Questions for Ms. Sylvia Mathews Burwell
Secretary of Health and Human Services-Designate
Committee on Health, Education, Labor, and Pensions
Hearing on May 8, 2014

Questions from Senator Alexander

Memberships and Positions Held Outside U.S. Government

1. On March 26, 2013, you submitted answers to the U.S. Senate Committee on Homeland Security and Governmental Affairs' Common Questions for Executive Nominees. Under memberships you listed yourself as a member of the Wasatch Group. Please explain the nature of this organization and your role therewith.

Answer: The Wasatch Group is an organization comprised of leaders from a variety of industries interested in working on youth issues. As a member, I attend the Group's annual gatherings in Wasatch, Utah.

2. In your April 2014 Executive Branch Personnel Public Financial Disclosure Report you list your participation in the Advisory Group for The Nike Foundation from March 2005 to April 2013. Please explain the full nature of your work for The Nike Foundation.

Answer: As a Member of the Nike Foundation Advisory Group, I provided advice to the CEO of the Nike Foundation on general issues of international development. The Nike Foundation is governed by a separate board of directors of which I was not a part.

3. Please explain the full nature of your work as a Director on the Board of Directors of MetLife.

Answer: The Board of Directors is responsible for managing the property, affairs and business of the Corporation. As a Director of the Corporation, and in accordance with the corporation's By-Laws, I also served on Board Committees, such as the Audit Committee and Governance and Corporate Responsibility Committee.

4. Please describe your work on "healthcare in the developing world" at the Gates Foundation that is referenced in your written testimony.

Answer: At the Gates Foundation, I worked on a range of issues in the health care space, from helping to create an office in India and supporting their work on HIV/AIDS, to working on creating a special purpose vehicle to increase private sector investments in vaccines for the developing world.

MetLife, Inc.

1. On February 28, 2013, the United States District Court for the Southern District of New York ruled that two of six claims related to allegations of an omission of material fact or untrue statement of material fact in an SEC filing could move forward against MetLife, Inc., MetLife executives, and 11 of 12 Directors from the MetLife Board of Directors. You were one of the Directors named as a defendant. Please explain your involvement in the defense of this ongoing litigation.

Answer: I am not directly involved in the defense of this litigation. It is being handled by MetLife and attorneys retained by MetLife.

2. When you appoint an agent for purposes of receiving service of process, and that agent receives notice of legal action taken against you, under the law you have received notice of the litigation. According to the court record in City of Westland Police and Fire Retirement System v. Metlife, Inc. et al, an attorney at Debevoise & Plimpton, LLP was designated as the attorney to receive service of process on your behalf, and a waiver of service was returned executed on May 5, 2012. On February 28, 2013, a United Stated District Court ruled that two claims in the suit could move forward against you and the other director defendants. However, your March 2013 Budget Committee and Homeland Security and Government Affairs Committee applications for your nomination as OMB Director did not disclose that you were a named party in this lawsuit, but stated in generic terms that you might be a defendant in litigation brought against MetLife. Why did you not disclose this specific, ongoing litigation to the U.S. Senate?

Answer: Like most corporations, MetLife is a defendant in a number of litigation matters and Board Members are sometimes named as defendants in those matters, as is the case in City of Westland Police and Fire Retirement System v. MetLife. Accordingly, in my response to the March 2013 questionnaires, I acknowledged the possibility that I might have been named in such matters. At that time, I did not recall any specific matters pertaining to my role as a MetLife Board Member in which I was a named defendant.

3. On February 26, 2013, you, along with your then-fellow MetLife Board Members, submitted an annual report to the SEC. In this report, the Board and MetLife executive officers stated the Patient Protection and Affordable Care Act (PPACA) and The Health Care and Education Reconciliation Act of 2010 "may lead to fundamental changes in the way that employers, including us, provide health care benefits, other benefits, and other forms of compensation to their employees and former employees." MetLife also highlighted that both laws imposed particular requirements on the company as a provider of non-medical health insurance benefits and thus, "could adversely affect our ability to offer certain [types] of these products in the same manner as we do today. They could also result in increased or unpredictable costs to provide certain products, and could harm our competitive position [if either laws have] a disparate impact on our products compared to products offered by our competitors."

Lastly, the report stated the following:

"In addition, we employ a substantial number of employees, including sales agents, in the United States to whom we offer employment-related benefits. We also currently provide benefits to certain [] retirees. These benefits are provided under complex plans that are subject to a variety of regulatory requirements. Either [law] could adversely affect our ability to attract, retain and motivate our associates. They could also result in increased or unpredictable costs to provide employee benefits, and could harm our competitive position if we are subject to fees, penalties, tax provisions or other limitations in the [laws] and our competitors are not."

4. Did PPACA and/or any other related regulations and/or regulatory actions lead to fundamental changes in the way MetLife provided health care benefits, other benefits, and/or other forms of compensation to its employees and/or former employees? If yes, how? Did PPACA and/or any other related regulations and/or regulatory actions adversely affect MetLife's ability to offer health care benefits, other benefits, and/or other forms of compensation to its employees and former employees? If yes, how?

Answer: The Annual Report contains forward-looking statements involving a number of risks and uncertainties affected by factors ranging from legislation to disruption in capital and credit markets. I resigned from the Board in April 2013 and do not have specific knowledge of the impact that subsequent factors, including the implementation of legislation or regulatory actions, may have on MetLife's business operations.

5. Did PPACA and/or any other related regulations and/or regulatory actions adversely affect MetLife's ability to offer non-medical health insurance benefits? If yes, how? Did PPACA and/or any other related regulations and/or regulatory actions result in increased and/or unpredictable costs for MetLife to provide certain products and/or harm MetLife's competitive position because PPACA and/or any other related regulations and/or regulatory actions had a disparate impact on MetLife's products compared to products offered by its competitors? If yes, how?

Answer: The Annual Report contains forward-looking statements involving a number of risks and uncertainties affected by factors ranging from legislation to disruption in capital and credit markets. I resigned from the Board in April 2013 and do not have specific knowledge of the impact that subsequent factors, including the implementation of legislation or regulatory actions, may have on MetLife's business operations.

6. Did PPACA and/or any other related regulations and/or regulatory actions adversely affect MetLife's ability to attract, retain and/or motivate its associates? If yes, how? Did the PPACA and/or any other related regulations and/or regulatory actions result in increased and/or unpredictable costs for MetLife to provide employee benefits? If yes, how? Did the PPACA and/or any other related regulations and/or regulatory actions harm MetLife's competitive position because MetLife was subject to fees, penalties, tax provisions and/or other limitations and its competitors were not?

Answer: The Annual Report contains forward-looking statements involving a number of risks and uncertainties affected by factors ranging from legislation to disruption in capital and credit markets. I resigned from the Board in April 2013 and do not have specific knowledge of the impact that subsequent factors, including the implementation of legislation or regulatory actions, may have on MetLife's business operations.

Priorities as U.S. Department of Health and Human Services (HHS) Secretary

1. **Health care costs and the cost of insurance continue to rise. What would you do as Secretary to address the key health cost drivers?**

Answer: We need to move from a health care system that rewards quantity of care provided to quality of care provided. There are several key areas I hope to focus on in this space: 1) implementing delivery system reforms that build on the Center for Medicare and Medicaid Innovation's work to transform payment models to encourage better collaboration, efficiency, and improved outcomes; 2) carefully implementing cost savings measures in the Affordable Care Act and advocating for savings proposals in the President's budget; and 3) ensuring that we continue to focus on fighting fraud and abuse. I believe that it is also important to engage with the private sector so that all payers are aligned in this process.

2. **On what specific policies will you work with Congress and the states to reduce the burdens of the new health care law that add to the cost of health insurance?**

Answer: The new health care law provides grants to states to enhance their rate review processes. With this funding, states can review proposed premium increases to ensure that they are justified, and depending on state authorities, can potentially modify or deny premium increases that are not justified. Thus far, this program has led to a significant decrease in the number of requested premium increases that are above 10%, saving Americans $1 billion in premiums since 2011. In addition, the premium stabilizations programs from the Affordable Care Act – risk adjustment, reinsurance, and risk corridors – will continue to help stabilize the insurance markets and keep quality coverage affordable.

3. **With many recent resignations, there are very few individuals in leadership roles with experience in private insurance left at HHS, the Centers for Medicare and Medicaid Services (CMS), or the Center for Consumer Information and Insurance Oversight (CCIIO). How would you plan to address this lack of expertise at HHS?**

Answer: Throughout the course of my career, including in several large and complex organizations, I have dedicated significant time and energy to recruiting and developing the best talent. You have to have the best people – and a range of experiences and viewpoints – around the table to solve the types of big challenges confronting OMB and HHS on a daily basis. I have worked to assemble a quality team at OMB and in all of my prior roles in the public and private sector. And, if confirmed, I will be committed to retaining and attracting the quality talent that the Department needs to deliver results for the American people.

4. **According to the Galen Institute, the administration has executed at least 22 extra-legal "fixes" to PPACA, many of them after open enrollment began on October 1, 2013. What will you do as HHS Secretary to provide more stability to the public and private health insurance market so that last-minute, extra-legal changes are not necessary? What changes to existing law and regulation do you anticipate having to make before December 31, 2014?**

Answer: If confirmed, I will work with Congress, policy experts, and stakeholder groups to help facilitate stability in the health insurance market. I am committed to ensuring as smooth a transition as possible for consumers and issuers, and will want to listen to participants across the health care system as implementation of the law continues.

Priorities as Office of Management and Budget (OMB) Director

1. **President Obama delivered his fiscal 2015 budget one month after its statutory deadline. How did this process, which you oversaw as OMB director, fall so far behind schedule? Please explain how you interpret a statutory deadline as having this level of flexibility. Do you believe that statutory requirements like this should routinely be ignored by the executive branch? Why or why not?**

   Answer: I take statutory deadlines extremely seriously and work very hard to meet them. Where possible, the President's Budget should incorporate final current year appropriations levels to provide Congress with an up-to-date fiscal picture. In this case, Congress did not file the near-final appropriations bills for Fiscal Year (FY) 2014 until January 13, 105 days after the start of the fiscal year. Given the delay in enactment of final FY 2014 appropriations, the Administration worked to release the President's Budget as soon as possible after the FY 2014 appropriations levels became known.

2. **As OMB Director you oversaw the Office of Information and Regulatory Affairs, which reviews the Regulatory Impact Analyses (RIAs) executive branch agencies produce when they issue major new regulations. Research from the Mercatus Center at George Mason University finds that RIAs produced by HHS are often seriously incomplete and less thorough than those produced by other executive branch agencies. The analyses accompanying the early regulations implementing PPACA were especially incomplete. What will you do as HHS secretary to ensure that Regulatory Impact Analyses provide thorough, evidence-based assessments of the factors Executive Order 12866 says they should assess, and that this analysis will be performed before HHS makes major regulatory decisions that the analysis is supposed to inform?**

Answer: I believe that thorough and robust regulatory impact analyses are very important. In general, it is important that the benefits of rules justify their costs and that rules accomplish their goals in the least burdensome way possible. It is also important that agencies use the most up-to-date economic information and the best available techniques for determining the estimated costs and benefits of a rule. Regulations should be tailored in such a way so as to impose the least burden on society while still accomplishing their goals.

OMB provides general guidance to agencies on how best to evaluate and present the economic impacts and benefits of rules. These factors and OMB guidance to agencies are set out in more detail in Executive Orders 12866 and 13563, and OMB Circular A-4, which is a guidance document to all agencies on how to conduct regulatory analysis. If confirmed, I would work to ensure that the analyses produced by HHS are consistent with these Executive Orders and the Circular.

Health Insurance Exchange

1. **Will you commit to being more transparent about enrollment in the new health insurance exchanges by providing weekly updates to Congress and the American people? How many people have paid their first month's premium? How many people have paid their second and third month's premium? How many people were previously uninsured? How much money, and on behalf of how many people, has the Administration paid to each insurance carrier in cost-sharing and premium assistance subsidies? How many additional people enrolled in Medicaid, broken down by poverty level? How many new Medicaid enrollees were previously eligible?**

Answer: If confirmed, I will continue the Department's longstanding focus on transparency and accuracy. When CMS has accurate and reliable data regarding premium payments, I will see that this information is made available. I have included information below that is publicly available.

Premium Payment
Some issuers have made public statements indicating that 80 percent to 90 percent of the people who have selected a Marketplace plan have made premium payments. Issuers have the flexibility to determine when premium payments are due.

Prior Coverage Status
In addition to the more than 8 million people who have selected plans through the Marketplace during the initial open enrollment period, CBO recently estimated that an additional 5 million people have purchased coverage outside of the Marketplace in Affordable Care Act-compliant plans. Moreover, recent national surveys indicate that the number of Americans with health insurance coverage is growing, and the number of 18 to 64 year olds who are uninsured is declining. For example, Gallup has found a 5 percentage point decrease in the uninsured rate for adults (18 and over) from the third quarter of 2014 to April 2014 (18 percent versus 15 percent, respectively. Similarly, the Urban Institute estimates a 2.7 percentage point decrease in the uninsured rate for adults (18 to 64) from October 1, 2013 to March 31, 2014 (corresponding to a 5.4 million decline in the number of uninsured adults). Meanwhile, the RAND Corporation estimates a 4.7 percentage point decrease in the uninsured rate (corresponding to a net decrease of 9.3 million uninsured adults, ages of 18 to 64) from the last week of September 2013 through March 2014.

Premium and Cost-sharing Support

More than eight out of ten (85 percent) of the people who selected a Marketplace plan through the SBMs and FFM during the 2014 open enrollment period are eligible to receive federal financial assistance in paying their premiums.

Medicaid and CHIP Enrollment
Compared to enrollment before the Marketplace opened last October, 4.8 million additional Americans are enrolled in Medicaid and CHIP through the end of March. A detailed report on state agencies' eligibility determination activities and state data on total enrollment in Medicaid and CHIP programs is available on the CMS website.

2. **The American people deserve to know the truth about their rising healthcare costs, and you promised in your confirmation hearing before the U.S. Senate HELP Committee that transparency would be a guiding principle in your work as Secretary. President Obama's administration has moved the start of the open enrollment season back to after this year's mid-term elections, meaning that voters will not know the full price of health insurance facing them next year when they head to the polls. Will you commit to fulfilling your promise of transparency and returning the open enrollment season to its original start date?**

Answer: I understand that this past March the Department shifted open enrollment for the 2015 plan year by approximately one month to give consumers more time to learn about plans and select a plan and health insurance companies additional time to collect additional rating experience. If confirmed, I look forward to working with you to address your concerns.

3. **The ongoing problems with healthcare.gov require issuers to manually correct errors in many enrollment records they receive. These problems mean that for many consumers the exchange has "bad data" about them. What steps are being taken to correct this in preparation for the upcoming re-enrollment period in November? When will the full enrollment data reconciliation functionality be developed, tested and implemented? What is the specific timeline to fix these problems with the website and put these systems in place? How will you use your background as a manager of large, complex organizations to ensure the website gets fixed?**

Answer: It is my understanding that the Department has made specific fixes to correct information provided to insurers that allow applications to be processed and consumers to complete their payments. CMS has prioritized correctly transmitting consumer information to issuers. My understanding is that additional upgrades have been installed, focusing on direct enrollment and improving the consumer experience.

By the end of the first open enrollment period, HealthCare.gov was working well and helped millions of consumers sign up for quality, affordable health coverage. As HHS enters the next phase of this work, the technology team remains vigilant in continuing to make improvements that will enhance the consumer experience.

If I am confirmed, I will focus quickly on understanding what the team sees as the core remaining challenges and opportunities in this space and working with them to ensure that we continue to build on the progress to date to strengthen all aspects of the system.

4. **The interim enrollment maintenance approach used by the exchange for special enrollment periods is error prone and has negatively impacted consumers because it is using cancellation and enrollment transactions in place of true maintenance transactions. When will the maintenance functionality to process "life events" be developed, tested and implemented?**

Answer: It is my understanding that after Open Enrollment, consumers may enroll in private coverage through the Marketplace if they have certain life events and other circumstances as provided in 45 C.F.R. § 155.420. Examples of such events and circumstances include a permanent move, loss of minimum essential coverage, certain changes in income, and changes in family size (for example, if you marry, divorce, or have a baby). Consumers are required to attest to their change in circumstance. In anticipation for a surge of user activity in March 2014, CMS enhanced Healthcare.gov at the end of February 2014 to include the ability for consumers to report relevant life events that could impact their eligibility and coverage.

5. **Currently, issuers are following an interim payment process by which they are reporting on a monthly basis to CMS what subsidy payments should be made to them. When will these payments to issuers be reconciled and when will CMS, using their records, develop, test and implement the formal payment process using transactions that are compliant with industry standards?**

Answer: It is my understanding that CMS continues to make improvements to the functionality of HealthCare.gov for the 2015 open enrollment period, including improvements to the financial management processes, and has put in place an interim process to calculate and make payments to issuers on time. This process includes regular data validation with issuers. This interim process-does not impact consumers' access to advance payment of premium tax credits or cost-sharing reductions.

6. **The current essential health benefits benchmark, as well as many exchange rules, only apply to 2014 and 2015. Both states and insurance carriers need to know as soon as possible if changes are likely for 2016. Do you believe these rules need to be changed for 2016 and beyond? What assurances can you give that states and carriers will be involved and notified in a timely manner?**

Answer: On January 1, 2014, millions of Americans gained access to critical consumer protections in a reformed health insurance market, including for the first time, a set of essential health benefits that individual and small group market plans must provide. In my role as OMB Director, I was not engaged on this topic. That said I understand that HHS has had close working relationships with states and the issuer community over the past several years. If confirmed, I assure you that I will continue to engage states, issuers and all stakeholders to ensure that future policy is developed with their input. Getting input to ensure that we continue to improve implementation is something I think is important.

7. **At least five state-based exchanges, including Oregon, Massachusetts, Nevada, Maryland, and Hawaii accepted tens of millions of federal taxpayer dollars but struggled to enroll people into their plans. What would you do to recoup the money wasted and ensure that future exchange establishment dollars are better spent?**

Answer: I believe that we need to determine what went wrong and why (and in states where things are going right understand that too). In those states where the federal government and the taxpayer has had funds misused, I believe that we need to use the full extent of the law to get those funds back for the taxpayer. Finally, we need to make sure that we try to ensure that all those who need access to quality, affordable health care receive that access.

8. **Will you attempt to recover any payments to contractors who may have acted negligently in building healthcare.gov and its related operations or may not have met contract standard of care terms? If no, why not?**

Answer: If confirmed, I look forward to learning more about this important issue and take the action necessary. It is my understanding that CMS continues to monitor and manage all of its contracts in accordance with the requirements of the Federal Acquisition Regulation. If confirmed, I will work with CMS to determine appropriate next steps for any contractors who may have acted negligently within the confines of federal acquisition regulations.

9. **The President's 2015 budget indicated that the risk corridor program will be budget neutral. Please clarify whether this program will be budget neutral every year (versus neutral over a three-year time period) and detail the safeguards in place to protect taxpayers from bailing out insurance companies if their losses exceed money available for reimbursement in the risk corridor program? In addition, where is HHS's statutory authority to reduce the risk corridor program payments to insurers on a pro-rated basis?**

Answer: The temporary risk corridor provision in the Affordable Care Act is an important safety valve for consumers and insurers as millions of Americans transition to a new coverage in a brand new Marketplace. For consumers, the program will play an important role in mitigating premium increases in the early years as issuers gain more experience in setting their rates for this new program. Current budget projections, including those by the Congressional Budget Office, reflect money collected from the risk corridor program will be sufficient for payments, allowing the program to be administered in a budget neutral manner during the three years for which it is authorized. In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

10. **A recent report by McKinsey and Co. found that 74 percent of those selecting a new 2014 plan were previously insured. In another McKinsey and Co. survey, only 83 percent of enrollees had paid their first month's premiums, bringing the effectuated enrollment rate for previous uninsured to 22 percent of this year's enrollees. What**

were the metrics for success for covering the uninsured, and do these figures meet that goal? If yes, how?

Answer: The Congressional Budget Office projected that 6 million people would obtain health insurance through the Marketplaces, and sign-ups indicate that we have surpassed that figure. There are a number of different surveys that indicate that the number of Americans with health insurance coverage is growing, and the number of 18 to 64 year olds who are uninsured is declining. Survey experts agree that data collection around prior insurance status leads to widely varying estimates depending on how the question is asked, and is prone to misinterpretation, so must be used cautiously.

11. At your confirmation hearing, you discussed the importance of metrics in establishing good health policy. An important metric for ascertaining the impact of the health reform law is an official count of the number of uninsured who have gained coverage under the law. What has HHS done and what will it do in the future to measure this number in a manner consistent with how these numbers were measured when the law was passed?

Answer: If confirmed, I will be sure that the Department continues to work with experts in the field and various survey instruments both within HHS and elsewhere to assess the number of uninsured and make those findings public.

12. A statement by CMS Administrator Marilyn Tavenner posted on the HHS website reads, "It is important to understand that the Hub is not a database; it does not retain or store information." However, Government Accountability Office (GAO) Report 13-601 says, "According to CMS, the agency is required to establish Data Use Agreements only with OPM and the Peace Corps because these two entities provide batch files of data for processing data hub queries, which CMS stores in the data hub environment." Please elaborate on what the Office of Personnel Management (OPM) and Peace Corps data is stored on the Data Hub, and on whether any other data is stored on the Hub.

Answer: It is my understanding that CMS has designed the Hub as a routing tool that helps Marketplaces provide accurate and timely eligibility determinations. The Hub verifies data against information contained in already existing, secure and trusted federal, state, and contractor databases. I understand from HHS that CMS has security and privacy agreements with all entities connecting to the Hub. The Hub is not a database; it does not retain or store information. The FFM and State-based Marketplace eligibility, redetermination, and appeals systems do store certain eligibility and enrollment records in order to fulfill specific functions, including helping a consumer with an application or eligibility problem. The FFM also stores the OPM and Peace Corps files needed to verify eligibility based on whether the individual has existing minimum essential coverage through these entities.

The privacy and security of consumer data is a top priority for HHS and CMS, and it will remain a top priority for me if confirmed. I understand that the Hub and its associated systems have been built with state-of-the art business processes based on federal and industry standards. CMS has developed an extremely strong enterprise information security program to protect consumer

information in a secure and efficient manner during open enrollment and beyond. I recognize that this is an area that will require ongoing vigilance, focus, and iterative improvement.

13. **In a February 5, 2014, letter to CMS Administrator Marilyn Tavenner, I asked the following questions:**
    a. **Which division within CMS is responsible for managing exchange-related appeals and which divisions had the ultimate responsibility for overseeing the development and operational functionality of the exchange appeals process?**
    b. **How many healthcare.gov appeals has CMS addressed and resolved to date?**
    c. **What is the schedule for resolving the current backlog of appeals?**
    d. **How long does CMS anticipate it will take to resolve the average appeal and how is CMS communicating to appellees about the length of time for resolution of their appeals?**
    e. **What is the timeline for building the infrastructure necessary to route appeals to the proper channels so that CMS officials can address their needs and resolve them expeditiously?**
    f. **When will consumers be able to file appeals by phone or electronically?**
    g. **What is CMS' rationale for not including the appeals infrastructure in the initial phase of the Federal exchange functionality?**
    h. **Why was a contingency plan for handling appeals not developed sooner given the lack of infrastructure to handle appeals that was present from the launch of the exchanges onward?**

Answer a-h: My understanding is that consumers applying for health coverage in the Marketplace receive an eligibility determination that informs them whether or not they are qualified to purchase coverage through the Marketplace or receive financial assistance. Consumers who disagree with the determination may request an appeal.

I further understand that CMS first attempts to resolve the appeal directly with the consumer through informal resolution, which involves contacting the consumer as expeditiously as possible to work through the consumer's concerns. This approach has worked particularly well for consumers who filed appeals early in the open enrollment period, before system errors were corrected. Many of these consumers have since been able to successfully enroll in a qualified health plan and have withdrawn their appeals. I also understand that CMS prioritizes medically urgent appeals, and as a result, is working to resolve those appeals as quickly as possible. CMS is now holding hearings for those cases that are not otherwise resolved through an informal process.

<u>Premiums, Co-Pays and Deductibles</u>

1. **President Obama promised that premiums would decrease for American families by an average of $2,500 per year. The opposite has come true, which outgoing Secretary Sebelius acknowledged when she said that "the increases are far less significant than what they were prior to the Affordable Care Act." How much has the average premium increased in the individual market?**

Answer: Before the Affordable Care Act, consumers in the individual market frequently saw double digit rate increases for their health insurance. The Affordable Care Act is contributing to a slowdown in health care spending growth. The Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. Average actual Marketplace premiums for 2014 were lower than those implied by initial Congressional Budget Office (CBO) projections. Additionally, CBO revised its projections for future premiums on April 14, 2014 and found that the Affordable Care Act's coverage expansion will cost $104 billion less over than next ten years than it originally estimated, citing lower than expected premiums as a "crucial factor" in the new estimate.

It is also important to remember advance premium tax credits will lower the actual cost of health insurance premiums for many consumers purchasing coverage through the Marketplace. More than eight out of ten (85 percent) of the people who selected a Marketplace plan through the SBMs and FFM during the 2014 open enrollment period are eligible to receive federal financial assistance in paying their premiums.

The Affordable Care Act also contains many tools to keep large premium increases in check. For example, the Affordable Care Act requires insurance companies to justify rate increase of more than 10%, shedding light on arbitrary or unnecessary costs and protecting consumers from unfair rate hikes. The rate review program works in conjunction with the 80/20 rule or Medical Loss Ratio rule, which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care, and no more than 20 percent (15 percent in the large group market) on administrative costs such as executive salaries, marketing, and profits.

2. **It is important for individuals and families choosing insurance plans on healthcare.gov to understand their total financial obligation, including premiums, subsidies, deductibles, co-payments and co-insurance. What would you do to better educate consumers and help them understand the total cost of products they are buying through the federal marketplace? What changes would you make to healthcare.gov?**

Answer: I believe it is critical that consumers have a clear understanding of the insurance plans from which they are able to choose, including their financial obligations under those plans, such as premiums, subsidies, deductibles, co-payments and co-insurance, as well as the quality of the plans. If confirmed, I would work to ensure that consumers can easily understand and compare the benefits and costs presented by each plan. Continuing to refine the consumer shopping experience on HealthCare.gov is a top priority for CMS, and will be a top priority for me if I am confirmed as Secretary.

3. **In comparing silver-level plans in the exchange to a typical employer-sponsored health plan, many individuals are finding more of their prescription drugs in higher cost-sharing tiers and fewer in-network doctors and hospitals. What steps, if any, would you take to ensure that consumers who are buying coverage through the**

exchanges have accurate, easily accessible information about which drugs are covered, which doctors are covered, and how much they cost?

Answer: I am committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the plans available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. If confirmed, I look forward to working with you to find ways to expand consumer access to information in an affordable manner.

4. **PPACA creates a 90-day grace period for individuals with subsidized coverage to pay their premiums before they are fully removed from their insurance. Patients are considered covered for this entire 90-day period, but insurers are only required to pay claims incurred in the first 30 days. That leaves a 60-day gap in which people are accessing health care services and incurring costs for which they may have no intention to pay. Who will pay the providers for the treatments that patients receive during this 60-day period?**

Answer: I understand that the Affordable Care Act provides individuals receiving a tax credit a three-month grace period to pay any unpaid premiums. This only applies to individuals who have already paid their first month's premium in full. The rules governing the grace period require plans to notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period. If confirmed, I look forward to working with plans and providers to make sure the grace period is implemented in a way to reduce adverse effects to plans, providers, and consumers.

5. **What has been the total cost of creating healthcare.gov to date? What has been the total cost of "fixing" healthcare.gov? Please include a detailed accounting of all costs associated with this website, including (but not limited to) salaries and expenditures, contractor costs, and training.**

Answer: It is my understanding that as of February 28, 2014, CMS has obligated a total of approximately $834 million on Marketplace-related IT contracts and interagency agreements. These expenditures include the website and the systems that support enrollment through the Marketplace, such as the data services hub as well as other supporting IT infrastructure, including cloud computing, to support Marketplace IT development.

6. **What financial outlays are expected for fixing the backend of healthcare.gov? Please include a detailed estimate of future costs for fixing and maintaining the website, including (but not limited to) salaries and expenditures, contractor costs, and training.**

Answer: The President's Budget reflects a need for approximately $200 million for all Marketplace-related IT in FY 2015, some of which is funded through user fees. Much of this amount reflects ongoing operational and maintenance costs of HealthCare.gov, as well as continued development.

7. **With the number of PPACA delays and exemptions approaching 40, there is a great deal of confusion as to what parts of the law are being enforced and which parts will be delayed indefinitely. Going forward, how will you approach enforcement of other unpopular provisions of the law that are necessary to holding down costs?**

Answer: I am committed to working with the President, Congress, states, and other federal agencies to continue the implementation of the Affordable Care Act in a common sense manner that is consistent with the law. If confirmed, I look forward to working with this Committee to help ensure that health care cost continue their downward trend toward affordability.

Before the Affordable Care Act, consumers in the individual market frequently saw double digit rate increases for their health insurance. The Affordable Care Act is contributing to a slowdown in health care spending growth. The Marketplace is encouraging plans to compete for consumers, resulting in affordable rates. Average actual Marketplace premiums for 2014 were lower than those implied by initial Congressional Budget Office (CBO) projections. Additionally, CBO revised its projections for future premiums on April 14, 2014 and found that the Affordable Care Act's coverage expansion will cost $104 billion less over than next ten years than it originally estimated, citing lower than expected premiums as a "crucial factor" in the new estimate.

It is also important to remember advance premium tax credits will lower the actual cost of health insurance premiums for many consumers purchasing coverage through the Marketplace. More than eight out of ten (85 percent) of the people who selected a Marketplace plan through the SBMs and FFM during the 2014 open enrollment period are eligible to receive federal financial assistance in paying their premiums.

The Affordable Care Act also contains many tools to keep large premium increases in check. For example, the Affordable Care Act requires insurance companies to justify rate increases of more than 10%, shedding light on arbitrary or unnecessary costs and protecting consumers from unfair rate hikes. The rate review program works in conjunction with the 80/20 rule or Medical Loss Ratio rule, which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care, and no more than 20 percent (15 percent in the large group market) on administrative costs such as executive salaries, marketing, and profits.

8. **Americans between the ages of 18 and 34 are typically the healthiest individuals in the population and therefore cost insurance companies the least. Yet under PPACA young men and women are seeing their insurance premiums double and even triple. This, in combination with the new guaranteed issue rules, has created a situation in which for many young people remaining uninsured is less risky and more financially reasonable than ever before. This is evidenced by the enrollment numbers showing young people are enrolling at lower than expected rates. What actions should we expect to see from you that would address the economic disincentives for young people to purchase health insurance under PPACA, and instead create an environment where young people are being incentivized to obtain health insurance?**

Answer: First, the provision that allows young people to stay on their parents' plans until they are 26 gives young Americans more flexibility early in their careers.

Additionally, consistent with expectations, through the end of 2014 open enrollment, the proportion of young adults (ages 18 to 34) who have selected a Marketplace plan through the SBMs and FFMs has remained strong. We expect that the robust sign-up numbers we are observing in the Marketplace's first year–8 million at the close of 2014 open enrollment–will encourage insurers to compete on price for consumers during next year's open enrollment period. In addition, provisions of the Affordable Care Act including, rate review and the medical loss ratio rule, will help protect consumers against unfair rate hikes.

SHOP Exchange

1. **Last year, CMS determined that eligible small business employees would not be able to select from any health plan on the SHOP exchange, but would only be able to enroll in a single health plan of the employer's choosing. Then, in November, CMS announced that small employers who applied for coverage through the federal SHOP had to start over and apply for coverage directly through participating health plans. This was very disruptive to small employers. What steps are being taken to ensure that HHS can implement what it had originally planned for 2014 that will allow employees to choose from among multiple health plans?**

Answer: It is my understanding that HHS is continuing to work toward implementing employee choice in all SHOPs, because in the long run employee choice will bring significant benefits to small business owners and their employees. As noted in the March 2014 proposed rule, *Exchange and Insurance Market Standards for 2015 and Beyond*, however, some issuers and state insurance commissioners have expressed concern that employee choice might significantly disrupt some small group markets, and might therefore have a negative effect on the ability of small business owners to access coverage. To address these concerns and smooth the transition, HHS has proposed, based on the recommendation of a state regulatory agency, to not implement employee choice in 2015 if doing so is not in the best interest of consumers. I understand that HHS issued a propose rule on this topic, and will issue a final rule in the near future.

2. **Are CMS, its vendors, and business partners working under a coordinated federal timeline for SHOP Exchange implementation? If so, what are the deadlines and key milestones in the timeline? Please supply that timeline to the Committee.**

Answer: In my role as OMB Director, I was not engaged on specific deadlines and key milestones on SHOP. It is my understanding, however, that CMS continues to work with stakeholders on SHOP. The Federally-facilitated SHOP is open to otherwise-eligible employers with 50 or fewer full-time-equivalent employees (FTEs) and enrollment is open year-round. If confirmed, I will commit to working as expeditiously as possible on this important issue.

Employer Issues

1. **The Congressional Budget Office projected in February of this year that there would be a decline in the number of full-time-equivalent workers of "about 2.5 million in 2024, compared with what would have occurred in the absence of the ACA." However, Secretary Sebelius has denied that PPACA would have any such impact, saying, "There is absolutely no evidence -- and every economist will tell you this -- that there is any job loss related to the Affordable Care Act." Do you agree with Secretary Sebelius, or do you accept the CBO's findings that the ACA will result in a decrease in the number of full-time workers in this country?**

Answer: Prior to the Affordable Care Act, many people could not leave their jobs because they relied on their jobs for health insurance. This "job lock" created significant strain both economically and personally. Over the longer run, the Affordable Care Act will give people more choices and, by providing people with a new source of coverage through the Marketplaces, people are now able to make employment decisions based on what works best for them, be it retiring early, working part-time, or changing to a different job that may not offer health benefits. These are active decisions on the part of empowered Americans.

2. **After the administration made two major delays to the employer mandate, former White House Press Secretary Robert Gibbs said that he does not believe the employer mandate will ever go into effect. Will the employer mandate go into effect? Will any more delays or changes to the employer mandate be made by the administration?**

Answer: For businesses with more than 100 employees, the employer mandate is scheduled to go into effect in January 2015. As you know, employer responsibility provisions are under the purview of the Department of Treasury, so I would respectfully refer you to the Department of Treasury for additional information regarding this question.

3. **Employers have clearly been responding to the incentives created by the ACA's definition of "full time employment" as 30 or more hours per week. Many employers are cutting hours or reducing the size of their workforce to avoid the employer mandate. Excepting the multitude of delays of the mandate, how should the negative effects of the ACA on the American workforce be addressed? If it became apparent that employers continued to be unwilling or unable to adhere to the mandate in December 2014, should we expect more delays?**

Answer: By providing quality, accessible health care coverage through the Health Insurance Marketplaces, the Affordable Care Act creates additional job mobility, puts small businesses on a level playing field with large businesses in the labor market, and enables people to make employment decisions that better suit their needs.

As CBO Director Doug Elmendorf testified, the Affordable Care Act "spurs employment and would reduce unemployment over the next few years." Additionally, CBO estimates indicate that the Affordable Care Act will reduce the deficit by about $100 billion over the budget window – a benefit for our nation's fiscal health.

Medicaid

In January, Kaiser Health News reported that problems with healthcare.gov were preventing the applications of almost 150,000 low income individuals from being transferred to the states for Medicaid and Children's Health Insurance Program enrollment. In response to this growing problem, Secretary Sebelius said during an April 10th Senate Finance Committee hearing that CMS may cut states' federal matching rate for Medicaid funds as an incentive for states to clear their transferred application backlogs.

1. **Are states responsible for the delay in processing applications from healthcare.gov?**

Answer: It is my understanding from HHS that CMS has been working collaboratively with the states in order to achieve a seamless eligibility system that provides consumers with a "no wrong door" approach to accessing affordable health coverage. CMS continues to work with these states to achieve this technical capability.

2. **How would cutting state funding that is available for processing Medicaid applications improve the process?**

Answer: One of the important impacts of the Affordable Care Act is a seamless eligibility system that allows consumers to access the offer of affordable health coverage through state Medicaid agencies or through the Federally-facilitated Marketplace (FFM). CMS has worked in partnership with states to achieve improvements to state eligibility systems so that seamless access to enrollment can be achieved. If confirmed, I look forward to working with you and with states to ensure consumers continue to have access to Medicaid

3. **Are applicants who have been deemed eligible for Medicaid on healthcare.gov being counted as Medicaid enrollees by HHS? If yes, how many?**

Answer: My understanding is that in the regular public reports on the Health Insurance Marketplaces, individuals determined or assessed as eligible for Medicaid or the Children's Health Insurance Program (CHIP) are not included in the FFM enrollment counts. Those determinations and assessments are listed elsewhere on the reports.

4. **What is done to inform these individuals on the status of their applications?**

Answer: It is my understanding from HHS that when an individual has applied at the Federally-facilitated Marketplace (FFM) and has been determined or assessed as eligible for Medicaid or CHIP, the individual receives a notice informing them of that decision and that their account is being transferred to the Medicaid agency for enrollment. In some cases the individual is contacted directly and encouraged to apply directly with the state Medicaid agency.

Medicare

1. **PPACA cut funding for the popular Medicare Advantage (MA) program. To date, PPACA has reduced benefits for seniors enrolled in MA by roughly $1,500 per**

beneficiary on average, and used the savings to fund new subsidies through the health care exchanges. However, only about 20 percent of the ACA mandated cuts to MA have been implemented so far. Would you support efforts to repeal these damaging cuts, which disproportionately impact low-income seniors who often cannot afford a Medigap plan? Or, do you believe it is appropriate to cut benefits to seniors to fund a new entitlement program?

Answer: I expect Medicare Advantage (MA) will continue its strong performance into the future. With enrollment at an all-time high and costs remaining stable, concerns that recent changes to the MA program would result in lower enrollment and higher costs have not come to fruition. Nationwide, over 15 million Medicare beneficiaries are now enrolled in an MA plan. This is a 30 percent increase in enrollment since 2010, and enrollment is projected to continue increasing. Plan participation continues to be robust with 99.1 percent of beneficiaries having access to an MA plan in their area. Since passage of the Affordable Care Act, average MA premiums are down by 9.8 percent. Robust access, growing enrollment, slow-growing premiums, and stable plan choices are all indications that the MA program can be expected to remain strong in the coming years. If confirmed, I will ensure that the Department continues to closely monitor the program to make sure it continues to provide access to Medicare benefits.

2. **The Medicare Part D program is a resounding success, coming in more than 40% under budget with a customer satisfaction rating in the middle 90s. In March, CMS rescinded the ill-advised proposed Part D rule that garnered bipartisan, bicameral opposition because of the drastic effect it would have on seniors. As HHS Secretary, would you commit to not implementing any of these controversial provisions pertaining to Medicare Part D as included in CMS' January 10th proposed rule?**

Answer: I understand that the proposed rule included many important provisions related to the Medicare Part C and D prescription drug program. During the rule's comment period, CMS received numerous concerns about some elements of the proposal from members of Congress and stakeholders. In particular, there were concerns raised about the proposals to lift the protected class definition on three drug classes, to set standards on Medicare Part D plans' requirements to participate in preferred pharmacy networks, to reduce the number of Part D plans a sponsor may offer, and clarifications to the non-interference provisions. Given the complexities of these issues and stakeholder input, I understand CMS has previously indicated that the final rule will not finalize these proposals.

3. **As HHS Secretary, would you commit to inviting a diverse group—including providers, beneficiary/patient advocacy groups, payer/plan sponsor groups and other related stakeholders in the Part D program—to advise and consult CMS on developing any future changes to the program so as to ensure greater transparency and collaboration in the rulemaking process?**

Answer: If confirmed, I am committed to continuing to work with Congress and external stakeholders to ensure that the Part D program works best for Medicare beneficiaries while remaining affordable.

4. **I was particularly concerned by CMS' re-interpretation of the "non-interference" clause in the January proposed Part D rule. Has the agency had the opportunity to review this re-interpretation in light of the agency's previous 9 years' experience, statements and rulemaking—as well as the HHS' OIG interpretation—of "non-interference"? Upon completing your review of all these materials, would you share your views of CMS' interpretation of the "non-interference rule" as put forward in the January Part D proposed rule?**

Answer: It is my understanding that, due to feedback on the proposal and the need for more time to consider the policy, CMS does not plan to finalize this proposal at this time.

5. **My understanding is that several of the policy changes put forth in the proposed Part D rule were based upon incomplete and inconclusive data analyses (specifically on networks and mail order/retail pharmacy costs). None of these studies were reviewed outside of CMS. CMS did not release the underlying data behind these studies and has not done so to this day. Many commenters (including MedPAC and several actuarial firms) have questioned CMS' methodologies behind these studies. Would you commit to requiring that CMS either submit future internal analyses/studies based on its data to peer-review, open public comment, the Office of the Actuary, and/or the Assistant Secretary for Policy and Evaluation before permitting their use as a basis for future policy changes to the Part D program?**

Answer: It is my understanding that data analyses that were used as the basis for proposed regulations in the Notice of Proposed Rulemaking (NPRM) entitled "Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs" were cited in the NPRM and made available for public comment. This is consistent with longstanding CMS practice in rulemaking.

The CMS Office of the Actuary also prepares independent analysis in support of the Regulatory Impact Analysis for proposed and final rules. External engagement and input is obtained through the notice and comment rulemaking process as well as through the frequent engagement between CMS staff and external stakeholders and experts, including MedPAC. If confirmed, I look forward to working to ensure that this practice is continued and to address any additional concerns you have regarding this process.

6. **Under the Sustainable Growth Rate (SGR) rules, the Medicare physician fee schedule should see a 20.1 percent cut in 2014. What has become known as the "Doc Fix" has continuously delayed implementing these cuts. If Congress fails to find a solution to the rapidly rising cost of Medicare by 2015, PPACA gives members of the Independent Payment Advisory Board–or if the board is not yet confirmed, the Secretary of HHS–the power to force Medicare cuts that would place an increased burden on Medicare Advantage and Medicare Part D plans in the first five years. How would you, if given the power, attempt to find the savings required by PPACA and PAYGO, without sacrificing Medicare access and quality?**

Answer: The Independent Payment Advisory Board (IPAB) serves as a backstop to protect against excessive cost growth in the Medicare program. IPAB may not propose increases in cost-sharing or beneficiary premiums, restrictions on benefits, rationing of health care, or changes in eligibility. According to analysis conducted by the independent CMS Actuary for the President's FY 2015 Budget, projected that per capita Medicare spending growth will not exceed the statutory-based target specified for IPAB until 2019, meaning that recommendations would not need to be submitted for Congressional consideration until at least 2018. The President's FY 2015 Budget, includes a package of legislative proposals that will save over $400 billion over 10 years by more closely aligning payments with costs of care, strengthening provider payment incentives to promote high-quality efficient care and creating incentives for beneficiaries to seek high-value services. Enactment of these proposals would delay the date of IPAB required recommendations for years beyond 2018.

Employer Wellness Plans

1. **During congressional consideration of the health care law, an amendment was adopted related to wellness incentives for employees. Wellness plans permit employers to offer incentives to employees who participate and achieve improved health outcomes through programs targeted at a few conditions that can be managed or improved to reduce long-term health effects. These programs help individuals lose weight, reduce high blood pressure, manage diabetes and quit smoking, for example. Unfortunately, the final rules hamper wellness efforts that incentivize employees to achieve a goal. Those employees who can't achieve a goal because of an underlying medical condition should certainly be exempt or given another alternative. But the final rules say that an employee, without a medical reason, must be given another option at any time during the plan year. At a time when the Administration is working to encourage all Americans, including employers, to design and participate in innovative approaches to achieving improved health outcomes, would you commit to urging the appropriate federal officials to give employers the regulatory flexibility they need, and currently do not have, to innovate and motivate employees to work to improve their own health and prevent diseases?**

Answer: Appropriately designed wellness programs have the potential to contribute importantly to promoting health and preventing disease. Figuring how to balance the laudable goals of wellness programs while ensuring that an employee does not face discrimination in eligibility, benefits or premiums based on a health factor, as required by the law, is key. I look forward to working with you on these issues if confirmed.

Health Insurance Tax

1. **The health insurance tax is levied on all insurers, including many federal programs, Medicare Advantage plans, and Medicaid managed care organizations. By taxing these programs, the federal government has in fact taxed itself (through its subsidization of Medicare and – in part – Medicaid) and state governments (through**

Medicaid). How much of the health insurance tax will be borne by the federal and state governments?

Answer: It is my understanding that the annual fee assessed on health insurance providers under section 9010 of the Affordable Care Act is administered by the Department of Treasury and Internal Revenue Service. I therefore respectively refer you to those agencies for further information regarding this issue.

Expatriate Health Plans

1. **When PPACA became law, it included dozens of new regulations on health insurers, but it did not distinguish between health insurance sold to consumers in the U.S. and expatriate health insurance sold to employees and families outside of the U.S. The House recently passed legislation with bipartisan support that would exempt expatriate plans from PPACA given the unique challenges of offering this coverage. HHS has already made several exemptions for expatriate plans through regulation. Would you support a permanent fix in legislation?**

Answer: The Administration remains willing to work with the Congress to address the special circumstances of expatriate plans and to maintain basic consumer protections for all workers. If confirmed, I look forward to working with you on this issue.

Regulatory Changes to PPACA

1. **Please cite the legal authority for each of the following delays, waivers, or changes to the statutory requirements in PPACA:**

***Medicare Advantage patch*: The administration ordered an advance draw on funds from a Medicare bonus program in order to provide extra payments to Medicare Advantage plans, in an effort to temporarily forestall cuts in benefits and therefore delay an early exodus of MA plans from the program. (April 19, 2011)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Employee reporting*: The administration instituted a one-year delay of the requirement that employers must report to their employees on their W-2 forms the full cost of their employer-provided health insurance. (January 1, 2012)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation

efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Department of Treasury. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Department of Treasury for any information about the relevant legal determination not contained in those documents.

***Subsidies may flow through federal exchanges*: The IRS issued a rule that allows premium assistance tax credits to be available in federal exchanges although the law only specified that they would be available "through an Exchange established by the State under Section 1311." (May 23, 2012)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Department of Treasury. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Department of Treasury for any information about the relevant legal determination not contained in those documents.

***Delaying a low-income plan*: The administration delayed implementation of the Basic Health Program until 2015. This program would have provided more-affordable health coverage for certain low-income individuals who were ineligible for Medicaid. (February 7, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Closing the high-risk pool*: The administration decided to halt enrollment in transitional federal high-risk pools created by the law, blocking coverage for an estimated 40,000 new applicants, citing a lack of funds. The administration had money from a fund under Secretary Sebelius's control to extend the pools, but instead used the money to pay for advertising for Obamacare enrollment and other purposes. (February 15, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Doubling allowed deductibles*: Because some group health plans use more than one benefits administrator, plans are allowed to apply separate patient cost-sharing limits for one year to different services, such as doctor/hospital and prescription drugs, allowing maximum out-of-pocket costs to be twice as high as the law intended. (February 20, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS along with other agencies. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Small businesses on hold*: The administration has said that the federal exchanges for small businesses will not be ready by the 2014 statutory deadline, and instead delayed until 2015 the provision of SHOP (Small-Employer Health Option Program) that requires the exchanges to offer a choice of qualified health plans. (March 11, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Employer-mandate delay*: By an administrative action that's contrary to statutory language in the ACA, the reporting requirements for employers were delayed by one year. (July 2, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Department of Treasury. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Department of Treasury for any information about the relevant legal determination not contained in those documents.

***Self-attestation*: Because of the difficulty of verifying income after the employer-reporting requirement was delayed, the administration decided it would allow "self-attestation" of income by applicants for health insurance in the exchanges. This was later partially retracted after congressional and public outcry over the likelihood of fraud. (July 15, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was

made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

Delaying the online SHOP exchange: **The administration first delayed for a month and later for a year until November 2014 the launch of the online insurance marketplace for small businesses. The exchange was originally scheduled to launch on October 1, 2013. (September 26, 2013) (November 27, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Congressional opt-out*: The administration decided to offer employer contributions to members of Congress and their staffs when they purchase insurance on the exchanges created by the ACA, a subsidy for which the law does not provide. (September 30, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Office of Personnel Management. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Office of Personnel Management for any information about the relevant legal determination not contained in those documents.

***Delaying the individual mandate*: The administration changed the deadline for the individual mandate, by declaring that customers who have purchased insurance by March 31, 2014 will avoid the tax penalty. Previously, they would have had to purchase a plan by mid-February. (October 23, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

Insurance companies may offer canceled plans: **The administration announced that insurance companies may reoffer plans that previous regulations forced them to cancel. (November 14, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

Exempting unions from reinsurance fee: **The administration gave unions an exemption from the reinsurance fee (one of PPACA's many new taxes). To make up for this exemption, non-exempt plans will have to pay a higher fee, which will likely be passed onto consumers in the form of higher premiums and deductibles. (December 2, 2013)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Extending Preexisting Condition Insurance Plan*: The administration extended the federal high risk pool until January 31, 2014 and again until March 15, 2014, and again until April 30, 2014 to prevent a coverage gap for the most vulnerable. The plans were scheduled to expire on December 31, but were extended because it has been impossible for some to sign up for new coverage on healthcare.gov. (December 12, 2013) (January 14, 2014) (March 14, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Expanding hardship waiver to those with canceled plans*: The administration expanded the hardship waiver, which excludes people from the individual mandate and allows some to purchase catastrophic health insurance, to people who have had their plans canceled because of PPACA regulations. The administration later extended this waiver until October 1, 2016. (December 19, 2013) (March 5, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was

made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

Equal employer coverage delayed: **Tax officials will not be enforcing in 2014 the mandate requiring employers to offer equal coverage to all their employees. This provision of the law was supposed to go into effect in 2010, but IRS officials have "yet to issue regulations for employers to follow." (January 18, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Department of Treasury. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Department of Treasury for any information about the relevant legal determination not contained in those documents.

Employer-mandate delayed again: **The administration delayed for an additional year provisions of the employer mandate, postponing enforcement of the requirement for medium-size employers until 2016 and relaxing some requirements for larger employers. Businesses with 100 or more employees must offer coverage to 70% of their full-time employees in 2015 and 95% in 2016 and beyond. (February 10, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by the Department of Treasury. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. I would respectfully refer you to the Department of Treasury for any information about the relevant legal determination not contained in those documents.

Extending subsidies to non-exchange plans**: The administration released a bulletin through CMS extending subsidies to individuals who purchased health insurance plans outside of the federal or state exchanges. The bulletin also requires retroactive coverage and subsidies for individuals from the date they applied on the marketplace rather than the date they actually enrolled in a plan. CRS issued a memo discussing the legality of these subsidies. (February 27, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Non-compliant health plans get two year extension*: The administration pushed back the deadline by two years that requires health insurers to cancel plans that are not compliant with PPACA's mandates. These "illegal" plans may now be offered until 2017. This extension will prevent a wave of cancellation notices from going out before the 2014 midterm elections. (March 5, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Delaying the sign-up deadline*: The administration delayed until mid-April the March 31 deadline to sign up for insurance. Applicants simply need to check a box on their application to qualify for this extended sign-up period. (March 26, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

***Canceling Medicare Advantage cuts:* The administration canceled scheduled cuts to Medicare Advantage. The ACA calls for $200 billion in cuts to Medicare Advantage over 10 years. (April 7, 2014)**

Answer: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Ultimately, final actions on implementation efforts rest with the relevant agencies. For the issue identified above, the final decision was made by HHS. The legal basis for such decisions may be described in rulemaking, guidance, or other relevant documents. Should you determine those materials do not contain the information you seek, if confirmed, I look forward to working with HHS counsel to address your remaining concerns.

Rights of Conscience

1. **The HHS regulation that all organizations which provide health insurance to their employees must provide the full range of contraceptive services, with only a few exceptions, flies in the face of religious liberty in this country. Is it your intention to maintain this requirement even against organizations that claim such a requirement violates their deeply held religious beliefs?**

Answer: I believe that religious freedom and women's preventative health are both important. The Department outlined a clear path forward to address religious liberty concerns while ensuring that women have access to key preventive services, including contraception. The final rule includes an accommodation for non-profit religious organizations, such as non-profit religious hospitals and universities that object to contraceptive coverage. Non-profit religious organizations are not required to provide, fund, administer, or contract or refer for contraceptive coverage, but their employees will be automatically provided separate contraceptive coverage without cost-sharing. There is also an exemption for houses of worship. Houses of worship are not required to provide, fund, administer, or contract or refer for contraceptive coverage.

2. **President Obama has said he supports current federal laws on protection of conscience rights, such as the Weldon amendment and the Church amendment. Do you support these protections? Do you intend to give them maximum effect in the way you administer programs at HHS?**

Answer: I support the protection of conscience rights, and if confirmed, I would ensure that HHS programs are administered consistent with all federal laws protecting conscience rights, including the Weldon and Church amendments.

3. **Secretary Sebelius has publicly committed to providing a list of exchange plans that do not provide abortion coverage, so that people can purchase insurance coverage that does not violate their conscience. I am unaware of that list having been made public. Please provide the list of plans in the state and federal exchanges that do not provide abortion coverage.**

Answer: As OMB Director, I was not directly engaged on this topic. I understand that CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the QHPs available to them. Additionally, each plan in the Marketplace must include a Summary of Benefits and Coverage and a link to the plan brochure, where consumers can learn more about which services are covered. If confirmed, I will continue the work of the CMS to assure that consumers have access to information regarding the coverage they are purchasing in the Marketplaces.

Health IT

1. **As the Meaningful Use Electronic Health Record Incentive program winds down in the next few years, do you plan to scale back the Office of National Coordinator's (ONC) role and allow market forces, patients, and providers, to determine the technologies, systems and practices best suited to increase efficiency and the quality of care in our health system? How will you ensure that the agency stays focused on its convening and coordination role and does not stray into over-regulating in ways that stifle Health IT innovation?**

Answer: ONC was first established in 2004 by Executive Order during the Bush Administration and was established by legislation in 2009, with the enactment of the HITECH Act, part of the

Recovery Act. HITECH provided broad, permanent authorities for ONC to promote the widespread adoption of standardized and certified health information technology, facilitate the secure use and exchange of interoperable health information, and promote the delivery of safe, high-quality, best-practice care.

As the federal entity charged with achieving this vision, ONC focuses on high-level coordination across the Administration and with the private sector. The agency will continue to serve as convener on health IT advancement and innovation in the nation with the aim of enabling and informing health delivery and payment reform and improving the public's health. If confirmed, I will work to ensure that ONC continues to meet its goals and objectives.

2. **Congress intended the Medicare and Medicaid electronic health record (EHR) incentive programs to support widespread adoption of interoperable technology to improve health care. A recent report from GAO (GAO-14-207) indicates that the first stage of the program has led to increased adoption, but noted that program changes make future participation difficult to estimate. Indeed, health care providers have expressed significant concerns about the readiness of EHR vendors to support the mandatory transition to the 2014 Edition Certified EHR in a safe and orderly fashion. They also have concerns about the overly complex, rigid requirements of the meaningful use program. Why hasn't the Administration taken steps to address provider concerns about the challenges adopting the 2014 Edition EHRs certified through the HHS program? If confirmed, what specific steps will you take between now and the end of the fiscal year to ensure that any provider making a good faith effort can meet the requirements?**

Answer: I am aware that HHS has been listening to providers, health care associations, EHR vendors, and its partners in the health care industry. In December 2013, HHS announced that it would engage in rulemaking to extend Stage 2 of meaningful use for one year and allow Stage 3 to begin in 2017. In addition, ONC issued a 2015 Edition EHR Certification Criteria Proposed Rule as part of its new regulatory approach to provide more frequent updates to the certification criteria. This approach is designed to provide more time for public input on policy proposals, enable the certification processes to more quickly adapt to include newer industry standards that can lead to greater interoperability, and add more predictability for EHR technology developers.

By extending Stage 2 until 2017, HHS would have an additional year of Stage 2 implementation data to help inform any program changes. An extension also allows CMS and ONC to better align quality performance measures across federal programs and to consider effective Stage 3 approaches to advance interoperability and clinical decision support capabilities that will help drive improved health outcomes.

In response to stakeholder concerns that providers were having difficulties meeting the requirements of Stage 2, CMS and ONC announced in February 2013 that additional flexibility would be provided that would allow eligible professionals and hospitals to request a hardship exception because they are unable to control the availability of Certified EHR Technology (CEHRT) at a practice location or a combination of practice locations.

If confirmed, I look forward to working with CMS and ONC on these ongoing efforts.

Patient Privacy

1. **Since the passage of the Patient Safety and Quality Improvement Act of 2005, CMS has engaged in a practice of encouraging State Survey Agencies to believe that they are entitled to receive and make public patient safety work product (confidential information). In spite of the fact that dissemination of this protected information is a criminal offense, many hospital executives must make a difficult choice between complying with the survey agencies' request and facing other survey sanctions. Efforts to get CMS and the Agency for Healthcare Research and Quality (AHRQ) to clarify this issue and to avoid continued violations of the Patient Safety and Quality Act have failed. Will you commit to working with this committee to continue to protect patient safety work product and to ensure that CMS and AHRQ do not issue policies or guidance or otherwise engage in practices that violate this fundamental protection?**

Answer: Yes, if confirmed I believe that patient safety should be one of the highest priorities and will be happy to review this issue with the Department and work with Congress to eliminate the risk of future violations.

Food and Drug Administration

1. **I have heard a lot lately about the cost and complexity of FDA regulations, and there seems to be a pattern that regulations from FDA officials have a well-intentioned goal, but do not provide evidence showing how the regulation will achieve the stated goal. As one example, the Animal Feed regulation claims reducedrisk to humans and animals as a benefit, but has no empirical evidence that contamination would be less likely if the proposed rule is implemented. Would you ensure that cost and complexity of FDA regulations are justified to protect the public health, and include evidence to justify that conclusion?**

Answer: In its rulemaking activities, FDA has complied with the numerous federal requirements to analyze the regulatory impact of each proposed rule and to conduct cost/benefit analyses. FDA's goal in implementing the FDA Food Safety Modernization Act (FSMA) has been to improve public health protections while minimizing undue burdens on the affected industry. FSMA provides an opportunity to significantly strengthen our food safety system by focusing more on preventing food safety problems rather than reacting to problems after they occur. The benefits of this shift to a focus on prevention are significant.

The proposed rule entitled, "Current Good Manufacturing Practice (CGMP) and Hazard Analysis and Risk-Based Preventive Controls for Food for Animals" (preventive controls for animal food proposed rule) would require facilities that produce animal food to identify the hazards associated with the product and control these hazards. The reduction in contaminated food would reduce the risk of illness or injury to animals, to humans handling animal food, and to

humans consuming food products of animal origin, which in turn would generate social benefits in the form of potential improvements in public health.

FDA solicited comment on the Preliminary Regulatory Impact Analysis (PRIA) report that accompanied the proposed rule and will carefully consider the comments before finalizing the rule.

2. **The FDA recently proposed a "tentative determination" to ban certain fats, a regulation which has reportedly driven some restaurants and food manufacturers to return to using regular liquid saturated fats with the same long standing oxidation problems (which were determined to lead to cirrhosis of the liver and early death). In addition to the increased health concerns with such a ban, this "determination" was issued by FDA without any OMB review even though the cost estimate is in the tens of billions of dollars. How did such a significant rule escape OMB review? Will you review this policy and proposal with an eye toward a true cost-benefit analysis?**

   Answer: FDA has established procedures under 21 CFR 170.38(b)(1) for issuing notices in the Federal Register when proposing to determine that a substance is not "Generally Recognized as Safe" (GRAS) and is, therefore, a food additive subject to section 409 of the Act. In short, the procedures include a requirement that FDA place all of the data and information it used to make this determination in the public docket, and publish a Federal Register notice with the name of the substance, its known uses, and a summary of the basis for the determination, for public notice and comment. Finally, the procedures require an additional Federal Register notice of the final determination, whether or not the substance is ultimately found to be GRAS.

   FDA followed these procedures when announcing its tentative determination that partially hydrogenated oils are no longer "GRAS." In addition, FDA shared a draft of this action with OMB, and we reviewed it including evidence of its costs and benefits. The comment period for this action closed on January 7, 2014. FDA is in the process of considering public comments and determining appropriate next steps.

3. **There was considerable interest in many of the decisions made by OMB related to implementation of the Sequester. One issue in particular that caused considerable consternation and required Congress to intervene was OMB's decision to sequester FDA user fees. Were you personally involved in OMB's decisions about how to implement the Sequester? Did you have a role in the decision to sequester FDA user fees? Do you believe that sequestration was the appropriate course of action for private industry-funded fees? Can you provide the specific statutory reference that mandates that privately paid user fees be sequestered by the government? What criteria did OMB use to deem a user feed "voluntary" versus "involuntary"? Would you commit to maintain the use of FDA user fees only for their intended and authorized purpose, and not for redirection to deficit reduction or other activities?**

   Answer: Determinations regarding the application of sequestration to specific accounts are made by OMB's Office of General Counsel, in consultation with the relevant agency general

counsel. The vast majority of such determinations were made before I became Director, including the determination regarding FDA user fees, and thus I was not personally involved in those determinations.

That said, the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended, provides the Administration with little flexibility with respect to the application of sequestration. As set forth in BBEDCA, sequestration reduces budgetary resources in all budget accounts, unless expressly exempted by the law.

Consistent with what OMB has stated in response to previous inquiries on this topic, the determination that FDA user fees are subject to sequestration is consistent with long-standing, government-wide application of the relevant provisions. Both BBEDCA and the Congressional Budget and Impoundment Control Act of 1974 provide that the authority to spend offsetting collections, such as FDA user fees, constitutes budgetary resources. As mentioned above, sequestration reduces budgetary resources in all budget accounts, unless expressly exempted by the law. No such exemption from sequestration applies to FDA's authority to spend offsetting collections.

Pursuant to BBEDCA, sequestered FDA user fees remain as an unavailable balance in FDA's Salaries and Expenses account and may not be used for other purposes. Congress can appropriate that funding in subsequent years, as it did in Fiscal Year 2014.

Early Childhood Development

1. **In 2012, the Government Accountability Office cited over 45 programs that may provide services for early childhood development, 12 of which have an explicit program purpose of providing early learning or child care services. If confirmed as Secretary, how will you work to allow states to implement GAO's recommendation to improve coordination among these programs in order to reduce program fragmentation and streamline the numerous early childhood programs the federal government funds, including those housed at the Department of Health and Human Services?**

Answer: Over the past several years, the Administration has been aggressively addressing alignment of early childhood programs by working toward aligning standards, streamlining monitoring, and coordinating technical assistance and professional development efforts, among other activities.

The Early Head Start-Child Care Partnerships (EHS-CCP) are an example of our strong commitment to alignment across programs. These grants are breaking down the barriers between two programs and in doing so enhancing their quality and reach. EHS-CCP grants align the Early Head Start and child care programs and provide more of our nation's children and families with high quality early learning experiences that will set them up for success in school and beyond.

The Administration plans to continue building on alignment efforts to develop and strengthen a seamless, high quality continuum of early education for children and families birth to school

entry. It's important to keep in mind however, that the most significant problem we face is access to high quality early education. Even Early Head Start, the largest federal early childhood program for infants and toddlers, only serves about 4% of all eligible children. We are not even close to filling the need, although the $500 million Congress provided in the Omnibus is welcomed and will expand access to high-quality care for infants and toddlers through partnerships and Early Head Start expansion.

If confirmed, I will continue to work with states and our partners across the federal government to assure strong alignment, with the goal of giving every child the early experiences that set them up to achieve their full potential, which directly affects our country's competitive edge in a global economy.

2. **If confirmed as Secretary, how will you create an environment to free up States to overcome the fragmentation that exists among early childhood programs so that they can serve a greater number of families while minimizing unwarranted overlap and reducing conflicting and inappropriate federal mandates on what states do with limited federal funds?**

Answer: If confirmed, I will build on the work that has begun at the Department to reduce any potential overlap and fragmentation in these important programs. For example, the EHS-CCPs demonstrate the Administration's strong commitment to eliminating fragmentation and aligning programs at the federal level, while also expanding the reach and enhancing the quality of early education for children across the country. States and local communities across the country, as well as non-profit and for-profit agencies, are eligible to apply for these grants, creating an important opportunity for federal-state and within-state policy alignment across child care, Head Start, and other early learning programs.

HHS is working toward ensuring statewide coordination and collaboration among the wide range of early childhood programs and services in the state through state advisory councils. If confirmed, I will continue the work that has begun at the Department on this effort.

3. **How can the Department of Health and Human Services help states have more control over Federal early childhood development programs so that states can determine the best methods of mixed delivery models that includes services provided by private providers, including child care centers that work for their populations?**

Answer: States across the country are taking the lead in expanding early education programs around the country. States like West Virginia, Georgia, and Oklahoma are doing incredible work using mixed delivery models that work for their children and families.

If confirmed, I look forward to working with states to make existing programs work better for them and for the young children and families that are depending on us to level the playing field, and give them a real shot at success by identifying best practices in states and supporting the sharing of information.

Head Start Program

1. **The implementation of the process required under the Head Start Act of 2007 under which underperforming Head Start grantees must re-compete in order to continue operating those centers was a dramatic improvement in the management of the Head Start program; now, Head Start grantees are more accountable for performance and maintaining the standards of the program. Will you commit to continuing this competitive process to re-designate Head Start grantees with questionable performance, and how might this process inform the way the Department of Health and Human Services manages other Federal programs and grants serving children and?**

Answer: If confirmed, I commit to continuing the Designation Renewal System (DRS) under which underperforming grantees must compete for funding. Additionally, I am committed to ensuring that the system promotes high quality services for children and families and continuous improvement for grantees. I will look at the results of the DRS evaluation once it is completed to assess it successes and challenges and to determine if it is applicable to other programs within the Department.

2. **The Head Start Act of 2007 authorized the designation of some 200 Centers of Excellence as a means to support best practices in early childhood programs as well as improve the dissemination of those practices to other Head Start centers and service providers. In 2009, HHS designated 10 Head Start Centers of Excellence and provided funding to support such activities through 2014. If confirmed as Secretary, will you commit to support effective implementation of the Centers of Excellence concept as a means to develop and disseminate best practices in order to improve the outcomes for Head Start participants?**

Answer: Yes, I commit to continuing to learn from the Centers of Excellence specifically and from local innovation generally. It is essential that local programs inform our understanding of best practices. The Centers of Excellence designation and funding has allowed programs to sustain best practices and disseminate information to other Head Start programs. Funding was previously provided to support one cohort of Centers of Excellence grants, and their period of performance ends in 2014. However, during the next year I understand that HHS will review the effort to see what it can learn from the program and how that information can be used going forward.

Child Abuse Prevention and Treatment

A 2014 report by the Government Accountability Office found that federal agencies have provided limited support in the form of training, guidance and resources, federal funding, and data collection related to child sexual abuse. Furthermore, these efforts are not well coordinated or disseminated. Most states and local officials are not aware of the federal resources that are currently available and have been left to address sexual abuse and misconduct with minimal federal guidance.

1. **As the principal federal agency that provides oversight, training, and education to states and local officials on implementation of federal child abuse and welfare requirements, how do you plan to strengthen the child abuse, neglect prevention, and treatment programs to raise awareness and reduce the incidents of child abuse and neglect nationwide?**

Answer: This is an important issue and a priority in terms of protecting some of our nation's most vulnerable children. The 2014 GAO report referenced, *Child Welfare: Federal Agencies Can Better Support State Efforts to Prevent and Respond to Sexual Abuse by School Personnel*, is specific to sexual assault by school personnel. It provides a review and assessment of efforts to address child sexual abuse by school personnel. As such, GAO's recommendations focus primarily on how the Department of Education should take action to prevent and respond to child sexual abuse by school personnel in collaboration with the Secretary of HHS and the Attorney General to leverage resources, expertise and capacities departments.

The purview of HHS through the Children's Bureau is the oversight of child welfare services, including the prevention of abuse and neglect of children by parents and caregivers as defined by state statute. In this capacity, efforts are underway to raise awareness and prevent the sexual abuse of children. Work includes the Children's Justice Act (CJA), the Community-Based Child Abuse Prevention Program (CBCAP), the Child Welfare Information Gateway and the annual Prevention Resource Guide.

If confirmed, I will continue to advance the current programmatic and awareness initiatives and partner with the Department of Education to assist with further efforts to address child abuse through leveraging resources, expertise and capacities across departments.

2. **What steps will you take to work with the U.S. Departments of Education, Justice, and other federal agencies to strengthen the coordination of the child abuse and neglect programs to ensure greater efficiency and focus for direct services?**

Answer: If confirmed, I look forward to working with the Departments of Education, Justice, and other federal agencies to strengthen the coordination of child abuse and neglect programs. The Department has managed efforts to broadly share and disseminate information, promote awareness, and create, foster and implement opportunities for collaborative efforts to address child abuse and neglect, including through the Federal Interagency Workgroup on Child Abuse and Neglect (FEDIAWG), which provides a forum for staff from federal agencies to share and disseminate information, promote awareness, and create, foster and implement opportunities for collaborative efforts to address child abuse and neglect.

<u>Child Care and Development Block Grant</u>

1. **The United States Senate recently passed the Child Care and Development Block Grant of 2014. If this reauthorization proposal becomes law, would the regulations proposed by the Department of Health and Human Services (45 CFR part 98) be withdrawn and new regulations proposed that fit within the framework authorized by Congress?**

Answer: Should Congress pass and the President sign legislation to reauthorize the Child Care and Development Block Grant program, the Administration would revisit the rule as part of its work to implement the new statute.

2. **How will the Department of Health and Human Services work to support services like those under the Child Care and Development Block Grant that provide States with flexibility to implement programs in a manner that meets the need of the State and encourages parental choice in order to meet the individual needs of residents?**

Answer: I understand that the Child Care and Development Block Grant provides state, territory, and tribal grantees with flexibility to meet the needs of low-income families and children within their jurisdiction, and I look forward to working with you to ensure that the program best meets the needs of those it serves. I understand that HHS has established national centers to provide technical assistance on topics such as child care quality improvement and subsidy innovation and accountability, as well as worked collaboratively with states, territories, and tribes through on-site visits and regional meetings. As implemented, the CCDF program ensures parental choice to a wide variety of child care providers—with over 460,000 providers participating across a range of settings, including centers and family child care homes.