EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

May 21, 2014

The Honorable Ted Cruz
United States Senate
Washington, D.C. 20510

The Honorable Michael S. Lee
United States Senate
Washington, D.C. 20510

Dear Senators Cruz and Lee:

Thank you for your recent letter regarding my nomination for Secretary of the U.S. Department of Health and Human Services (HHS). I appreciate you taking the time to share your views and priorities for the Department, and if confirmed, I hope to work closely with you in these areas and others. Senator Lee, I very much look forward to discussing these issues further in our meeting on Thursday. Senator Cruz, I know that my office reached out to find time, and I hope that we will have that opportunity.

As you know, a number of the questions you raise deal with issues specific to HHS that I have not been directly involved with in my current role as Director of the Office of Management and Budget (OMB). However, the answers enclosed represent my current best understanding. If confirmed, I would be happy to meet with you to discuss these and other issues in further detail. Please do not hesitate to reach out to my office at any point.

I appreciate your thoughtful consideration of my nomination.

Sincerely,

Sylvia M. Burwell
Director

Enclosure

Sylvia M. Burwell responses to inquiries:

- On May 7, 2014, Mark Pratt with America's Health Insurance Plans (AHIP) testified before the House Energy and Commerce Committee's Subcommittee on Oversight and Investigations and stated that due to challenges during open enrollment, insurers have many duplicate enrollments. Does your estimate that there have been approximately 8 million exchange enrollees take duplicate enrollments into consideration and remove them from the count? What percentage of exchange enrollees, broken down by age ranges, has paid its first month's premium? Will you commit to disclosing the percentage of exchange enrollees, broken down by age ranges, that have paid subsequent premiums-first two months, first three months, etc?

  Response: If confirmed, as I have stated in my testimony, I will focus on transparency and accuracy in providing information to both Congress and the public. I have shown a strong commitment to responsiveness throughout my time at OMB, and I plan on continuing this approach at HHS, if confirmed.

  As I understand from HHS, de-duplicating data is an ongoing activity, and CMS believes that the 8 million represents unique individuals. With respect to a complete and accurate percentage of enrollees making premium payments, as I mentioned in my hearing, that is not information that the Administration has at this time, because issuers are still providing their final numbers. However, 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. When CMS has accurate and reliable data regarding premium payments, I will see that this information is made available in a timely manner.

- What percentage of exchange enrollees had some form of health insurance during 2013 prior to their enrollment in an exchange? Because the federal exchange's application asks if individuals have insurance either through a job or elsewhere, you should have access to this information.

  Response: The Affordable Care Act (ACA) has set the nation on a path to expand access to coverage, to improve the quality of care, and to help bend the health care cost growth curve. Thanks to the ACA, Americans with pre-existing conditions no longer have to worry that they will be discriminated against when they seek the health care coverage that they need. Reducing the rate of the uninsured is an important metric of success, but the question that you reference on the enrollment application was not designed to collect that data or to replace other public and private mechanisms for collecting that data in a standardized way. The Assistant Secretary for Planning and Evaluation's issue brief published on May 1, 2014, includes a detailed appendix about the coverage status of individuals at the time of application. As noted there, CMS only collects data on health insurance coverage at the time of application for individuals seeking financial assistance and only those seeking assistance through the Federally-facilitated Marketplace. This appendix also notes that the coverage question on the Marketplace application form is designed to capture whether an individual

currently has health insurance, and not whether an individual may have been covered prior to the time of application.

That report indicates that, of the 5.45 million people who selected a Marketplace plan through the FFM during the period October 1, 2013–March 31, 2014 (including Special Enrollment Period (SEP) activity through April 19, 2014), 5.18 million applied for financial assistance and were required to answer a question about their health insurance coverage. Of these 5.18 million who applied for financial assistance and selected in a plan, 695,011 (13 percent) indicated that they had coverage at the time of application. CMS is also requesting information from SBMs on coverage at the time of application. These data will be available at a later date. In terms of publicly available information, at least two State-based Marketplaces have publicly released information on previous health insurance coverage at the time of application among persons who selected Marketplace plans. NY State of Health has reported that about 30 percent of its combined 960,000 enrollees in Marketplace plans and in Medicaid/CHIP through April 15, 2014 had insurance coverage at the time of application—twice the level of health insurance coverage at the time of application among persons who applied for financial assistance and selected Marketplace plans through the FFM. Preliminary data from Kynect, Kentucky's Marketplace, showed that as of March, 25 percent of the persons who selected Marketplace plans had insurance before signing up.

Additionally, recent publically-available 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 2013 to April 2014 (18 percent versus 13 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. These data suggest that the number of Americans without health insurance is going down, in part due to the effects of the Affordable Care Act

- Earlier this year, the Congressional Budget Office (CBO) projected the PPACA's three risk- spreading mechanisms would be budget neutral. In Apri1 2014, the Centers for Medicare & Medicaid Services (CMS) released guidance on how the agency would keep PPACA risk corridors budget neutral. Will CMS use any taxpayer dollars to supplement the risk corridor collections made by insurers? If not, will you maintain this commitment even as the industry exerts pressure on you to reverse such a decision and even if exchange premiums rise?

Response: 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.

- Just last year the OMB issued a report indicating that consistent with the law PPACA's insurance cost-sharing subsidies would be subject to the sequester. Yet on March 10, 2014 under your leadership, OMB changed its position to exempt these cost-sharing subsidies from the sequester. Under what legal authority did OMB take such action? Could you elaborate on the specific considerations which prompted this reversal of policy?

  Response: The *OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2015* does not list a reduction to payments made from account 009-38-0126, "Reduced Cost Sharing for Individuals Enrolling in Qualified Health Plans," because no such payments will be made from this account in fiscal year 2015. No such payments from account 009-38-0126 have been made in fiscal year 2014.

  To improve the efficiency in the administration of the subsidy payments made pursuant to the ACA for insurers as well as the federal government, the cost-sharing subsidy payments are being made through the advance payments program and will be paid out of the same account from which the premium tax credit portion of the advance payments for that program are paid. The payments made from this account, 015-45-0949, "Refundable Premium Tax Credit and Cost-sharing Reductions," are not subject to sequestration, pursuant to section 255(d) of the Balanced Budget and Emergency Deficit Control Act, as amended.

- As you know, the Secretary of HHS serves as an ex officio member of the Independent Payment Advisory Board (IPAB), PPACA's fifteen-member panel tasked with reducing Medicare expenditures. To date, President Obama has not nominated anybody to serve on IPAB, and absent an IPAB proposal put before HHS, the Secretary is tasked with creating her own Medicare proposal. In a confirmation hearing, you mentioned that your goal was to ensure that IPAB is never triggered. Therefore, would you support its full repeal, which is the only way to guarantee it is never activated and never has the chance to ration care? If not, how do you envision the Secretary's role as a member of IPAB and what specific Medicare spending reductions would you support as part of a proposal?

  Response: The Independent Payment Advisory Board (IPAB) serves as a backstop to protect against excessive cost growth in the Medicare program – a goal that I think many share. IPAB may not propose increases in cost-sharing or beneficiary premiums, restrictions on benefits, rationing of health care, or changes in eligibility. 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 2018. If confirmed, I would work with Congress to look for ways to

achieve efficiencies in the Medicare program and improve its long-term sustainability without undermining health care quality and access to care.

- Members from both the House and Senate have sought greater transparency on the exchanges, particularly related to the disclosure of abortion coverage, but HHS has continually resisted. To date, Congress has not received the list of insurers that do and do not include elective abortion coverage in their plans, even though Secretary Sebelius promised to provide such information. Will you commit to delivering such a list? If yes, when could we expect it? Additionally, do you believe all Americans should be informed about elective abortion coverage prior to their selection and purchase of a plan? If so, would you be willing to ensure that such information is available and clearly identifiable to consumers prior to their enrollment in a plan?

  Response: 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.

- The administration has delayed the employer mandate and reporting requirements multiple times but has refused to provide the same relief to hardworking Americans through a delay in the individual mandate. In your view, were these decisions made with political considerations in mind and for the benefit of big businesses? Do you share former Secretary of State Hillary Clinton's concern that she voiced in 1993 as First Lady that an individual mandate without a strong employer mandate would lead to a decrease in employers offering health coverage?

  Response: The Administration has focused on implementing the Affordable Care Act in a common sense manner consistent with the law. Based on feedback from employers and other stakeholders, the Administration sought to provide greater flexibility in an effort to ensure as smooth a transition as possible. As I have said in my testimony, with regard to the question of the employer responsibility provision, the Administration is committed to making sure that companies have the clarity and the tools that they need to implement the new requirements. Moreover, the Administration is committed to ensuring that individuals who face hardships also have the flexibility and support that they need, as provided for within the law.