Americans gain some health insurance coverage, a significant step forward for equality. At the same time, without smart fixes, the ACA threatens the middle class with higher premiums, loss of hours, and a shift to part-time work and less comprehensive coverage.

- **Transferring A Trillion Dollars in Wealth:** Most of the ACA's $965 billion in subsidies will go directly to commercial insurance companies, one of the largest transfers of public wealth to private hands ever. Since the ACA passed, the average stock price of the big for-profit health insurers doubled, their top executives were paid more than a half billion dollars in cash and stock options, and in the past 2 years, the top 10 insurers have spent $25 billion on mergers and acquisitions.
- **Strangling Fair Competition:** Before reform, different types of health plans were regulated under different bodies of law. The Obama Administration has blocked many non-profit health funds from competing for the law's proposed trillion dollars in subsidies by refusing to set fair regulations for different types of plans. The unbalanced playing field will give employers of people covered by these plans powerful incentives to drop coverage.
- **Moving to Part Time Work:** The Administration's experts say employers won't follow the incentives and drop coverage. But they also told the nation that employers would not cut workers' hours to get below the 30-hour per week threshold for "full time" work, even as 388 employers announced hours cuts since early 2012.
- **Cutting People's Pay:** If employers follow the incentives in the law, they will push families onto the exchanges to buy coverage. This will force low-wage service industry employees to spend $2.00, $3.00 or even $5.00 an hour of their pay to buy similar coverage.

A Trillion Dollar Wealth Transfer

$965 Billion: Projected insurance subsidies under Obamacare, 10 years

$25.4 Billion: Mergers and acquisitions by top 10 health insurers last 2 years

$548.4 Million: Cash and stock options to 32 execs of Big 5 for-profit insurers since Obamacare[3]

45: States with two health insurers controlling 50+% of the market[4]

0: Likely anti-trust enforcement actions against health insurers. ACA preserved their exemption from federal laws.

The Congressional Budget Office projects that the federal government will spend at least $965 billion in subsidies to make coverage purchased through the new online marketplaces affordable.[1] Nearly all of that money will go directly to health insurance companies, one of the largest transfers of wealth from public to private hands in history. This is the heart of the ACA — subsidies to persuade health insurers to make their products affordable to new customers.

Even before subsidy checks, the ACA is benefiting for-profit health insurers. The average share prices of the top 5 for-profits — Wellpoint, United, Aetna, Cigna, Humana — have more than doubled since the March 23, 2010 passage of the ACA. At a time of record stock prices, the Big 5's aggregate share prices have increased almost twice as fast as the Standard and Poor's 500 index of blue chip stocks.[2]

For-Profit Health Insurance Stocks Since Obamacare

"We continue to believe that public exchanges can represent a longer-term upside opportunity."

—Aetna CEO Mark J. Bertolini, *New York Times,* October 26, 2013

Strangling Fair Competition

For decades, unions and their employers have provided affordable comprehensive benefits to employees through "Taft-Hartley" plans. Named for the anti-union law passed in 1947, these benefit funds are governed by a separate regulatory scheme from commercial insurers, and are a non-profit market counterweight to the for-profit companies. Their joint union-management governance structure gives patients a unique democratic voice in plan governance.

These plans face extinction because the Obama Administration's regulators have saddled them with all of the regulatory burdens but none of the benefits of health reform. Three key problems combine to drive a potential five-year death spiral:

An Example, UNITE HERE Health

2013:

- **Bad Actors Rewarded, Good Actors Punished:** Like all plans, Taft-Hartleys have eliminated lifetime limits on coverage and now cover dependents until 26 years of age. New ACA rules prohibit plans not already charging a premium for dependents from going back and imposing one. So plans that achieved efficiencies through providing good health care prior to reform are punished. Plans that "solved" financial problems by increasing employee costs before reform are rewarded by continuing to charge high premiums and cost sharing.
- **Employers respond to perverse incentives.** A year before implementation of the employer mandate:
  - **Cutting hours.** Close to 400 employers announce plans to cut workers' hours back to less than 30 to stay below the 50-worker full-time threshold, more than a year in advance of the employer mandate.
  - **Dropping coverage:** The IRS arbitrarily defined "affordability" as only applying to employees. In response, UPS and other major employers eliminate coverage for working spouses.

2014:

- **Exchanges open.** Self-funded plans including Taft-Hartleys are prohibited from offering plans to the public.
- **Subsidies begin to flow.** First of a trillion tax dollars moves to commercial insurers.
- **"Belly Button Tax" imposed.** All plans pay $63 per head to ease the transition for insurers offering on the exchanges.
  - Aetna, Cigna, United, Wellpoint, Humana and the Big Blues can recoup their taxes because they can offer plans on the exchanges.
  - Taft-Hartleys and self-funded plans can only pay.

- Employer penalties for dropping coverage are far smaller than the cost of providing coverage — even though many Taft-Hartleys plans cost far less than the market.
- Only plans that offer coverage on the exchanges can receive subsidies.
- Self-funded plans like Taft-Hartleys are not permitted to offer plans to the public, and the Administration has refused to find a way to allow them to do so.

Taft-Hartley plans are entering a skewed marketplace facing competition with multibillion dollar insurers poised to pocket a trillion tax dollars over the next decade. Looking down the road, these plans face an accelerating slide down this uneven playing field:

2015:

- **Employer mandate begins.** Employers must choose: pay $8,000–$12,000 per employee for coverage, or cut coverage and pay a $2,000 per employee fine. Hospitality industry economics create a strong temptation to dump lower-income employees.
- **Employee income declines.** For dropped employees, being pushed onto the exchanges will mean a major loss of income or health benefits. Families moving to the exchanges may lose between 4% and 25% of income to maintain equivalent benefits.

2016-2017:

- **Pressure to drop intensifies.** The cumulative effect of unsubsidized mandates on Taft-Hartley plans will escalate the gap between the cost of benefits and the penalties, raising pressure to drop.
- **States allowed to form interstate compacts for commercial insurers.** This will give commercial insurers the ability to sell the same products in multiple states, as self-insured plans can, with no reciprocal access to subsidies for the self-insureds. Unequal competition intensifies..
- **"Cadillac tax" implemented.** Without subsidies or the ability to tweak premium shares, and with the new mandates raising costs, plans face fatal taxation of 40% of the value of the plan.

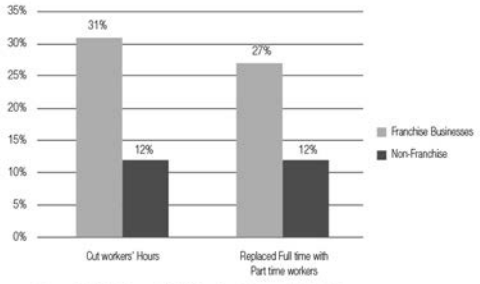
Part Time America: Test Case for Dropping Coverage

Many experts sympathetic to the Obama Administration say employers will not dump coverage in large numbers. Yet Obama Administration officials also frequently say that employers will not respond to the ACA's requirement that employers with more than 50 full time employees provide coverage for everyone working more than 30 hours per week.

Yet polling commissioned by the U.S. Chamber of Commerce and the International Franchise Association found that nearly a third of U.S. franchise businesses have already cut workers' hours, and more than a quarter of franchisers have replaced full time with part time workers. A majority of businesses close to the 50-worker employer mandate threshold said they planned personnel moves to stay below 50 full time workers.[5]

Investors.com, website of *Investors Business Daily*, has documented 388 public announcements of plans to reduce workers' hours or cut jobs since early 2012, and several large businesses have eliminated health insurance for part time workers, providing a counterpoint to the Administration's reassuring statements.

A Year Before Employer Mandate, Businesses have already:



Source: Public Opinion Strategies for US Chamber of Commerce, Int'l Franchise Assn https://www.uschamber.com/sites/default/files/legacy/reports/IFAChamberFinal.pdf

The Congressional Budget Office now estimates that the ACA will reduce the annual hours worked in the economy from between 1.5% and 2.0% through 2024, the equivalent of losing 2 – 2.5 million full time jobs. The CBO says this will happen primarily because workers will choose to work less. If those estimates are correct, the ACA's impact could be much worse than the CBO's new prediction. Polling and a long list of announced job and benefit cuts suggest that employer behavior is reducing jobs and hours, too.

Cap and Cut: Employers Respond to Obamacare

Investors.com: Feb. 1, 2012 – July 15, 2013	**244** articles, announcements, public notices and hearing records of employers planning to cut workers' hours or benefits, or hire part time instead of full time workers
Obama Administration: July 15 (Press Secretary Jay Carney)	*"[I]f you look at the economic data, the suggestion that the ACA is reducing full-time employment is belied by the facts."*[6]
Investors.com: July 16-August 1	**23** additional reports of hours cuts in just two weeks, including 140 workers at Central Michigan University and 37 in Brevard County FL.
Obama Administration: August 1 (CMS Director Marilyn Tavenner)	*"I do hear isolated incidents of individuals trying to cut back hours. I've been all across this country. I actually talked to over 1,000 small businesses in Miami a couple months ago, and . . . they're trying to learn about the law and see if they can make it work for them."*[7]
Investors.com: August 2 – August 13, 2013	**10** more reports in the next 11 days, including 50 Maine Subway workers limited to less than thirty hours.
Obama Administration: August 13 (Jason Furman, Chairman, Council of Economic Advisers)	*"We are seeing no systematic evidence that the Affordable Care Act is having an adverse impact on job growth or the number of hours employees are working."*[8]
Investors.com: August 14 – October 22, 2013	**61** further reports in the ensuing 7 weeks, including national retail chain Forever 21 reducing the hours of 300 workers to 29.5 per week.
Obama Administration: October 22 (Press Secretary Jay Carney)	*"The percentage of full-time jobs versus part-time jobs has been at the level of previous recoveries or greater than previous recoveries, again, disproving a charge that seems to be made regularly unchallenged."*[9]
Investors.com: October 23 – December 31, 2013	**42** more reports, including retail giant Staples' decision to cap the weekly hours of 35,067 part time workers at 25,[10] sparking a national furor.[11]

"Experts predict more employers in industries with large numbers of part-time workers will make similar decisions to keep costs low.... 'Employers who employ a lot of unskilled [workers] will more often eliminate benefits,' said Robert Laszewki, a healthcare industry consultant."

—*LA Times* 1/23/2014, reporting Target's announcement that it will drop coverage for up to 36,000 part time workers.

Obamacare and Inequality: UNITE HERE Example

UNITE HERE represents 300,000 workers in hotels, food service and gaming nationwide. Many receive benefits through UNITE HERE Health's Taft-Hartley funds. If employers follow the incentives in Obamacare, the hospitality industry will face labor strife, UNITE HERE members from around the nation will face pay cuts to keep good coverage, and the funds that deliver innovative care to thousands of service workers will be destroyed.

For example, The *New York Daily News* described how the New York Hotel-Motel Trades Council plan offers "platinum" coverage at "silver" prices:

> "[w]ith industry financing, the hotel workers union has operated health-care clinics for some six decades. The network includes 200 doctors and provides full ambulatory medical, dental, optical and pharmaceutical services at five locations in Manhattan, Brooklyn and Queens.
>
> "The health plan contracts with an additional 200 doctors to provide specialized care and services. As a result, the union's medical coverage costs about one-third of what other employers pay to buy health insurance."

Angela Portillo
Guest Room Attendant
Mandalay Bay Resort, Las Vegas
Married
Household Income $61,000
(393% federal poverty level)

"Housekeeping is a tough job—many of us suffer serious injuries doing this work. And ObamaCare would cause my husband and I even more pain. The Obamacare website says we would have to pay $8,057.04 a year more to keep the great insurance we have now. That's a $3.87 per hour pay cut. We work hard for our insurance. Why should we have to take a cut in pay for it?"

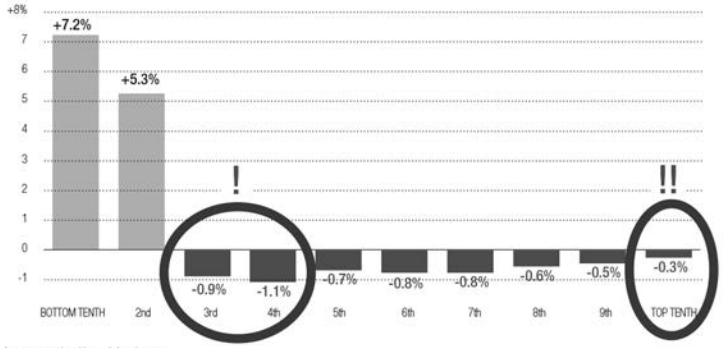
Earl Baskerville
50 year old food service worker,
University of Hartford, CT
Household Income: $45,000
(392% federal poverty level)
Single

"The health care crisis hit our workplace hard. We tried three different plans in a three year contract. When the for-profit insurance companies were going through the roof, we switched to our union's plan to keep good benefits. But Obamacare will give government money to those plans and not ours. Obamacare would cost me $4,855.20 a year more, or a $2.33 an hour pay cut. That's not right. We just want to be treated like everyone else."

Does Washington Understand Inequality?

The Associated Press headline for a new Brookings Institution study says that the ACA will have a "Big Impact on Income Gap." People in the bottom two tenths of the income distribution would see average gains of 5.3% and 7.2% from the ACA. But take a close look at Brookings' graph. Families in the next lowest 20% (family income $20,000 to $38,000) would suffer significant income declines to achieve these gains. Meanwhile, the top ten percent would give up the smallest percentage of income. Only in Washington could asking the bottom of the middle class to finance health care for the poorest families be seen as reducing inequality.

Change in average income under the Affordable Care Act, by income decile



Learn more at brookings.edu/aca-income

Arturo Marquez
Cook, Hotel Vitale, San Francisco CA
Single Father, 2 children
Household Income $44,000 (225% federal poverty level)

"I'm a single dad and need every penny for my kids. The best deal Obamacare could offer me would take $1,908 more than our union plan. That's like a dollar an hour pay cut. If I get really sick and wind up in the hospital, they can charge me $3,700 more out of pocket. I can't imagine taking care of my son and daughter while taking a $2.70 an hour pay cut."

Conclusion

For two years, labor unions and employer partners have patiently explained to the Obama Administration and Congress the potential damage that the ACA poses to these unique, successful non-profit health plans.

Having already made efforts to accommodate businesses, churches and congressional staff, it is ironic that the Administration is now highlighting issues of economic inequality without acting to preserve health plans that have been achieving the goals of the ACA for decades. Without a smart fix, the ACA will heighten the inequality that the Administration seeks to reduce.

We take seriously the promise that "if you like your health plan, you can keep it. Period." UNITE HERE members like their health plans. UNITE HERE's plans are ready to compete with the corporate giants of the health insurance industry if Washington will simply create a level playing field.

Endnotes

1 Congress of the United States, Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2013 to 2023*, May 2013. ["CBO Baseline"]
2 Yahoo Finance Historical Share Prices. Weekly closing prices for United Healthcare, Aetna, Cigna, Humana and Wellpoint were downloaded along with the S&P 500 index from March 23, 2010 through November 26, 2013. The prices on March 23, 2010 for all six data sets were indexed to 100, and the five company share prices averaged. Four of the five exceeded the S&P 500, one of the five, Wellpoint, slightly underperformed the index, increasing 48.5% over the period measured. The indexed prices for the other four individual companies: United: 227; Aetna: 200.47; Cigna: 245.63; Humana: 219.24.
3 SEC Schedules 14A for United HealthGroup Incorporated, Aetna Inc., Cigna Corporation, Wellpoint, Inc., and Humana, Inc., 2011, 2012, 2013
4 "AMA Analysis Lists States Where One Private Health Insurer Rules", http://www.ama-assn.org/ama/pub/news/news/2013/2013-11-07-study-anticompetitive-market-conditions.page
5 http://pos.org/documents/ifa-chamber_survey_findings.pdf
6 http://thehill.com/blogs/healthwatch/health-reform-implementation/311393-carney-suggestion-obamacare-prevents-full-time-hiring-belied-by-the-facts
7 http://www.reuters.com/article/2013/08/01/net-us-usa-healthcare-tavenner-idUSBRE96U1F520130801
8 http://investigations.nbcnews.com/_news/2013/08/13/20010062-businesses-claim-obamacare-has-forced-them-to-cut-employee-hours?lite
9 http://www.mediaite.com/online/jay-carney-september-jobs-report-disproves-anti-obamacare-part-time-jobs-talking-point/
10 http://www.buzzfeed.com/sapna/staples-accused-of-cutting-employee-hours-ahead-of-obamacare
11 http://www.change.org/Staples

APPENDIX

C

Labor Market Effects of the Affordable Care Act: Updated Estimates

Overview

The baseline economic projections developed by the Congressional Budget Office (CBO) incorporate the agency's estimates of the future effects of federal policies under current law. The agency updates those projections regularly to account for new information and analysis regarding federal fiscal policies and many other influences on the economy. In preparing economic projections for the February 2014 baseline, CBO has updated its estimates of the effects of the Affordable Care Act (ACA) on labor markets.[1]

The ACA includes a range of provisions that will take full effect over the next several years and that will influence the supply of and demand for labor through various channels. For example, some provisions will raise effective tax rates on earnings from labor and thus will reduce the amount of labor that some workers choose to supply. In particular, the health insurance subsidies that the act provides to some people will be phased out as their income rises—creating an implicit tax on additional earnings—whereas for other people, the act imposes higher taxes on labor income directly. The ACA also will exert conflicting pressures on the quantity of labor that employers demand, primarily during the next few years.

How Much Will the ACA Reduce Employment in the Longer Term?

The ACA's largest impact on labor markets will probably occur after 2016, once its major provisions have taken full effect and overall economic output nears its maximum sustainable level. CBO estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive. Because the largest declines in labor supply will probably occur among lower-wage workers, the reduction in aggregate compensation (wages, salaries, and fringe benefits) and the impact on the overall economy will be proportionally smaller than the reduction in hours worked. Specifically, CBO estimates that the ACA will cause a reduction of roughly 1 percent in aggregate labor compensation over the 2017–2024 period, compared with what it would have been otherwise. Although such effects are likely to continue after 2024 (the end of the current 10-year budget window), CBO has not estimated their magnitude or duration over a longer period.

The reduction in CBO's projections of hours worked represents a decline in the number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024. Although CBO projects that total employment (and compensation) will increase over the coming decade, that increase will be smaller than it would have been in the absence of the ACA. The decline in full-time-equivalent employment stemming from the ACA will consist of some people not being employed at all and other people working fewer hours; however, CBO has not tried to quantify those two components of the overall effect. The estimated reduction stems almost entirely from a net decline in the amount of labor that workers choose to supply, rather than from a net drop in businesses' demand for labor, so it will appear almost entirely as a reduction in labor force participation and in hours worked relative to what would have occurred otherwise

1. As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

rather than as an increase in unemployment (that is, more workers seeking but not finding jobs) or underemployment (such as part-time workers who would prefer to work more hours per week).

CBO's estimate that the ACA will reduce employment reflects some of the inherent trade-offs involved in designing such legislation. Subsidies that help lower-income people purchase an expensive product like health insurance must be relatively large to encourage a significant proportion of eligible people to enroll. If those subsidies are phased out with rising income in order to limit their total costs, the phaseout effectively raises people's marginal tax rates (the tax rates applying to their last dollar of income), thus discouraging work. In addition, if the subsidies are financed at least in part by higher taxes, those taxes will further discourage work or create other economic distortions, depending on how the taxes are designed. Alternatively, if subsidies are not phased out or eliminated with rising income, then the increase in taxes required to finance the subsidies would be much larger.

CBO's estimate of the ACA's impact on labor markets is subject to substantial uncertainty, which arises in part because many of the ACA's provisions have never been implemented on such a broad scale and in part because available estimates of many key responses vary considerably. CBO seeks to provide estimates that lie in the middle of the distribution of potential outcomes, but the actual effects could differ notably from those estimates. For example, if fewer people obtain subsidized insurance coverage through exchanges than CBO expects, then the effects of the ACA on employment would be smaller than CBO estimates in this report. Alternatively, if more people obtain subsidized coverage through exchanges, then the impact on the labor market would be larger.

Why Will Those Reductions Be Smaller in the Short Term?

CBO estimates that the ACA will cause smaller declines in employment over the 2014–2016 period than in later years, for three reasons. First, fewer people will receive subsidies through health insurance exchanges in that period, so fewer people will face the implicit tax that results when higher earnings reduce those subsidies. Second, CBO expects the unemployment rate to remain higher than normal over the next few years, so more people will be applying for each available job—meaning that if some people seek to work less, other applicants will be readily available to fill those positions and the overall effect on employment will be muted. Third, the ACA's subsidies for health insurance will both stimulate demand for health care services and allow low-income households to redirect some of the funds that they would have spent on that care toward the purchase of other goods and services—thereby increasing overall demand. That increase in overall demand while the economy remains somewhat weak will induce some employers to hire more workers or to increase the hours of current employees during that period.

Why Does CBO Estimate Larger Reductions Than It Did in 2010?

In 2010, CBO estimated that the ACA, on net, would reduce the amount of labor used in the economy by roughly half a percent—primarily by reducing the amount of labor that workers choose to supply.[2] That measure of labor use was calculated in dollar terms, representing the approximate change in aggregate labor compensation that would result. Hence, that estimate can be compared with the roughly 1 percent reduction in aggregate compensation that CBO now estimates to result from the act. There are several reasons for that difference: CBO has now incorporated into its analysis additional channels through which the ACA will affect labor supply, reviewed new research about those effects, and revised upward its estimates of the responsiveness of labor supply to changes in tax rates.

Effects of the ACA on the Supply of Labor

CBO anticipates that the ACA will lead to a net reduction in the supply of labor. In the agency's judgment, the effects will be most evident in some segments of the workforce and will be small or negligible for most categories of workers. (The ACA also will slightly affect employers' demand for labor, as discussed below, and the total effect on labor use will consist of the combined effects on supply and on demand.) In CBO's view, the ACA's effects on labor supply will stem mainly from the following provisions, roughly in order of importance:

2. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- The subsidies for health insurance purchased through exchanges;
- The expansion of eligibility for Medicaid;
- The penalties on employers that decline to offer insurance; and
- The new taxes imposed on labor income.

Some of those provisions will reduce the amount of labor supplied by some workers; other provisions will increase the amount of labor supplied by other workers. Several provisions also will combine to affect retirement decisions.

The ACA also could alter labor productivity—the amount of output generated per hour of work—which in turn would influence employment (for example, by affecting workers' health or firms' investments in training of workers). The effects on productivity could be positive or negative, however, and their net impact is uncertain, so they are not reflected in CBO's estimates of labor supply or demand. Because the ACA could affect labor markets through many channels, with substantial uncertainty surrounding the magnitude of the effects and their interactions, CBO has chosen not to report specific estimates for each of the channels encompassed by its analysis.

Effects of Insurance Subsidies on the Supply of Labor

Beginning in 2014, many people who purchase insurance through exchanges will be eligible for federal tax credits to defray the cost of their premiums, and some also will be eligible for cost-sharing subsidies to reduce out-of-pocket expenditures for health care. Those subsidies are largest for people whose income is near the federal poverty guideline (also known as the federal poverty level, or FPL), and they decline with rising income.[3]

In 2014, for example, a single person or a family whose income is 150 percent of the FPL and is eligible for subsidies will pay 4 percent of their income for a certain "silver" health care plan purchased through an exchange; if their income is 200 percent of the FPL, they will pay 6.3 percent of their income for that plan.[4] An increase in income thus raises the enrollee premium (and reduces the subsidy) both because the percentage-of-income formula applies to a larger dollar amount and because that percentage itself increases. People whose income exceeds 400 percent of the FPL are ineligible for premium subsidies, and for some people those subsidies will drop abruptly to zero when income crosses that threshold. Cost-sharing subsidies also phase out in steps with rising income, declining sharply at 150 percent, 200 percent, and 250 percent of the FPL.

CBO's estimate of the impact that the subsidies will have on labor supply has three components: the magnitude of the incentive, the number and types of people affected, and the degree of responsiveness to the incentive among those who are affected.

The Magnitude of the Incentive to Reduce Labor Supply. For some people, the availability of exchange subsidies under the ACA will reduce incentives to work both through a substitution effect and through an income effect. The former arises because subsidies decline with rising income (and increase as income falls), thus making work less attractive. As a result, some people will choose not to work or will work less—thus substituting other activities for work. The income effect arises because subsidies increase available resources—similar to giving people greater income—thereby allowing some people to maintain the same standard of living while working less. The magnitude of the incentive to reduce labor supply thus depends on the size of the subsidies and the rate at which they are phased out.

The Number and Types of Workers Likely To Be Affected. Subsidies clearly alter recipients' incentives to work and can certainly influence the labor supply of those who would gain eligibility by working and earning slightly less. But most full-time workers do not confront that particular choice—either their income is well above 400 percent of the FPL or they are offered employment-based health insurance and thus are generally ineligible for subsidies regardless of their income. Even so, one line of research indicates that the subsidies will affect the labor supply of many full-time workers with health insurance

3. In 2013, the FPL (which is indexed to inflation) was $11,490 for a single person and $23,550 for a family of four. Calculations of exchange subsidies for 2014 use the 2013 FPL schedule.

4. A silver plan pays about 70 percent of covered health costs, on average. For the second-least-expensive silver plan offered on the exchanges, the premium, net of subsidies, for a family of four in 2014 would be $1,413 at 150 percent of the FPL ($35,325) but would rise to $2,967 at 200 percent of the FPL ($47,100).

from their employer—precisely because they effectively forgo exchange subsidies when they take or keep a job with health insurance.[5] If instead a worker switched to a part-time job, which typically does not offer health insurance, that worker could become eligible for exchange subsidies. In that view, exchange subsidies effectively constitute a tax on labor supply for a broad range of workers.

In CBO's judgment, however, the cost of forgoing exchange subsidies operates primarily as an implicit tax on employment-based insurance, which does not imply a change in hours worked. Instead, the tax can be avoided if a worker switches to a different full-time job without health insurance (or possibly two part-time jobs) or if the employer decides to stop offering that benefit. The consequences of that implicit tax are incorporated into CBO's estimate of the ACA's effect on employment-based coverage—which is projected to decline, on net, by about 4 percent because of the ACA (see Appendix B).[6] Correspondingly, the negative effects of exchange subsidies on incentives to work will be relevant primarily for a limited segment of the population—mostly people who have no offer of employment-based coverage and whose income is either below or near 400 percent of the FPL.

Nonetheless, another subgroup that has employment-based insurance does seem likely to reduce their labor supply somewhat. Specifically, those people whose income would make them eligible for subsidies through exchanges (or for Medicaid), and who work less than a full year (roughly 10 to 15 percent of workers in that income range in a typical year), would tend to work somewhat less because of the ACA's subsidies. For those workers, the loss of subsidies upon returning to a job with health insurance is an implicit tax on working (and is equivalent to an average tax rate of roughly 15 percent, CBO estimates). That implicit tax will cause some of those workers to lengthen the time they are out of work—similar to the effect of unemployment benefits.

Responsiveness of Affected Groups. The implicit taxes that arise from the phaseout of the subsidies have effects on net income that are similar to the effects of direct taxes. With tax changes, however, the income and substitution effects typically work in opposite directions, whereas with the insurance subsidies the income and substitution effects work in the same direction to decrease labor supply.[7] CBO's estimate of the response of labor supply to the subsidies is based on research concerning the way changes in marginal tax rates affect labor supply and on studies analyzing how labor supply responds to changes in after-tax income.[8]

Effects of the Medicaid Expansion on Labor Supply

The ACA significantly increases eligibility for Medicaid for residents of states that choose to expand their programs. In states that adopt the expansion, Medicaid eligibility is extended to most nonelderly residents whose income is below 138 percent of the FPL—including childless adults who previously were ineligible for Medicaid in most states regardless of their income. In states that have not expanded Medicaid, people whose income is between 100 percent and 138 percent of the FPL become eligible for subsidies through the exchanges; in those states, subsidies could decline abruptly if an enrollee's income fell from just above the FPL to just below it (and vice versa). By 2018, CBO expects that around 80 percent of the potentially eligible population will live in states that have expanded Medicaid.

5. See Casey B. Mulligan, *Average Marginal Tax Rates Under the Affordable Care Act*, Working Paper 19365 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19365, and *Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective*, Working Paper 19366 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19366.

6. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), www.cbo.gov/publication/43082.

7. To see how the substitution and income effects can create counteracting pressures on people's willingness to work when tax rates change, consider the case of an increase in tax rates. The resulting reduction in take-home pay for an additional hour of work makes work less valuable relative to other uses of time and encourages people to work less. Reduced after-tax income from a given amount of work, however, encourages people to work more to limit the decline in their standard of living.

8. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674; Robert McClelland and Shannon Mok, *A Review of Recent Research on Labor Supply Elasticities*, Working Paper 2012-12 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43675; and Felix Reichling and Charles Whalen, *Review of Estimates of the Frisch Elasticity of Labor Supply*, Working Paper 2012-13 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43676.

Incentives to Change Labor Supply and Groups Affected. For some people, the ACA's expansion of Medicaid will reduce the incentive to work—but among other people it will increase that incentive. As with exchange subsidies, access to Medicaid confers financial benefits that are phased out with rising income or (more commonly) eliminated when income exceeds a threshold; some people will thus work fewer hours or withdraw from the labor force to become or remain eligible (the substitution effect). Moreover, those financial benefits will lead some people to work less because the increase in their available resources enables them to reduce work without a decline in their standard of living (the income effect).

At the same time, some people who would have been eligible for Medicaid under prior law—in particular, working parents with very low income—will work more as a result of the ACA's provisions. In 2013, the median income threshold for that group's Medicaid eligibility was 64 percent of the FPL (albeit with substantial state-to-state variation). The incentives and groups affected depend on whether a state has adopted the Medicaid expansion (and, in both cases, those incentives are intertwined with the effects of the exchange subsidies):

- In states that have chosen to expand Medicaid, the ACA now allows parents to qualify for Medicaid with income up to 138 percent of the FPL. And if their income rises above that threshold, those parents would generally be eligible for premium tax credits and cost-sharing subsidies for insurance purchased through the exchanges unless they are offered qualified employment-based health insurance. The subsidies will cover a smaller share of enrollees' medical costs than Medicaid would, but under prior law those participants ultimately would have become ineligible for Medicaid and lost all benefits. As a result, some people who would have curtailed their hours of work in order to maintain access to Medicaid under prior law will now be able to increase their hours and income while remaining eligible for subsidized insurance.
- In states that choose not to expand Medicaid, the availability of exchange subsidies also will lead some people to work more. Specifically, some people who would otherwise have income below the FPL will work more so that they can qualify for the substantial exchange subsidies that become available when income is equal to or just above the FPL.

Responses of Affected Groups. A number of studies examining the impact of changes in Medicaid eligibility for parents and children have shown either no effects or small effects on the labor supply of single mothers; effects on two-parent households appear to be somewhat larger, in part because health insurance has stronger effects on the labor supply of secondary earners.[9]

More recently, several studies have examined changes in state policies that affect childless adults—who constitute the majority of those gaining coverage through the Medicaid expansion—and larger effects have been reported. Some reductions in employment are reported among people who have gained Medicaid eligibility, although the findings differ regarding the magnitude and statistical significance of that effect.[10] Similarly, other research shows a rise in employment rates with the withdrawal of Medicaid coverage from childless adults who had previously been turned down for private insurance.[11] Because those studies examined state-level policy initiatives affecting program eligibility—instead of changes in eligibility attributable to income changes, which could merely reflect changes in employment—the results provide some useful insights into the potential effects of the ACA (even though other aspects of the studies raise questions about their applicability to an analysis of the ACA).

Taking that research into account, CBO estimates that expanded Medicaid eligibility under the ACA will, on balance, reduce incentives to work. That effect has a relatively modest influence on total labor supply, however, because the expansion of eligibility for Medicaid primarily affects a relatively small segment of the total population—both because most people's income will

9. See Jonathan Gruber and Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature*, Working Paper 8817 (National Bureau of Economic Research, February 2002), www.nber.org/papers/w8817.

10. See Katherine Baicker and others, *The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment*, Working Paper 19547 (National Bureau of Economic Research, October 2013), www.nber.org/papers/w19547; and Laura Dague, Thomas DeLeire, and Lindsey Leininger, "The Effect of Public Insurance Coverage for Childless Adults on Labor Supply" (draft, March 2013), www.uh.edu/~achin/conference/dague.pdf (950 KB).

11. Craig Garthwaite, Tal Gross, and Matthew J. Notowidigdo, *Public Health Insurance, Labor Supply, and Employment Lock*, Working Paper 19220 (National Bureau of Economic Research, July 2013), www.nber.org/papers/w19220.

significantly exceed the cutoff for Medicaid eligibility and because some low-income people live in states that are not expected to expand Medicaid.

Effects of the Employer Penalty on Labor Supply

Under the ACA, employers with 50 or more full-time-equivalent employees will face a penalty if they do not offer insurance (or if the insurance they offer does not meet certain criteria) and if at least one of their full-time workers receives a subsidy through an exchange. Originally scheduled to take effect in 2014, that penalty is now scheduled to be enforced beginning in 2015. In CBO's judgment, the costs of the penalty eventually will be borne primarily by workers in the form of reductions in wages or other compensation—just as the costs of a payroll tax levied on employers will generally be passed along to employees.[12] Because the supply of labor is responsive to changes in compensation, the employer penalty will ultimately induce some workers to supply less labor.

In the next few years, however, when wages probably will not adjust fully, those penalties will tend to reduce the demand for labor more than the supply. In the longer run, some businesses also may decide to reduce their hiring or shift their demand toward part-time hiring—either to stay below the threshold of 50 full-time-equivalent workers or to limit the number of full-time workers that generate penalty payments. But such shifts might not reduce the overall use of labor, as discussed below.

Effects of Higher Marginal Tax Rates on Labor Supply

To cover part of the cost of the expansion of coverage, the ACA also imposes higher taxes on some people.[13] In particular, the payroll tax for Medicare's Hospital Insurance program has increased by 0.9 percentage points for workers whose earnings are above $200,000 ($250,000 for those filing a joint return).[14] As with other tax increases, those changes will exert competing pressures on labor supply: Lower after-tax compensation will encourage people to work more to make up for the lost income, but the decline in after-tax hourly compensation also will reduce the return on each additional hour of work, thus tending to reduce the incentive to work. On net, CBO anticipates, the second effect will be larger than the first, and the tax will yield a small net reduction in labor supply.

In addition, beginning in 2018, the ACA imposes an excise tax on certain high-cost health insurance plans. CBO expects that the burden of that tax will, over time, be borne primarily by workers in the form of smaller after-tax compensation. Some firms may seek to avoid or limit the amount of the excise tax they pay by switching to less expensive health plans, and in that case workers' wages should rise by a corresponding amount. Those wages will be subject to income and payroll taxes, however, so total tax payments by those workers will be higher than they would have been in the absence of the ACA. After-tax compensation will thus fall whether firms pay the excise tax or take steps to avoid it, and the resulting increases in average and marginal tax rates will cause a slight decline in the supply of labor, CBO estimates.

Under certain circumstances, the ACA also imposes a penalty tax on people who do not have qualified health insurance. That tax is to be phased in over time; by 2016, it will generally be the greater of $695 annually per adult or 2.5 percent of taxable income (each subject to a cap).[15] For people who are subject to the percentage-of-income penalty, that tax discourages work—but CBO estimates

12. By contrast, if employers add health insurance coverage as a benefit in response to the penalty or drop coverage despite it, CBO estimates that their workers' wages will adjust by roughly the employers' cost of providing that coverage—so total compensation would stay about the same and labor supply would not be affected by the change in employer coverage.

13. CBO and the staff of the Joint Committee on Taxation have estimated that, on balance, the ACA will reduce the cumulative deficit over the 2013–2022 period because cuts in other spending more than offset the rest of the cost of the expansion in coverage. Therefore, repealing the ACA would increase budget deficits by a corresponding amount over that period; see Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

14. The ACA has also raised the tax rate on capital income for some higher-income households and imposed taxes on certain goods and services (such as medical devices), but CBO does not expect those provisions to have a noticeable effect on the overall labor market.

15. For families who are subject to the dollar penalty, the penalty per child is one-half the adult penalty, and in 2016 the payment is capped at $2,085; for people who are subject to the percentage-of-income penalty, the tax payment is capped at the average cost of a "bronze" insurance plan (which, on average, covers 60 percent of enrollees' health costs) offered through the exchanges. After 2016, the dollar penalty is indexed to general inflation.

that a relatively small number of workers will be affected. About 6 million workers and dependents will be subject to the penalty tax in 2016, and among the workers who pay it, a large share will be subject to the dollar penalty rather than the percentage-of-income penalty.[16] As a result, CBO estimates that its impact on aggregate labor supply will be negligible.

Effects on Retirement Decisions and Disabled Workers

Changes to the health insurance market under the ACA, including provisions that prohibit insurers from denying coverage to people with preexisting conditions and those that restrict variability in premiums on the basis of age or health status, will lower the cost of health insurance plans offered to older workers outside the workplace. As a result, some will choose to retire earlier than they otherwise would—another channel through which the ACA will reduce the supply of labor.

The new insurance rules and wider availability of subsidies also could affect the employment decisions of people with disabilities, but the net impact on their labor supply is not clear. In the absence of the ACA, some workers with disabilities would leave the workforce to enroll in such programs as Disability Insurance (DI) or Supplemental Security Income (SSI) and receive subsidized health insurance. (SSI enrollees also receive Medicaid; DI enrollees become eligible for Medicare after a two-year waiting period.) Under the ACA, however, they could be eligible for subsidized health insurance offered through the exchanges, and they cannot be denied coverage or charged higher premiums because of health problems. As a result, some disabled workers who would otherwise have been out of the workforce might stay employed or seek employment. At the same time, those subsidies and new insurance rules might lead other disabled workers to leave the workforce earlier than they otherwise would. Unlike DI applicants who are ineligible for SSI, they would not have to wait two years before they received the ACA's Medicaid benefits or exchange subsidies—making it more attractive to leave the labor force and apply for DI.

16. See Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* (September 2012), www.cbo.gov/publication/43628.

Possible Effects on Labor Supply Through Productivity

In addition to the effects discussed above, the ACA could shape the labor market or the operations of the health sector in ways that affect labor productivity. For example, to the extent that increases in insurance coverage lead to improved health among workers, labor productivity could be enhanced. In addition, the ACA could influence labor productivity indirectly by making it easier for some employees to obtain health insurance outside the workplace and thereby prompting those workers to take jobs that better match their skills, regardless of whether those jobs offered employment-based insurance.

Some employers, however, might invest less in their workers—by reducing training, for example—if the turnover of employees increased because their health insurance was no longer tied so closely to their jobs. Furthermore, productivity could be reduced if businesses shifted toward hiring more part-time employees to avoid paying the employer penalty and if part-time workers operated less efficiently than full-time workers did. (If the dollar loss in productivity exceeded the cost of the employer penalty, however, businesses might not shift toward hiring more part-time employees.)

Whether any of those changes would have a noticeable influence on overall economic productivity, however, is not clear. Moreover, those changes are difficult to quantify and they influence labor productivity in opposing directions. As a result, their effects are not incorporated into CBO's estimates of the effects of the ACA on the labor market.

Some recent analyses also have suggested that the ACA will lead to higher productivity in the health care sector—in particular, by avoiding costs for low-value health care services—and thus to slower growth in health care costs under employment-based health plans.[17] Slower growth in those costs would effectively increase workers' compensation, making work more attractive. Those effects could increase the supply of labor (and could increase the demand for labor in the near term, if some of the savings were not immediately passed on to workers).

17. See Council of Economic Advisers, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act* (November 2013), http://go.usa.gov/ZJFJ; and David Cutler and Neeraj Sooj, *New Jobs Through Better Health Care* (Center for American Progress, January 2010), http://tinyurl.com/oc2zdta.

Whether the ACA already has or will reduce health care costs in the private sector, however, is hard to determine. The ACA's reductions in payment rates to hospitals and other providers have slowed the growth of Medicare spending (compared with projections under prior law) and thus contributed to the slow rate of overall cost growth in health care since the law's enactment. Private health care costs (as well as national health expenditures) have grown more slowly in recent years as well, but analysts differ about the shares of that slowdown that can be attributed to the deep recession and weak recovery, to provisions of the ACA, and to other changes within the health sector. Moreover, the overall influence of the ACA on the cost of employment-based coverage is difficult to predict—in part because some provisions could either increase or decrease private-sector spending on health care and in part because many provisions have not yet been fully implemented or evaluated.[18] Consequently, CBO has not attributed to the ACA any employment effects stemming from slower growth of premiums in the private sector.

Effects of the ACA on the Demand for Labor

The ACA also will affect employers' demand for workers, mostly over the next few years, both by increasing labor costs through the employer penalty (which will reduce labor demand) and by boosting overall demand for goods and services (which will increase labor demand).

Effects of the Employer Penalty on the Demand for Labor

Beginning in 2015, employers of 50 or more full-time-equivalent workers that do not offer health insurance (or that offer health insurance that does not meet certain criteria) will generally pay a penalty. That penalty will initially reduce employers' demand for labor and thereby tend to lower employment. Over time, CBO expects, the penalty will be borne primarily by workers in the form of reduced wages or other compensation, at which point the penalty will have little effect on labor *demand* but will reduce labor *supply* and will lower employment slightly through that channel.

Businesses face two constraints, however, in seeking to shift the costs of the penalty to workers. First, there is considerable evidence that employers refrain from cutting their employees' wages, even when unemployment is high (a phenomenon sometimes referred to as sticky wages).[19] For that reason, some employers might leave wages unchanged and instead employ a smaller workforce. That effect will probably dissipate entirely over several years for most workers because companies that face the penalty can restrain wage growth until workers have absorbed the cost of the penalty—thus gradually eliminating the negative effect on labor demand that comes from sticky wages.

A second and more durable constraint is that businesses generally cannot reduce workers' wages below the statutory minimum wage.[20] As a result, some employers will respond to the penalty by hiring fewer people at or just above the minimum wage—an effect that would be similar to the impact of raising the minimum wage for those companies' employees. Over time, as worker productivity rises and inflation erodes the value of the minimum wage, that effect is projected to decline because wages for fewer jobs will be constrained by the minimum wage. The effect will not disappear completely over the next 10 years, however, because some wages are still projected to be constrained (that is, wages for some jobs will be at or just above the minimum wage).

Businesses also may respond to the employer penalty by seeking to reduce or limit their full-time staffing and to hire more part-time employees. Those responses might occur because the employer penalty will apply only to businesses with 50 or more full-time-equivalent employees, and employers will be charged only for each full-time employee (not counting the first 30 employees). People are generally considered full time under the ACA if they work 30 hours or more per week, on average, so

18. Before the ACA was enacted, CBO estimated that the provisions of a similar proposal might cause a small increase or decrease in premiums for employment-based coverage, although that analysis did not take into account the effects of the excise tax on certain high-cost employment-based plans. See Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

19. See, for example, Peter Gottschalk, "Downward Nominal Wage Flexibility: Real or Measurement Error?" *Review of Economics and Statistics*, vol. 87, no. 3 (August 2005), pp. 556–568, http://tinyurl.com/k9bcxss; and Alessandro Brattieri, Susanto Basu, and Peter Gottschalk, *Some Evidence on the Importance of Sticky Wages*, Working Paper 16130 (National Bureau of Economic Research, June 2010), www.nber.org/papers/w16130.

20. As of January 2014, the federal minimum wage was $7.25 per hour. Roughly half of all workers, however, live in states or communities where the minimum wage is higher.

employers have an incentive, for example, to shift from hiring a single 40-hour, full-time employee to hiring two, 20-hour part-time employees to avoid bearing the costs of the penalty.

Such a change might or might not, on its own, reduce the total number of hours worked. In the example just offered, the total amount of work is unaffected by the changes. Moreover, adjustments of that sort can take time and be quite costly—in particular, because of the time and costs that arise in dismissing full-time workers (which may involve the loss of workers with valuable job-specific skills); the time and costs associated with hiring new part-time workers (including the effort spent on interviewing and training); and, perhaps most important, the time and costs of changing work processes to accommodate a larger number of employees working shorter and different schedules. The extent to which people would be willing to work at more than one part-time job instead of a single full-time job is unclear as well; although hourly wages for full-time jobs might be lower than those for part-time jobs (once wages adjust to the penalty), workers also would incur additional costs associated with holding more than one job at a time.

In CBO's judgment, there is no compelling evidence that part-time employment has increased as a result of the ACA. On the one hand, there have been anecdotal reports of firms responding to the employer penalty by limiting workers' hours, and the share of workers in part-time jobs has declined relatively slowly since the end of the recent recession. On the other hand, the share of workers in part-time jobs generally declines slowly after recessions, so whether that share would have declined more quickly during the past few years in the absence of the ACA is difficult to determine.[21] In any event, because the employer penalty will not take effect until 2015, the current lack of direct evidence may not be very informative about the ultimate effects of the ACA.

More generally, some employers have expressed doubts about whether and how the provisions of the ACA will unfold. Uncertainty in several areas—including the timing and sequence of policy changes and implementation procedures and their effects on health insurance premiums and workers' demand for health insurance—probably has encouraged some employers to delay hiring. However, those effects are difficult to quantify separately from other developments in the labor market, and possible effects on the demand for labor through such channels have not been incorporated into CBO's estimates of the ACA's impact.

Effects of Changes in the Demand for Goods and Services on the Demand for Labor

CBO estimates that, over the next few years, the various provisions of the ACA that affect federal revenues and outlays will increase demand for goods and services, on net. Most important, the expansion of Medicaid coverage and the provision of exchange subsidies (and the resulting rise in health insurance coverage) will not only stimulate greater demand for health care services but also allow lower-income households that gain subsidized coverage to increase their spending on other goods and services—thereby raising overall demand in the economy. A partial offset will come from the increased taxes and reductions in Medicare's payments to health care providers that are included in the ACA to offset the costs of the coverage expansion.

On balance, CBO estimates that the ACA will boost overall demand for goods and services over the next few years because the people who will benefit from the expansion of Medicaid and from access to the exchange subsidies are predominantly in lower-income households and thus are likely to spend a considerable fraction of their additional resources on goods and services—whereas people who will pay the higher taxes are predominantly in higher-income households and are likely to change their spending to a lesser degree. Similarly, reduced payments under Medicare to hospitals and other providers will lessen their income or profits, but those changes are likely to decrease demand by a relatively small amount.

The net increase in demand for goods and services will in turn boost demand for labor over the next few years, CBO estimates.[22] Those effects on labor demand tend to be especially strong under conditions such as those now prevailing in the United States, where output is so far below its maximum sustainable level that the Federal Reserve has kept short-term interest rates near zero for several years and probably would not adjust those rates to

21. See Congressional Budget Office, *The Slow Recovery of the Labor Market* (February 2014), www.cbo.gov/publication/45011.

22. For further discussion of CBO's analysis of the economic effects of budgetary policies, see Congressional Budget Office, *Economic Effects of Policies Contributing to Fiscal Tightening in 2013* (November 2012), pp. 2–5, www.cbo.gov/publication/43694.

offset the effects of changes in federal spending and taxes. Over time, however, those effects are expected to dissipate as overall economic output moves back toward its maximum sustainable level.

Why Short-Term Effects Will Be Smaller Than Longer-Term Effects

CBO estimates that the reduction in the use of labor that is attributable to the ACA will be smaller between 2014 and 2016 than it will be between 2017 and 2024. That difference is a result of three factors in particular—two that reflect smaller negative effects on the supply of labor and one that reflects a more positive effect on the demand for labor:

- The number of people who will receive exchange subsidies—and who thus will face an implicit tax from the phaseout of those subsidies that discourages them from working—will be smaller initially than it will be in later years. The number of enrollees (workers and their dependents) purchasing their own coverage through the exchanges is projected to rise from about 6 million in 2014 to about 25 million in 2017 and later years, and most of those enrollees will receive subsidies. Although the number of people who will be eligible for exchange subsidies is similar from year to year, workers who are eligible but do not enroll may either be unaware of their eligibility or be unaffected by it and thus are unlikely to change their supply of labor in response to the availability of those subsidies.

- CBO anticipates that the unemployment rate will remain high for the next few years. If changes in incentives lead some workers to reduce the amount of hours they want to work or to leave the labor force altogether, many unemployed workers will be available to take those jobs—so the effect on overall employment of reductions in labor supply will be greatly dampened.

- The expanded federal subsidies for health insurance will stimulate demand for goods and services, and that effect will mostly occur over the next few years. That increase in demand will induce some employers to hire more workers or to increase their employees' hours during that period.

CBO anticipates that output will return nearly to its maximum sustainable level in 2017 (see Chapter 2). Once that occurs, the net decline in the amount of labor that workers choose to supply because of the ACA will be fully reflected in a decline in total employment and hours worked relative to what would otherwise occur.

Differences From CBO's Previous Estimates of the ACA's Effects on Labor Markets

CBO's estimate that the ACA will reduce aggregate labor compensation in the economy by about 1 percent over the 2017–2024 period—compared with what would have occurred in the absence of the act—is substantially larger than the estimate the agency issued in August 2010.[23] At that time, CBO estimated that, once it was fully implemented, the ACA would reduce the use of labor by about one-half of a percent. That measure of labor use was calculated in dollar terms, representing the change in aggregate labor compensation that would result. Thus it can be compared with the reduction in aggregate compensation that CBO now estimates to result from the act (rather than with the projected decline in the number of hours worked).

The increase in that estimate primarily reflects three factors:

- The revised estimate is based on a more detailed analysis of the ACA that incorporates additional channels through which that law will affect labor supply. In particular, CBO's 2010 estimate did not include an effect on labor supply from the employer penalty and the resulting reduction in wages (as the costs of that penalty are passed on to workers), and it did not include an effect from encouraging part-year workers to delay returning to work in order to retain their insurance subsidies.

- CBO has analyzed the findings of several studies published since 2010 concerning the impact of provisions of the ACA (or similar policy initiatives) on labor markets. In particular, studies of past expansions or contractions in Medicaid eligibility for childless adults have pointed to a larger effect on labor supply than CBO had estimated previously.

23. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- CBO made an upward revision in its estimates of the impact that changes in after-tax wages have on labor supply, reflecting a broad review of the tax literature that has informed several of CBO's estimates and analyses.[24]

CBO's updated estimate of the decrease in hours worked translates to a reduction in full-time-equivalent employment of about 2.0 million in 2017, rising to about 2.5 million in 2024, compared with what would have occurred in the absence of the ACA. Previously, the agency estimated that if the ACA did not affect the average number of hours worked per employed person, it would reduce household employment in 2021 by about 800,000.[25] By way of comparison, CBO's current estimate for 2021 is a reduction in full-time-equivalent employment of about 2.3 million.

The current estimate of the ACA's impact on hours worked and full-time-equivalent employment is considerably higher for two significant reasons.[26] First, as described above, CBO has boosted its estimate of the ACA's effect on aggregate labor compensation in the economy from about 0.5 percent to about 1 percent. Second, CBO has increased its estimate of the effect of a given reduction in aggregate compensation under the ACA on hours worked. CBO's earlier estimate was based on a simplifying assumption that affected workers would have average earnings—in which case the percentage reductions in compensation and hours worked would be roughly the same. However, people whose employment or hours worked will be most affected by the ACA are expected to have below-average earnings because the effects of the subsidies that are available through exchanges and of expanded Medicaid eligibility on the amount of labor supplied by lower-income people are likely to be greater than the effects of increased taxes on the amount of labor supplied by higher-income people. According to CBO's more detailed analysis, the 1 percent reduction in aggregate compensation that will occur as a result of the ACA corresponds to a reduction of about 1.5 percent to 2.0 percent in hours worked.

The reduction in full-time-equivalent employment that CBO expects will arise from the ACA includes some people choosing not to work at all and other people choosing to work fewer hours than they would have in the absence of the law; however, CBO has not tried to quantify those two components of the overall effect. Because some people will reduce the amount of hours they work rather than stopping work altogether, the number who will choose to leave employment because of the ACA in 2024 is likely to be substantially less than 2.5 million. At the same time, more than 2.5 million people are likely to reduce the amount of labor they choose to supply to some degree because of the ACA, even though many of them will not leave the labor force entirely.

24. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674.

25. See testimony of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health of the House Energy and Commerce Committee, *CBO's Analysis of the Major Health Care Legislation Enacted in 2010* (March 30, 2011), pp. 31–33, www.cbo.gov/publication/22077.

26. The estimates also differ in that the first estimate was presented in terms of household employment and the current estimate is presented in terms of full-time-equivalent employment. However, that difference is relatively small when comparing CBO's previous estimate with the current one.

New health plans might not include local hospital

Written by Russ Zimmer CentralOhio.com
Mar. 10, 2014 |

marionstar.com

Marion General Hospital

Currently, the only insurance carrier on the exchange that considers MGH and any other OhioHealth-affiliated facility to be an in-network provider is Medical Mutual of Ohio. Consumers have until March 31 to enroll in a plan on the exchange or, in certain instances, switch plans.

Imagine buying medical coverage on the federal health exchange only to later learn that the insurance you chose doesn't include your doctor or local hospital, making them unaffordable options for your health care.

Officials and observers in the health industry say that has been happening in Ohio, though it's unclear how widespread the problem is.

Only six of the 23 "Obamacare" plans marketed to Marion County residents classify OhioHealth, which runs Marion General Hospital and the local group practice formerly known as the Smith Clinic, as in-network.

Out-of-network services generally don't count toward the same deductible as in-network and have worse cost-sharing splits for the consumer, meaning they end up paying more out of pocket than if they would have sought help from the insurer's preferred providers.

The hospitals and the insurance companies are sparring over reimbursement rates, or how much the insurer is willing to pay for medical services rendered by the hospital.

"Sometimes they are able to come to agreements with providers on these rates, and sometimes they cannot," said Amy Rohling McGee, president of the Health Policy Institute of Ohio, which tracks the changing health care industry.

Cindy Webster, vice president of finance at Licking Memorial Health Systems, said Medical Mutual agreed to terms and rates that were similar to their other plans not available on the exchange.

The other insurers, some of which have existing agreements with the hospital on non-exchange plans, see a difference between the "Obamacare" plans and their other offerings.

"That difference is significant enough that we haven't been able to come to an agreement," she said.

One approach insurance companies are taking, McGee said, is to contract with a select number of hospitals. She said the insurers can dangle the prospect of more customers for the hospital — from people wanting to avoid the out-of-network costs — to secure more favorable rates.

That can lead to individuals and families being forced to travel for medical care, even if the same

service is offered down the street.

Area residents have come into Fairfield Medical Center to get procedures such as an MRI done only to find out their CareSource Just4Me plan didn't consider the Lancaster hospital to be an in-network provider, said Sharon Scruggs, contracts and collections manager for FMC.

"They had to go to an in-network facility, and unfortunately for them, that was in Columbus, that was Ohio State (University's Wexner Medical Center)," she said.

McGee said acquiring insurance on the exchange requires shoppers to be more engaged, including calling or emailing the company to get answers and documenting whom you spoke to and what they told you. Buying insurance on the exchange might be a new, bewildering experience, even to those who have been covered in the past.

Somebody who had insurance previously through their employer might be inclined to use the exchange to buy a plan with that same insurer, thinking they could continue to go to see the same doctor or specialist. That might not be the case.

"For example, while we are a commercial insurance provider for Anthem and would be listed as part of that network, we are not a provider for the exchange plan," said Ron Weiner, vice president of finance at Magruder Hospital in Port Clinton. "This could be confusing to a consumer."

It's unclear how many people have been affected by this, as the policies wouldn't have started until Jan. 1 at the earliest. The problem, however, is not unique to the relatively small hospital systems, which often have less service area to leverage in negotiations.

A spokesman for OhioHealth, which operates 10 hospitals in addition to a network of physician groups and outpatient facilities, has a deal in place only with Medical Mutual for plans from the exchange. OhioHealth is aware that "some patients" are encountering the out-of-network issue, the spokesman said.

CareSource declined to comment for this story, and Anthem did not return messages seeking comment.

Last month, the Centers for Medicare and Medicaid Services sent out guidance to the industry, revising its earlier position that, once a premium was paid, the policy was locked in for that year.

The new rules allow for policyholders to switch plans if they want a larger provider network, but they can migrate only to a plan offered by the same carrier and must do so before the end of the enrollment period, which is the end of this month.

That won't help people who need to switch insurance companies to find a plan with their local hospital or physician's network in 2014. CMS did announce last month that it will be collecting provider network data for next year to ensure insurance carriers are meeting the requirements on accessibility with their Obamacare offerings.

The Patient Protection and Affordable Care Act created the health insurance exchanges and

enacted a number of consumer protections, one of those being forbidding insurers from applying the out-of-network designation to emergency medical care.

But for those times when consumers have a choice of where to go, Scruggs said it's FMC's policy to communicate to the patient their financial responsibility when seeking out-of-network care.

America's Health Insurance Plans, the industry's national trade group, released a report earlier this year showing about 88 percent of claims in 2011 were paid in-network. But those who went out-of-network were sometimes hit with exorbitant charges, the AHIP report found, including an instance in which an Ohio patient was charged 20 times — nearly $14,000 — what Medicare would pay for an MRI.

A few hospitals are employing counselors to help people understand what they're getting when they sign up through the marketplace. Avita Health Systems, which runs hospitals in Bucyrus and Galion, has three certified application counselors that have helped about 250 families, mostly in Crawford and Richland counties, said Rhonda Ridenour, Avita's patient financial services director.

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mansfieldnewsjournal.com

OhioHealth MedCentral Hospitals

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Only six of the 23 "Obamacare" plans marketed to Richland County residents classify OhioHealth, which runs MedCentral hospitals in Mansfield and Shelby and has 500 more central Ohio doctors under its banner, as in-network.

Out-of-network services generally don't count toward the same deductible as in-network and have worse cost-sharing splits for the consumer, meaning they end up paying more out of pocket than if they would have sought help from the insurer's preferred providers.

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Will your health plan include your doctor?

Coverage might not include local hospital

Mar. 09, 2014 | 2 Comments

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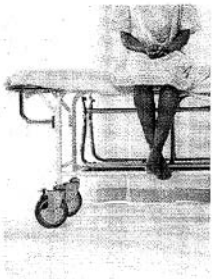

Hospitals are reporting that some patients are finding out the medical coverage they purchased on the federal health insurance marketplace considers the local hospital to be 'out-of-network,' which can result in excessive out-of-pocket costs to the consumer. / Getty Images

Written by
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CentralOhio.com

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Licking Memorial Health Systems

Imagine buying medical coverage on the federal health exchange only to later learn that the insurance you chose doesn't include your doctor or local hospital, making them unaffordable options for your health care.

Officials and observers in the health industry say that has been happening in Ohio, though it's unclear how widespread the problem is.

Only six of the 26 "Obamacare" plans marketed to Licking County residents classify Licking Memorial Health Systems, which runs the only hospital in the county and has 100 more local doctors under its banner, as in-network.

Out-of-network services generally don't count toward the same deductible as in-network and have worse cost-sharing splits for the consumer, meaning they end up paying more out of pocket than if they would have sought help from the insurer's preferred providers.

The hospitals and the insurance companies are sparring over reimbursement rates, or how much the insurer is willing to pay for medical services rendered by the hospital.

"Sometimes they are able to come to agreements with providers on these rates, and sometimes they cannot," said Amy Rohling McGee, president of the Health Policy Institute of Ohio, which tracks the changing health care industry.

Cindy Webster, vice president of finance at Licking Memorial Health Systems, said Medical Mutual agreed to terms and rates that were similar to their other plans not available on the exchange.

The other insurers, some of which have existing agreements with the hospital on non-exchange plans, see a difference between the "Obamacare" plans and their other offerings.

"That difference is significant enough that we haven't been able to come to an agreement,"

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Hospitals are reporting that some patients are finding out the medical coverage they purchased on the federal health insurance marketplace considers the local hospital to be "out-of-network," which can result in excessive out-of-pocket costs, to the tune of ... / Getty Images

Licking Memorial Hospital

Currently, the only insurance carrier on the exchange that considers LMH to be an in-network provider is Medical Mutual of Ohio. Consumers from UHC and Aetna

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she said.

One approach insurance companies are taking, McGee said, is to contract with a select number of hospitals. She said the insurers can dangle the prospect of more customers for the hospital — from people wanting to avoid the out-of-network costs — to secure more favorable rates.

That can lead to individuals and families being forced to travel for medical care, even if the same service is offered down the street.

Area residents have come into Fairfield Medical Center to get procedures such as an MRI done only to find out their CareSource Just4Me plan didn't consider the Lancaster hospital to be an in-network provider, said Sharon Scruggs, contracts and collections manager for FMC.

"They had to go to an in-network facility, and unfortunately for them, that was in Columbus, that was Ohio State (University's Wexner Medical Center)," she said.

McGee said acquiring insurance on the exchange requires shoppers to be more engaged, including calling or emailing the company to get answers and documenting whom you spoke to and what they told you. Buying insurance on the exchange might be a new, bewildering experience, even to those who have been covered in the past.

Somebody who had insurance previously through their employer might be inclined to use the exchange to buy a plan with that same insurer, thinking they could continue to go to see the same doctor or specialist. That might not be the case.

"For example, while we are a commercial insurance provider for Anthem and would be listed as part of that network, we are not a provider for the exchange plan," said Ron Weiner, vice president of finance at Magruder Hospital in Port Clinton. "This could be confusing to a consumer."

It's unclear how many people have been affected by this, as the policies wouldn't have started until Jan. 1 at the earliest. The problem, however, is not unique to the relatively small hospital systems, which often have less service area to leverage in negotiations.

A spokesman for OhioHealth, which operates 10 hospitals in addition to a network of physician groups and outpatient facilities, has a deal in place only with Medical Mutual for plans from the exchange. OhioHealth is aware that "some patients" are encountering the out-of-network issue, the spokesman said.

CareSource declined to comment for this story, and Anthem did not return messages seeking comment.

Last month, the Centers for Medicare and Medicaid Services sent out guidance to the industry, revising its earlier position that, once a

premium was paid, the policy was locked in for that year.

The new rules allow for policyholders to switch plans if they want a larger provider network, but they can migrate only to a plan offered by the same carrier and must do so before the end of the enrollment period, which is the end of this month.

That won't help people who need to switch insurance companies to find a plan with their local hospital or physician's network in 2014. CMS did announce last month that it will be collecting provider network data for next year to ensure insurance carriers are meeting the requirements on accessibility with their Obamacare offerings.

The Patient Protection and Affordable Care Act created the health insurance exchanges and enacted a number of consumer protections, one of those being forbidding insurers from applying the out-of-network designation to emergency medical care.

But for those times when consumers have a choice of where to go, Scruggs said it's FMC's policy to communicate to the patient their financial responsibility when seeking out-of-network care.

America's Health Insurance Plans, the industry's national trade group, released a report earlier this year showing about 88 percent of claims in 2011 were paid in-network. But those who went out-of-network were sometimes hit with exorbitant charges, the AHIP report found, including an instance in which an Ohio patient was charged 20 times — nearly $14,000 — what Medicare would pay for an MRI.

A few hospitals are employing counselors to help people understand what they're getting when they sign up through the marketplace. Avita Health Systems, which runs hospitals in Bucyrus and Galion, has three certified application counselors that have helped about 250 families, mostly in Crawford and Richland counties, said Rhonda Ridenour, Avita's patient financial services director.

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

February 21, 2014

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

Dear Mr. Speaker:

Thank you for your letter to the President on the Medicare Advantage program and the impact that the Affordable Care Act is having on our nation's seniors. He has asked that I respond on his behalf.

The facts demonstrate that the Affordable Care Act has contributed to lower health care cost growth, stronger Medicare Advantage plans, and lower costs for beneficiaries. For example, from 2000 through 2007, the average annual growth rate in real Medicare spending per beneficiary was nearly 4 percent. Since 2010, on the other hand, growth in real Medicare spending per beneficiary has been virtually zero. This is good news for the Medicare Trust Fund and for every senior benefitting from Medicare, since lower Medicare costs means lower premiums and out-of-pocket spending for seniors. In fact, since the Affordable Care Act passed in 2010, average Medicare Advantage premiums have fallen by 9.8 percent and enrollment has increased by more than 30 percent to an all-time high of more than 15 million beneficiaries. The Medicare Advantage program is stronger than ever and provides higher quality options to seniors as a result of the law and our efforts.

The Affordable Care Act strengthens Medicare by reducing excessive payments to insurance companies. As you know, nearly every Republican in the House of Representatives voted for or supported the very same savings you are protesting in your letter. In fact, these savings were part of the Republican budgets written by House Budget Chair Paul Ryan in 2011, 2012 and 2013. The same policies put in place by the Affordable Care Act were continued in these budgets, and a majority of House Republicans voted for them each of those years.

Before passage of the Affordable Care Act, Medicare paid $800 per year more for every person in Medicare Advantage as compared to the traditional Medicare fee-for-service (FFS) program. These excessive payments wasted billions of taxpayer dollars each year and drove up Medicare premiums for all beneficiaries. The Affordable Care Act ended these excessive payments in a common-sense fashion by tying Medicare Advantage payments to FFS spending, phasing out the overpayments, and instituting a requirement that Medicare Advantage organizations use 85 percent of their Medicare payments for patient care and quality improvement, a requirement similar to one the Affordable Care Act imposed on all commercial insurers.

Far from undermining the program, Medicare Advantage has grown under the Affordable Care Act. Enrollment in the program increased by a third since passage of the law—reaching almost

New York Times

Fear Mongering With Medicare

By THE EDITORIAL BOARD

MARCH 1, 2014

The Obama administration's proposed cuts to Medicare Advantage plans — the private insurance plans that cover almost 30 percent of all Medicare beneficiaries — are fair and reasonable. As it happens, they are also mandated by law. Yet Republicans, sensing a campaign issue, are telling older and disabled Americans that the administration is "raiding Medicare Advantage to pay for Obamacare." The health insurance industry, for its part, is warning that enrollees will suffer higher premiums, lower benefits and fewer choices among doctors if the cuts go into force.

Some of this could in fact happen, although the industry has cried wolf before and continues to thrive. But the key point is this: Over the past decade, enrollees in Medicare Advantage have received lots of extra benefits, thanks to unjustified federal subsidies to the insurance companies. Now they will have to do with somewhat less, unless the insurers are willing to absorb the cuts while maintaining benefits. Enrollment in these private plans, offered by companies like UnitedHealth and Humana, has more than doubled since 2006, in part because of lower premiums and extra benefits, like gym memberships, that are not included in traditional fee-for-service Medicare.

What made these perks possible was, in effect, a subsidy from taxpayers and other Medicare beneficiaries. The federal government paid the private plans, on average, 14 percent more in 2009 than it would cost to treat the same people in traditional Medicare. The insurers used this extra money to reduce enrollees' costs and add benefits.

The 2010 Affordable Care Act rightly required that these subsidies be reduced, although it stopped short of completely eliminating them. The reductions began to take effect in 2012, and have not, so far, visibly harmed beneficiaries or the plans. Since enactment of the law, Medicare Advantage premiums have fallen by 10 percent, the opposite of what some expected, and enrollment has increased by nearly 33 percent, according to the administration. But as the law intended, federal payments to the private plans dropped — from 7 percent more than services under traditional Medicare in 2012 to 4 percent more last year. The administration now proposes to further reduce the payments to Medicare Advantage plans in 2015. The loudest criticism has come from Republicans, but plenty of Democrats have chimed in.

In the Senate, a group of 19 Democrats and 21 Republicans urged that payments be kept at current levels, echoing the view of a trade group campaign called "Seniors Are Watching" that is clearly intended to intimidate politicians in an election year.

March 7, 2014

Marilyn Tavenner, Administrator
Centers for Medicare and Medicaid Services (CMS)
200 Independence Avenue SW
Washington, DC 20201

Dear Ms. Tavenner:

The undersigned organizations are writing to express our support for policies enacted through the Affordable Care Act (ACA) that will gradually align Medicare Advantage (MA) reimbursements with traditional Medicare. We share a commitment to advancing the health and economic security of older adults and people with disabilities, while also promoting the long-term sustainability of the Medicare program.

CMS acknowledges that proposed MA payment rates are calculated in accordance with the law. Prior to the ACA, MA plans were significantly overpaid relative to the traditional Medicare program. In 2009, Medicare paid MA plans $14 billion more than if the same care had been provided under traditional Medicare, about $1,000 more per beneficiary. On average, MA plans were paid 114% of costs under traditional Medicare, with some plans paid as much as 118%.[1]

We believe the above mentioned policies are critical to stabilizing the fiscal health of the Medicare program, and to ensuring efficient spending of taxpayer dollars. CMS' proposed payment rates are reflective of these policies, and we support their implementation as such.

At the same time, the law requires that MA payment rates be revisited on an annual basis to account for estimated per beneficiary spending by traditional Medicare. Both Medicare cost growth and national health expenditures have grown at historically small rates over the last several years. These slowed rates translate into an improved financial outlook for the Medicare program as well as lower costs and stable premiums for beneficiaries. The 2015 MA payment rates proposed by CMS appropriately reflect this slower growth. We do not believe that MA plans should be insulated from these encouraging trends.

We urge CMS to continue to monitor the MA plan landscape to ensure that plans are optimally serving people with Medicare under the revised payment system. MA plans continue to be a popular option for Medicare beneficiaries. MA enrollment is on the rise, increasing 30% from 2010 to 2013 to 15 million enrollees.[2] According to Congressional Budget Office projections, enrollment in MA plans will continue

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[1] MedPAC, Report to the Congress: Medicare Payment Policy," (March 2009), available at: http://www.medpac.gov/documents/mar09_entirereport.pdf

[2] Jacobson, G., "Projecting Medicare Advantage Enrollment: Expect the Unexpected?" (Kaiser Family Foundation: July 2013), available at: http://kff.org/medicare/perspective/projecting-medicare-advantage-enrollment-expect-the-unexpected/

APPENDIX

C

Labor Market Effects of the Affordable Care Act: Updated Estimates

Overview

The baseline economic projections developed by the Congressional Budget Office (CBO) incorporate the agency's estimates of the future effects of federal policies under current law. The agency updates those projections regularly to account for new information and analysis regarding federal fiscal policies and many other influences on the economy. In preparing economic projections for the February 2014 baseline, CBO has updated its estimates of the effects of the Affordable Care Act (ACA) on labor markets.[1]

The ACA includes a range of provisions that will take full effect over the next several years and that will influence the supply of and demand for labor through various channels. For example, some provisions will raise effective tax rates on earnings from labor and thus will reduce the amount of labor that some workers choose to supply. In particular, the health insurance subsidies that the act provides to some people will be phased out as their income rises—creating an implicit tax on additional earnings—whereas for other people, the act imposes higher taxes on labor income directly. The ACA also will exert conflicting pressures on the quantity of labor that employers demand, primarily during the next few years.

How Much Will the ACA Reduce Employment in the Longer Term?

The ACA's largest impact on labor markets will probably occur after 2016, once its major provisions have taken full effect and overall economic output nears its maximum sustainable level. CBO estimates that the ACA will reduce the total number of hours worked, on net, by about 1.5 percent to 2.0 percent during the period from 2017 to 2024, almost entirely because workers will choose to supply less labor—given the new taxes and other incentives they will face and the financial benefits some will receive. Because the largest declines in labor supply will probably occur among lower-wage workers, the reduction in aggregate compensation (wages, salaries, and fringe benefits) and the impact on the overall economy will be proportionally smaller than the reduction in hours worked. Specifically, CBO estimates that the ACA will cause a reduction of roughly 1 percent in aggregate labor compensation over the 2017–2024 period, compared with what it would have been otherwise. Although such effects are likely to continue after 2024 (the end of the current 10-year budget window), CBO has not estimated their magnitude or duration over a longer period.

The reduction in CBO's projections of hours worked represents a decline in the number of full-time-equivalent workers of about 2.0 million in 2017, rising to about 2.5 million in 2024. Although CBO projects that total employment (and compensation) will increase over the coming decade, that increase will be smaller than it would have been in the absence of the ACA. The decline in full-time-equivalent employment stemming from the ACA will consist of some people not being employed at all and other people working fewer hours; however, CBO has not tried to quantify those two components of the overall effect. The estimated reduction stems almost entirely from a net decline in the amount of labor that workers choose to supply, rather than from a net drop in businesses' demand for labor, so it will appear almost entirely as a reduction in labor force participation and in hours worked relative to what would have occurred otherwise

1. As referred to in this report, the Affordable Care Act comprises the Patient Protection and Affordable Care Act (Public Law 111-148); the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152); and the effects of subsequent judicial decisions, statutory changes, and administrative actions.

rather than as an increase in unemployment (that is, more workers seeking but not finding jobs) or underemployment (such as part-time workers who would prefer to work more hours per week).

CBO's estimate that the ACA will reduce employment reflects some of the inherent trade-offs involved in designing such legislation. Subsidies that help lower-income people purchase an expensive product like health insurance must be relatively large to encourage a significant proportion of eligible people to enroll. If those subsidies are phased out with rising income in order to limit their total costs, the phaseout effectively raises people's marginal tax rates (the tax rates applying to their last dollar of income), thus discouraging work. In addition, if the subsidies are financed at least in part by higher taxes, those taxes will further discourage work or create other economic distortions, depending on how the taxes are designed. Alternatively, if subsidies are not phased out or eliminated with rising income, then the increase in taxes required to finance the subsidies would be much larger.

CBO's estimate of the ACA's impact on labor markets is subject to substantial uncertainty, which arises in part because many of the ACA's provisions have never been implemented on such a broad scale and in part because available estimates of many key responses vary considerably. CBO seeks to provide estimates that lie in the middle of the distribution of potential outcomes, but the actual effects could differ notably from those estimates. For example, if fewer people obtain subsidized insurance coverage through exchanges than CBO expects, then the effects of the ACA on employment would be smaller than CBO estimates in this report. Alternatively, if more people obtain subsidized coverage through exchanges, then the impact on the labor market would be larger.

Why Will Those Reductions Be Smaller in the Short Term?

CBO estimates that the ACA will cause smaller declines in employment over the 2014–2016 period than in later years, for three reasons. First, fewer people will receive subsidies through health insurance exchanges in that period, so fewer people will face the implicit tax that results when higher earnings reduce those subsidies. Second, CBO expects the unemployment rate to remain higher than normal over the next few years, so more people will be applying for each available job—meaning that if some people seek to work less, other applicants will be readily available to fill those positions and the overall effect on employment will be muted. Third, the ACA's subsidies for health insurance will both stimulate demand for health care services and allow low-income households to redirect some of the funds that they would have spent on that care toward the purchase of other goods and services—thereby increasing overall demand. That increase in overall demand while the economy remains somewhat weak will induce some employers to hire more workers or to increase the hours of current employees during that period.

Why Does CBO Estimate Larger Reductions Than It Did in 2010?

In 2010, CBO estimated that the ACA, on net, would reduce the amount of labor used in the economy by roughly half a percent—primarily by reducing the amount of labor that workers choose to supply.[2] That measure of labor use was calculated in dollar terms, representing the approximate change in aggregate labor compensation that would result. Hence, that estimate can be compared with the roughly 1 percent reduction in aggregate compensation that CBO now estimates to result from the act. There are several reasons for that difference: CBO has now incorporated into its analysis additional channels through which the ACA will affect labor supply, reviewed new research about those effects, and revised upward its estimates of the responsiveness of labor supply to changes in tax rates.

Effects of the ACA on the Supply of Labor

CBO anticipates that the ACA will lead to a net reduction in the supply of labor. In the agency's judgment, the effects will be most evident in some segments of the workforce and will be small or negligible for most categories of workers. (The ACA also will slightly affect employers' demand for labor, as discussed below, and the total effect on labor use will consist of the combined effects on supply and on demand.) In CBO's view, the ACA's effects on labor supply will stem mainly from the following provisions, roughly in order of importance:

2. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- The subsidies for health insurance purchased through exchanges;
- The expansion of eligibility for Medicaid;
- The penalties on employers that decline to offer insurance; and
- The new taxes imposed on labor income.

Some of those provisions will reduce the amount of labor supplied by some workers; other provisions will increase the amount of labor supplied by other workers. Several provisions also will combine to affect retirement decisions.

The ACA also could alter labor productivity—the amount of output generated per hour of work—which in turn would influence employment (for example, by affecting workers' health or firms' investments in training of workers). The effects on productivity could be positive or negative, however, and their net impact is uncertain, so they are not reflected in CBO's estimates of labor supply or demand. Because the ACA could affect labor markets through many channels, with substantial uncertainty surrounding the magnitude of the effects and their interactions, CBO has chosen not to report specific estimates for each of the channels encompassed by its analysis.

Effects of Insurance Subsidies on the Supply of Labor

Beginning in 2014, many people who purchase insurance through exchanges will be eligible for federal tax credits to defray the cost of their premiums, and some also will be eligible for cost-sharing subsidies to reduce out-of-pocket expenditures for health care. Those subsidies are largest for people whose income is near the federal poverty guideline (also known as the federal poverty level, or FPL), and they decline with rising income.[3]

In 2014, for example, a single person or a family whose income is 150 percent of the FPL and is eligible for subsidies will pay 4 percent of their income for a certain "silver" health care plan purchased through an exchange; if their income is 200 percent of the FPL, they will pay 6.3 percent of their income for that plan.[4] An increase in income thus raises the enrollee premium (and reduces the subsidy) both because the percentage-of-income formula applies to a larger dollar amount and because that percentage itself increases. People whose income exceeds 400 percent of the FPL are ineligible for premium subsidies, and for some people those subsidies will drop abruptly to zero when income crosses that threshold. Cost-sharing subsidies also phase out in steps with rising income, declining sharply at 150 percent, 200 percent, and 250 percent of the FPL.

CBO's estimate of the impact that the subsidies will have on labor supply has three components: the magnitude of the incentive, the number and types of people affected, and the degree of responsiveness to the incentive among those who are affected.

The Magnitude of the Incentive to Reduce Labor Supply. For some people, the availability of exchange subsidies under the ACA will reduce incentives to work both through a substitution effect and through an income effect. The former arises because subsidies decline with rising income (and increase as income falls), thus making work less attractive. As a result, some people will choose not to work or will work less—thus substituting other activities for work. The income effect arises because subsidies increase available resources—similar to giving people greater income—thereby allowing some people to maintain the same standard of living while working less. The magnitude of the incentive to reduce labor supply thus depends on the size of the subsidies and the rate at which they are phased out.

The Number and Types of Workers Likely To Be Affected. Subsidies clearly alter recipients' incentives to work and can certainly influence the labor supply of those who would gain eligibility by working and earning slightly less. But most full-time workers do not confront that particular choice—either their income is well above 400 percent of the FPL or they are offered employment-based health insurance and thus are generally ineligible for subsidies regardless of their income. Even so, one line of research indicates that the subsidies will affect the labor supply of many full-time workers with health insurance

3. In 2013, the FPL (which is indexed to inflation) was $11,490 for a single person and $23,550 for a family of four. Calculations of exchange subsidies for 2014 use the 2013 FPL schedule.

4. A silver plan pays about 70 percent of covered health costs, on average. For the second-least-expensive silver plan offered on the exchanges, the premium, net of subsidies, for a family of four in 2014 would be $1,413 at 150 percent of the FPL ($35,325) but would rise to $2,967 at 200 percent of the FPL ($47,100).

from their employer—precisely because they effectively forgo exchange subsidies when they take or keep a job with health insurance.[5] If instead a worker switched to a part-time job, which typically does not offer health insurance, that worker could become eligible for exchange subsidies. In that view, exchange subsidies effectively constitute a tax on labor supply for a broad range of workers.

In CBO's judgment, however, the cost of forgoing exchange subsidies operates primarily as an implicit tax on employment-based insurance, which does not imply a change in hours worked. Instead, the tax can be avoided if a worker switches to a different full-time job without health insurance (or possibly two part-time jobs) or if the employer decides to stop offering that benefit. The consequences of that implicit tax are incorporated into CBO's estimate of the ACA's effect on employment-based coverage—which is projected to decline, on net, by about 4 percent because of the ACA (see Appendix B).[6] Correspondingly, the negative effects of exchange subsidies on incentives to work will be relevant primarily for a limited segment of the population—mostly people who have no offer of employment-based coverage and whose income is either below or near 400 percent of the FPL.

Nonetheless, another subgroup that has employment-based insurance does seem likely to reduce their labor supply somewhat. Specifically, those people whose income would make them eligible for subsidies through exchanges (or for Medicaid), and who work less than a full year (roughly 10 to 15 percent of workers in that income range in a typical year), would tend to work somewhat less because of the ACA's subsidies. For those workers, the loss of subsidies upon returning to a job with health insurance is an implicit tax on working (and is equivalent to an average tax rate of roughly 15 percent, CBO estimates). That implicit tax will cause some of those workers to lengthen the time they are out of work—similar to the effect of unemployment benefits.

Responsiveness of Affected Groups. The implicit taxes that arise from the phaseout of the subsidies have effects on net income that are similar to the effects of direct taxes. With tax changes, however, the income and substitution effects typically work in opposite directions, whereas with the insurance subsidies the income and substitution effects work in the same direction to decrease labor supply.[7] CBO's estimate of the response of labor supply to the subsidies is based on research concerning the way changes in marginal tax rates affect labor supply and on studies analyzing how labor supply responds to changes in after-tax income.[8]

Effects of the Medicaid Expansion on Labor Supply

The ACA significantly increases eligibility for Medicaid for residents of states that choose to expand their programs. In states that adopt the expansion, Medicaid eligibility is extended to most nonelderly residents whose income is below 138 percent of the FPL—including childless adults who previously were ineligible for Medicaid in most states regardless of their income. In states that have not expanded Medicaid, people whose income is between 100 percent and 138 percent of the FPL become eligible for subsidies through the exchanges; in those states, subsidies could decline abruptly if an enrollee's income fell from just above the FPL to just below it (and vice versa). By 2018, CBO expects that around 80 percent of the potentially eligible population will live in states that have expanded Medicaid.

5. See Casey B. Mulligan, *Average Marginal Tax Rates Under the Affordable Care Act*, Working Paper 19365 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19365, and *Is the Affordable Care Act Different From Romneycare? A Labor Economics Perspective*, Working Paper 19366 (National Bureau of Economic Research, August 2013), www.nber.org/papers/w19366.

6. See Congressional Budget Office, *CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance* (March 2012), www.cbo.gov/publication/43082.

7. To see how the substitution and income effects can create counteracting pressures on people's willingness to work when tax rates change, consider the case of an increase in tax rates. The resulting reduction in take-home pay for an additional hour of work makes work less valuable relative to other uses of time and encourages people to work less. Reduced after-tax income from a given amount of work, however, encourages people to work more to limit the decline in their standard of living.

8. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674; Robert McClelland and Shannon Mok, *A Review of Recent Research on Labor Supply Elasticities*, Working Paper 2012-12 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43675; and Felix Reichling and Charles Whalen, *Review of Estimates of the Frisch Elasticity of Labor Supply*, Working Paper 2012-13 (Congressional Budget Office, October 2012), www.cbo.gov/publication/43676.

Incentives to Change Labor Supply and Groups Affected. For some people, the ACA's expansion of Medicaid will reduce the incentive to work—but among other people it will increase that incentive. As with exchange subsidies, access to Medicaid confers financial benefits that are phased out with rising income or (more commonly) eliminated when income exceeds a threshold; some people will thus work fewer hours or withdraw from the labor force to become or remain eligible (the substitution effect). Moreover, those financial benefits will lead some people to work less because the increase in their available resources enables them to reduce work without a decline in their standard of living (the income effect).

At the same time, some people who would have been eligible for Medicaid under prior law—in particular, working parents with very low income—will work more as a result of the ACA's provisions. In 2013, the median income threshold for that group's Medicaid eligibility was 64 percent of the FPL (albeit with substantial state-to-state variation). The incentives and groups affected depend on whether a state has adopted the Medicaid expansion (and, in both cases, those incentives are intertwined with the effects of the exchange subsidies):

- In states that have chosen to expand Medicaid, the ACA now allows parents to qualify for Medicaid with income up to 138 percent of the FPL. And if their income rises above that threshold, those parents would generally be eligible for premium tax credits and cost-sharing subsidies for insurance purchased through the exchanges unless they are offered qualified employment-based health insurance. The subsidies will cover a smaller share of enrollees' medical costs than Medicaid would, but under prior law those participants ultimately would have become ineligible for Medicaid and lost all benefits. As a result, some people who would have curtailed their hours of work in order to maintain access to Medicaid under prior law will now be able to increase their hours and income while remaining eligible for subsidized insurance.
- In states that choose not to expand Medicaid, the availability of exchange subsidies also will lead some people to work more. Specifically, some people who would otherwise have income below the FPL will work more so that they can qualify for the substantial exchange subsidies that become available when income is equal to or just above the FPL.

Responses of Affected Groups. A number of studies examining the impact of changes in Medicaid eligibility for parents and children have shown either no effects or small effects on the labor supply of single mothers; effects on two-parent households appear to be somewhat larger, in part because health insurance has stronger effects on the labor supply of secondary earners.[9]

More recently, several studies have examined changes in state policies that affect childless adults—who constitute the majority of those gaining coverage through the Medicaid expansion—and larger effects have been reported. Some reductions in employment are reported among people who have gained Medicaid eligibility, although the findings differ regarding the magnitude and statistical significance of that effect.[10] Similarly, other research shows a rise in employment rates with the withdrawal of Medicaid coverage from childless adults who had previously been turned down for private insurance.[11] Because those studies examined state-level policy initiatives affecting program eligibility—instead of changes in eligibility attributable to income changes, which could merely reflect changes in employment—the results provide some useful insights into the potential effects of the ACA (even though other aspects of the studies raise questions about their applicability to an analysis of the ACA).

Taking that research into account, CBO estimates that expanded Medicaid eligibility under the ACA will, on balance, reduce incentives to work. That effect has a relatively modest influence on total labor supply, however, because the expansion of eligibility for Medicaid primarily affects a relatively small segment of the total population—both because most people's income will

9. See Jonathan Gruber and Brigitte C. Madrian, *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature*, Working Paper 8817 (National Bureau of Economic Research, February 2002), www.nber.org/papers/w8817.

10. See Katherine Baicker and others, *The Impact of Medicaid on Labor Force Activity and Program Participation: Evidence from the Oregon Health Insurance Experiment*, Working Paper 19547 (National Bureau of Economic Research, October 2013), www.nber.org/papers/w19547; and Laura Dague, Thomas DeLeire, and Lindsey Leininger, "The Effect of Public Insurance Coverage for Childless Adults on Labor Supply" (draft, March 2013), www.uh.edu/~achin/conference/dague.pdf (950 KB).

11. Craig Garthwaite, Tal Gross, and Matthew J. Notowidigdo, *Public Health Insurance, Labor Supply, and Employment Lock*, Working Paper 19220 (National Bureau of Economic Research, July 2013), www.nber.org/papers/w19220.

significantly exceed the cutoff for Medicaid eligibility and because some low-income people live in states that are not expected to expand Medicaid.

Effects of the Employer Penalty on Labor Supply

Under the ACA, employers with 50 or more full-time-equivalent employees will face a penalty if they do not offer insurance (or if the insurance they offer does not meet certain criteria) and if at least one of their full-time workers receives a subsidy through an exchange. Originally scheduled to take effect in 2014, that penalty is now scheduled to be enforced beginning in 2015. In CBO's judgment, the costs of the penalty eventually will be borne primarily by workers in the form of reductions in wages or other compensation—just as the costs of a payroll tax levied on employers will generally be passed along to employees.[12] Because the supply of labor is responsive to changes in compensation, the employer penalty will ultimately induce some workers to supply less labor.

In the next few years, however, when wages probably will not adjust fully, those penalties will tend to reduce the demand for labor more than the supply. In the longer run, some businesses also may decide to reduce their hiring or shift their demand toward part-time hiring—either to stay below the threshold of 50 full-time-equivalent workers or to limit the number of full-time workers that generate penalty payments. But such shifts might not reduce the overall use of labor, as discussed below.

Effects of Higher Marginal Tax Rates on Labor Supply

To cover part of the cost of the expansion of coverage, the ACA also imposes higher taxes on some people.[13] In particular, the payroll tax for Medicare's Hospital Insurance program has increased by 0.9 percentage points for workers whose earnings are above $200,000 ($250,000 for those filing a joint return).[14] As with other tax increases, those changes will exert competing pressures on labor supply: Lower after-tax compensation will encourage people to work more to make up for the lost income, but the decline in after-tax hourly compensation also will reduce the return on each additional hour of work, thus tending to reduce the incentive to work. On net, CBO anticipates, the second effect will be larger than the first, and the tax will yield a small net reduction in labor supply.

In addition, beginning in 2018, the ACA imposes an excise tax on certain high-cost health insurance plans. CBO expects that the burden of that tax will, over time, be borne primarily by workers in the form of smaller after-tax compensation. Some firms may seek to avoid or limit the amount of the excise tax they pay by switching to less expensive health plans, and in that case workers' wages should rise by a corresponding amount. Those wages will be subject to income and payroll taxes, however, so total tax payments by those workers will be higher than they would have been in the absence of the ACA. After-tax compensation will thus fall whether firms pay the excise tax or take steps to avoid it, and the resulting increases in average and marginal tax rates will cause a slight decline in the supply of labor, CBO estimates.

Under certain circumstances, the ACA also imposes a penalty tax on people who do not have qualified health insurance. That tax is to be phased in over time; by 2016, it will generally be the greater of $695 annually per adult or 2.5 percent of taxable income (each subject to a cap).[15] For people who are subject to the percentage-of-income penalty, that tax discourages work—but CBO estimates

12. By contrast, if employers add health insurance coverage as a benefit in response to the penalty or drop coverage despite it, CBO estimates that their workers' wages will adjust by roughly the employers' cost of providing that coverage—so total compensation would stay about the same and labor supply would not be affected by the change in employer coverage.

13. CBO and the staff of the Joint Committee on Taxation have estimated that, on balance, the ACA will reduce the cumulative deficit over the 2013–2022 period because cuts in other spending more than offset the rest of the cost of the expansion in coverage. Therefore, repealing the ACA would increase budget deficits by a corresponding amount over that period; see Congressional Budget Office, letter to the Honorable John Boehner providing an estimate for H.R. 6079, the Repeal of Obamacare Act (July 24, 2012), www.cbo.gov/publication/43471.

14. The ACA has also raised the tax rate on capital income for some higher-income households and imposed taxes on certain goods and services (such as medical devices), but CBO does not expect those provisions to have a noticeable effect on the overall labor market.

15. For families who are subject to the dollar penalty, the penalty per child is one-half the adult penalty, and in 2016 the payment is capped at $2,085; for people who are subject to the percentage-of-income penalty, the tax payment is capped at the average cost of a "bronze" insurance plan (which, on average, covers 60 percent of enrollees' health costs) offered through the exchanges. After 2016, the dollar penalty is indexed to general inflation.

that a relatively small number of workers will be affected. About 6 million workers and dependents will be subject to the penalty tax in 2016, and among the workers who pay it, a large share will be subject to the dollar penalty rather than the percentage-of-income penalty.[16] As a result, CBO estimates that its impact on aggregate labor supply will be negligible.

Effects on Retirement Decisions and Disabled Workers

Changes to the health insurance market under the ACA, including provisions that prohibit insurers from denying coverage to people with preexisting conditions and those that restrict variability in premiums on the basis of age or health status, will lower the cost of health insurance plans offered to older workers outside the workplace. As a result, some will choose to retire earlier than they otherwise would—another channel through which the ACA will reduce the supply of labor.

The new insurance rules and wider availability of subsidies also could affect the employment decisions of people with disabilities, but the net impact on their labor supply is not clear. In the absence of the ACA, some workers with disabilities would leave the workforce to enroll in such programs as Disability Insurance (DI) or Supplemental Security Income (SSI) and receive subsidized health insurance. (SSI enrollees also receive Medicaid; DI enrollees become eligible for Medicare after a two-year waiting period.) Under the ACA, however, they could be eligible for subsidized health insurance offered through the exchanges, and they cannot be denied coverage or charged higher premiums because of health problems. As a result, some disabled workers who would otherwise have been out of the workforce might stay employed or seek employment. At the same time, those subsidies and new insurance rules might lead other disabled workers to leave the workforce earlier than they otherwise would. Unlike DI applicants who are ineligible for SSI, they would not have to wait two years before they received the ACA's Medicaid benefits or exchange subsidies—making it more attractive to leave the labor force and apply for DI.

16. See Congressional Budget Office, *Payments of Penalties for Being Uninsured Under the Affordable Care Act* (September 2012), www.cbo.gov/publication/43628.

Possible Effects on Labor Supply Through Productivity

In addition to the effects discussed above, the ACA could shape the labor market or the operations of the health sector in ways that affect labor productivity. For example, to the extent that increases in insurance coverage lead to improved health among workers, labor productivity could be enhanced. In addition, the ACA could influence labor productivity indirectly by making it easier for some employees to obtain health insurance outside the workplace and thereby prompting those workers to take jobs that better match their skills, regardless of whether those jobs offered employment-based insurance.

Some employers, however, might invest less in their workers—by reducing training, for example—if the turnover of employees increased because their health insurance was no longer tied so closely to their jobs. Furthermore, productivity could be reduced if businesses shifted toward hiring more part-time employees to avoid paying the employer penalty and if part-time workers operated less efficiently than full-time workers did. (If the dollar loss in productivity exceeded the cost of the employer penalty, however, businesses might not shift toward hiring more part-time employees.)

Whether any of those changes would have a noticeable influence on overall economic productivity, however, is not clear. Moreover, those changes are difficult to quantify and they influence labor productivity in opposing directions. As a result, their effects are not incorporated into CBO's estimates of the effects of the ACA on the labor market.

Some recent analyses also have suggested that the ACA will lead to higher productivity in the health care sector—in particular, by avoiding costs for low-value health care services—and thus to slower growth in health care costs under employment-based health plans.[17] Slower growth in those costs would effectively increase workers' compensation, making work more attractive. Those effects could increase the supply of labor (and could increase the demand for labor in the near term, if some of the savings were not immediately passed on to workers).

17. See Council of Economic Advisers, *Trends in Health Care Cost Growth and the Role of the Affordable Care Act* (November 2013), http://go.usa.gov/ZJFJ; and David Cutler and Neeraj Sooj, *New Jobs Through Better Health Care* (Center for American Progress, January 2010), http://tinyurl.com/oc2zdta.

Whether the ACA already has or will reduce health care costs in the private sector, however, is hard to determine. The ACA's reductions in payment rates to hospitals and other providers have slowed the growth of Medicare spending (compared with projections under prior law) and thus contributed to the slow rate of overall cost growth in health care since the law's enactment. Private health care costs (as well as national health expenditures) have grown more slowly in recent years as well, but analysts differ about the shares of that slowdown that can be attributed to the deep recession and weak recovery, to provisions of the ACA, and to other changes within the health sector. Moreover, the overall influence of the ACA on the cost of employment-based coverage is difficult to predict—in part because some provisions could either increase or decrease private-sector spending on health care and in part because many provisions have not yet been fully implemented or evaluated.[18] Consequently, CBO has not attributed to the ACA any employment effects stemming from slower growth of premiums in the private sector.

Effects of the ACA on the Demand for Labor

The ACA also will affect employers' demand for workers, mostly over the next few years, both by increasing labor costs through the employer penalty (which will reduce labor demand) and by boosting overall demand for goods and services (which will increase labor demand).

Effects of the Employer Penalty on the Demand for Labor

Beginning in 2015, employers of 50 or more full-time-equivalent workers that do not offer health insurance (or that offer health insurance that does not meet certain criteria) will generally pay a penalty. That penalty will initially reduce employers' demand for labor and thereby tend to lower employment. Over time, CBO expects, the penalty will be borne primarily by workers in the form of reduced wages or other compensation, at which point the penalty will have little effect on labor *demand* but will reduce labor *supply* and will lower employment slightly through that channel.

Businesses face two constraints, however, in seeking to shift the costs of the penalty to workers. First, there is considerable evidence that employers refrain from cutting their employees' wages, even when unemployment is high (a phenomenon sometimes referred to as sticky wages).[19] For that reason, some employers might leave wages unchanged and instead employ a smaller workforce. That effect will probably dissipate entirely over several years for most workers because companies that face the penalty can restrain wage growth until workers have absorbed the cost of the penalty—thus gradually eliminating the negative effect on labor demand that comes from sticky wages.

A second and more durable constraint is that businesses generally cannot reduce workers' wages below the statutory minimum wage.[20] As a result, some employers will respond to the penalty by hiring fewer people at or just above the minimum wage—an effect that would be similar to the impact of raising the minimum wage for those companies' employees. Over time, as worker productivity rises and inflation erodes the value of the minimum wage, that effect is projected to decline because wages for fewer jobs will be constrained by the minimum wage. The effect will not disappear completely over the next 10 years, however, because some wages are still projected to be constrained (that is, wages for some jobs will be at or just above the minimum wage).

Businesses also may respond to the employer penalty by seeking to reduce or limit their full-time staffing and to hire more part-time employees. Those responses might occur because the employer penalty will apply only to businesses with 50 or more full-time-equivalent employees, and employers will be charged only for each full-time employee (not counting the first 30 employees). People are generally considered full time under the ACA if they work 30 hours or more per week, on average, so

18. Before the ACA was enacted, CBO estimated that the provisions of a similar proposal might cause a small increase or decrease in premiums for employment-based coverage, although that analysis did not take into account the effects of the excise tax on certain high-cost employment-based plans. See Congressional Budget Office, *An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (November 2009), www.cbo.gov/publication/41792.

19. See, for example, Peter Gottschalk, "Downward Nominal Wage Flexibility: Real or Measurement Error?" *Review of Economics and Statistics*, vol. 87, no. 3 (August 2005), pp. 556–568, http://tinyurl.com/k9bcxss; and Alessandro Brattieri, Susanto Basu, and Peter Gottschalk, *Some Evidence on the Importance of Sticky Wages*, Working Paper 16130 (National Bureau of Economic Research, June 2010), www.nber.org/papers/w16130.

20. As of January 2014, the federal minimum wage was $7.25 per hour. Roughly half of all workers, however, live in states or communities where the minimum wage is higher.

employers have an incentive, for example, to shift from hiring a single 40-hour, full-time employee to hiring two, 20-hour part-time employees to avoid bearing the costs of the penalty.

Such a change might or might not, on its own, reduce the total number of hours worked. In the example just offered, the total amount of work is unaffected by the changes. Moreover, adjustments of that sort can take time and be quite costly—in particular, because of the time and costs that arise in dismissing full-time workers (which may involve the loss of workers with valuable job-specific skills); the time and costs associated with hiring new part-time workers (including the effort spent on interviewing and training); and, perhaps most important, the time and costs of changing work processes to accommodate a larger number of employees working shorter and different schedules. The extent to which people would be willing to work at more than one part-time job instead of a single full-time job is unclear as well; although hourly wages for full-time jobs might be lower than those for part-time jobs (once wages adjust to the penalty), workers also would incur additional costs associated with holding more than one job at a time.

In CBO's judgment, there is no compelling evidence that part-time employment has increased as a result of the ACA. On the one hand, there have been anecdotal reports of firms responding to the employer penalty by limiting workers' hours, and the share of workers in part-time jobs has declined relatively slowly since the end of the recent recession. On the other hand, the share of workers in part-time jobs generally declines slowly after recessions, so whether that share would have declined more quickly during the past few years in the absence of the ACA is difficult to determine.[21] In any event, because the employer penalty will not take effect until 2015, the current lack of direct evidence may not be very informative about the ultimate effects of the ACA.

More generally, some employers have expressed doubts about whether and how the provisions of the ACA will unfold. Uncertainty in several areas—including the timing and sequence of policy changes and implementation procedures and their effects on health insurance premiums and workers' demand for health insurance—probably has encouraged some employers to delay hiring. However, those effects are difficult to quantify separately from other developments in the labor market, and possible effects on the demand for labor through such channels have not been incorporated into CBO's estimates of the ACA's impact.

Effects of Changes in the Demand for Goods and Services on the Demand for Labor

CBO estimates that, over the next few years, the various provisions of the ACA that affect federal revenues and outlays will increase demand for goods and services, on net. Most important, the expansion of Medicaid coverage and the provision of exchange subsidies (and the resulting rise in health insurance coverage) will not only stimulate greater demand for health care services but also allow lower-income households that gain subsidized coverage to increase their spending on other goods and services—thereby raising overall demand in the economy. A partial offset will come from the increased taxes and reductions in Medicare's payments to health care providers that are included in the ACA to offset the costs of the coverage expansion.

On balance, CBO estimates that the ACA will boost overall demand for goods and services over the next few years because the people who will benefit from the expansion of Medicaid and from access to the exchange subsidies are predominantly in lower-income households and thus are likely to spend a considerable fraction of their additional resources on goods and services—whereas people who will pay the higher taxes are predominantly in higher-income households and are likely to change their spending to a lesser degree. Similarly, reduced payments under Medicare to hospitals and other providers will lessen their income or profits, but those changes are likely to decrease demand by a relatively small amount.

The net increase in demand for goods and services will in turn boost demand for labor over the next few years, CBO estimates.[22] Those effects on labor demand tend to be especially strong under conditions such as those now prevailing in the United States, where output is so far below its maximum sustainable level that the Federal Reserve has kept short-term interest rates near zero for several years and probably would not adjust those rates to

21. See Congressional Budget Office, *The Slow Recovery of the Labor Market* (February 2014), www.cbo.gov/publication/45011.

22. For further discussion of CBO's analysis of the economic effects of budgetary policies, see Congressional Budget Office, *Economic Effects of Policies Contributing to Fiscal Tightening in 2013* (November 2012), pp. 2–5, www.cbo.gov/publication/43694.

offset the effects of changes in federal spending and taxes. Over time, however, those effects are expected to dissipate as overall economic output moves back toward its maximum sustainable level.

Why Short-Term Effects Will Be Smaller Than Longer-Term Effects

CBO estimates that the reduction in the use of labor that is attributable to the ACA will be smaller between 2014 and 2016 than it will be between 2017 and 2024. That difference is a result of three factors in particular—two that reflect smaller negative effects on the supply of labor and one that reflects a more positive effect on the demand for labor:

- The number of people who will receive exchange subsidies—and who thus will face an implicit tax from the phaseout of those subsidies that discourages them from working—will be smaller initially than it will be in later years. The number of enrollees (workers and their dependents) purchasing their own coverage through the exchanges is projected to rise from about 6 million in 2014 to about 25 million in 2017 and later years, and most of those enrollees will receive subsidies. Although the number of people who will be eligible for exchange subsidies is similar from year to year, workers who are eligible but do not enroll may either be unaware of their eligibility or be unaffected by it and thus are unlikely to change their supply of labor in response to the availability of those subsidies.

- CBO anticipates that the unemployment rate will remain high for the next few years. If changes in incentives lead some workers to reduce the amount of hours they want to work or to leave the labor force altogether, many unemployed workers will be available to take those jobs—so the effect on overall employment of reductions in labor supply will be greatly dampened.

- The expanded federal subsidies for health insurance will stimulate demand for goods and services, and that effect will mostly occur over the next few years. That increase in demand will induce some employers to hire more workers or to increase their employees' hours during that period.

CBO anticipates that output will return nearly to its maximum sustainable level in 2017 (see Chapter 2). Once that occurs, the net decline in the amount of labor that workers choose to supply because of the ACA will be fully reflected in a decline in total employment and hours worked relative to what would otherwise occur.

Differences From CBO's Previous Estimates of the ACA's Effects on Labor Markets

CBO's estimate that the ACA will reduce aggregate labor compensation in the economy by about 1 percent over the 2017–2024 period—compared with what would have occurred in the absence of the act—is substantially larger than the estimate the agency issued in August 2010.[23] At that time, CBO estimated that, once it was fully implemented, the ACA would reduce the use of labor by about one-half of a percent. That measure of labor use was calculated in dollar terms, representing the change in aggregate labor compensation that would result. Thus it can be compared with the reduction in aggregate compensation that CBO now estimates to result from the act (rather than with the projected decline in the number of hours worked).

The increase in that estimate primarily reflects three factors:

- The revised estimate is based on a more detailed analysis of the ACA that incorporates additional channels through which that law will affect labor supply. In particular, CBO's 2010 estimate did not include an effect on labor supply from the employer penalty and the resulting reduction in wages (as the costs of that penalty are passed on to workers), and it did not include an effect from encouraging part-year workers to delay returning to work in order to retain their insurance subsidies.

- CBO has analyzed the findings of several studies published since 2010 concerning the impact of provisions of the ACA (or similar policy initiatives) on labor markets. In particular, studies of past expansions or contractions in Medicaid eligibility for childless adults have pointed to a larger effect on labor supply than CBO had estimated previously.

23. See Congressional Budget Office, *The Budget and Economic Outlook: An Update* (August 2010), Box 2-1, www.cbo.gov/publication/21670.

- CBO made an upward revision in its estimates of the impact that changes in after-tax wages have on labor supply, reflecting a broad review of the tax literature that has informed several of CBO's estimates and analyses.[24]

CBO's updated estimate of the decrease in hours worked translates to a reduction in full-time-equivalent employment of about 2.0 million in 2017, rising to about 2.5 million in 2024, compared with what would have occurred in the absence of the ACA. Previously, the agency estimated that if the ACA did not affect the average number of hours worked per employed person, it would reduce household employment in 2021 by about 800,000.[25] By way of comparison, CBO's current estimate for 2021 is a reduction in full-time-equivalent employment of about 2.3 million.

The current estimate of the ACA's impact on hours worked and full-time-equivalent employment is considerably higher for two significant reasons.[26] First, as described above, CBO has boosted its estimate of the ACA's effect on aggregate labor compensation in the economy from about 0.5 percent to about 1 percent. Second, CBO has increased its estimate of the effect of a given reduction in aggregate compensation under the ACA on hours worked. CBO's earlier estimate was based on a simplifying assumption that affected workers would have average earnings—in which case the percentage reductions in compensation and hours worked would be roughly the same. However, people whose employment or hours worked will be most affected by the ACA are expected to have below-average earnings because the effects of the subsidies that are available through exchanges and of expanded Medicaid eligibility on the amount of labor supplied by lower-income people are likely to be greater than the effects of increased taxes on the amount of labor supplied by higher-income people. According to CBO's more detailed analysis, the 1 percent reduction in aggregate compensation that will occur as a result of the ACA corresponds to a reduction of about 1.5 percent to 2.0 percent in hours worked.

The reduction in full-time-equivalent employment that CBO expects will arise from the ACA includes some people choosing not to work at all and other people choosing to work fewer hours than they would have in the absence of the law; however, CBO has not tried to quantify those two components of the overall effect. Because some people will reduce the amount of hours they work rather than stopping work altogether, the number who will choose to leave employment because of the ACA in 2024 is likely to be substantially less than 2.5 million. At the same time, more than 2.5 million people are likely to reduce the amount of labor they choose to supply to some degree because of the ACA, even though many of them will not leave the labor force entirely.

24. See Congressional Budget Office, *How the Supply of Labor Responds to Changes in Fiscal Policy* (October 2012), www.cbo.gov/publication/43674.

25. See testimony of Douglas W. Elmendorf, Director, Congressional Budget Office, before the Subcommittee on Health of the House Energy and Commerce Committee, *CBO's Analysis of the Major Health Care Legislation Enacted in 2010* (March 30, 2011), pp. 31–33, www.cbo.gov/publication/22077.

26. The estimates also differ in that the first estimate was presented in terms of household employment and the current estimate is presented in terms of full-time-equivalent employment. However, that difference is relatively small when comparing CBO's previous estimate with the current one.