IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

UNITED STATES HOUSE OF REPRESENTATIVES, Plaintiff, v. SYLVIA MATHEWS BURWELL, in her official capacity as Secretary of the United States Department of Health and Human Services, et al., Defendants.	)	Case No. 14-cv-01967-RMC

EXHIBIT AA

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, AND EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 2014

WEDNESDAY, APRIL 24, 2013

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 10:05 a.m., in room SD–138, Dirksen Senate Office Building, Hon. Tom Harkin (chairman) presiding.

Present: Senators Harkin, Pryor, Shaheen, Merkley, Moran, Cochran, Alexander, Johanns, and Boozman.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF THE SECRETARY

STATEMENT OF HON. KATHLEEN SEBELIUS, SECRETARY

OPENING STATEMENT OF SENATOR TOM HARKIN

Senator HARKIN. The Subcommittee on Labor, Health and Human Services, and Education will please come to order.

Madam Secretary, welcome back to the subcommittee. I want to start by commending you for the outstanding work you're doing to implement the Affordable Care Act (ACA) since President Obama signed it into law 3 years ago.

Since 2010, some 6.3 million seniors have received more than $6.1 billion in discounts on their prescription drugs. Last year, almost 40,000 seniors in my State of Iowa saved an average of $650 each.

More than 3.1 million young adults are staying on their parents' insurance from graduation to age 26.

But most important of all, 105 million Americans have received a free preventative screening or service because of the Affordable Care Act.

Your Department is carrying out these reforms with great skill, and I thank you for your leadership.

More work remains, of course. The President's budget request for fiscal year 2014 includes additional funding at the Centers for Medicare and Medicaid Services (CMS) for operating the marketplaces that will allow consumers and small businesses to compare private health plans.

As chairman of both this subcommittee and the Health, Education, Labor, and Pensions (HELP) Committee, the authorizing

care subsidies. The proposed $200 million child care quality initiative would support systemic reform of policies at the State level that will support and strengthen the community-level Early Head Start/Child Care Partnerships.

The proposed competitive grants to improve child care quality and the new Early Head Start/Child Care Partnerships are part of the President's Plan for Early Education for All Americans, a series of new investments that will create a continuum of high-quality early learning services for children beginning at birth and through age 5. The President's Plan also includes a mandatory initiative that would provide high-quality preschool for all 4-year-olds in low- and moderate-income families through a new Federal-State partnership at the Department of Education and additional mandatory funding to extend and expand current Federal investment in voluntary home visiting programs.

QUESTIONS SUBMITTED BY SENATOR PATTY MURRAY

EARLY HEAD START/CHILD CARE PARTNERSHIP

Question. As you know, I strongly support the Administration's goal of expanding access to high-quality early learning opportunities. Your budget calls for a new Early Head Start/Child Care Partnership competitive grant. What type of entities would be eligible to apply for those grants? How will this program provide a pathway toward raising child care quality and access?

Answer. As part of President Obama's Early Education Plan, we would expand high quality early learning by approximately 110,000 full-day full-year high-quality Early Head Start slots through the Early Head Start—Child Care Partnerships. All entities currently eligible to apply for Early Head Start including State, local and tribal governments, not for profit and for profit organizations and other community based organizations would be eligible to apply for this competitive grant program. These partnerships will provide a pathway for improving child care access and quality as Early Head Start grantees will partner with center-based and family child care providers who agree to meet Early Head Start Program Performance Standards and provide comprehensive, high-quality services to infants and toddlers from low-income families.

HEAD START RESEARCH

Question. Some have suggested reducing or eliminating Head Start, a program serving about a million of our most at-risk children and families because of a misinterpretation of the Impact Study and the conflicting results shown when the children were in third grade. In fact, some of the best lasting impacts of a two-generational intervention like Head Start, including those elements that stabilize families and teach kids how to persevere, are shown by researchers to be present later in life. Can you please speak to the research that has been done on Head Start? What are the short-, mid-, and long-range outcomes? Did the Head Start Impact Study not find statistically significant differences between the Head Start group and the control group on every measure of children's preschool experiences? One report that is often under the radar is the 2010 report out of Maryland's Montgomery County Public Schools—showing that students who went to full-day Head Start pre-K needed only half the special education services as their fellow kindergartners. Given our recent bad practice of cutting indiscriminately, rather than wisely investing in what works and produces a good return on investment, the study estimated a savings of $10,100 per child for each child who went to full day Head Start. What other such savings is the Department aware of?

Answer. The 1998 reauthorization of the Head Start Act required the Secretary of Health and Human Services to study the program's impact on children and families. In 2000, the Department commissioned the first large-scale randomized control trial of the national Head Start program from an independent contractor: The Head Start Impact Study. A report of interim findings was submitted to Congress in 2005 and a final report with findings through children's first grade year was provided to Congress in January 2010. The third grade study was not required by Congress but was undertaken by ACF in order to understand longer term impacts on children and families. This report, presenting findings through third grade, was completed in December 2012.

The Head Start Impact Study includes a nationally representative sample, including programs at all levels of quality; employs a randomized design; and examines all domains of children's development and achievement as well as parenting through third grade. It examines the average impact of providing children access to one program year of Head Start at age 3 or age 4. It compares children randomly assigned

to receive Head Start in 2002 to children who were denied Head Start but could—and often did—attend other early childhood programs. The study is unique from other studies of early care and education in that it includes a nationally representative sample, a randomized control design, and examines a comprehensive set of outcomes for children and families through third grade.

The study indeed found that that there were statistically significant differences between the Head Start group and the control group on every measure of children's preschool experiences measured in this study. These effects were found both for the 4-year-old cohort and for the 3-year-old cohort during the year in which they were admitted to Head Start. The measures that were examined included, but were not limited to, teacher qualifications, including their training and education; classroom literacy and math instructional activities; classroom teacher-child ratios; the nature of teacher-child interactions; and global measures of the care environment as measured by research based observation tools.

Looking at impacts on child and family well-being in the short and longer term, the study found that there were initial positive impacts of Head Start, for both age cohorts and across domains of development, but by the end of first grade and again at third grade there were very few impacts found for either cohort in any of the four outcome domains examined: Cognitive, social-emotional, health and parenting practices. The few impacts that were found did not show a clear pattern of favorable or unfavorable impacts for children.

While the Head Start Impact Study cannot speak to impacts beyond third grade, the Advisory Committee on Head Start Research and Evaluation's final report reflects on the interpretation of this and other studies of Head Start and the implications of the body of evidence on Head Start for longer term outcomes. Further, one possible explanation for the perceived "fade out" of effects of early childhood programs may be that children who did not attend early childhood programs "catch up" to their peers later in elementary school. The committee concluded that both the Head Start and Early Head Start impact studies show immediate impacts on child and family well-being, and that while those immediate impacts do not persist into elementary school in the two impact studies conducted by HHS, the broader literature suggests that longer term impacts might still be found in adulthood. To support this conclusion, the committee cited both evidence from nonexperimental longitudinal studies of Head Start that have found beneficial effects into adulthood, as well as studies of other early childhood intervention programs that have found long-term impacts in adulthood despite diminished or no impacts during earlier follow-ups.

Regarding your question on the savings of full-day Head Start versus other options, we do not have rigorous studies that can speak to the benefits of providing access to full-day Head Start. However, we do have research from quasi-experimental studies (Currie and Thomas, 1995; Garces, Thomas and Currie, 2002; Ludwig and Miller 2007) that suggest that the long-term benefits of Head Start have outweighed the costs for cohorts of children, with a benefit-cost ratio as large as 7-to-1.

SEQUESTRATION

Question. How has sequestration impacted LIHEAP, Head Start, Early Head Start and child care beneficiaries? Besides the immediate effects on families, what are the wider-reaching effects of cutting these programs on communities?

Answer. Like almost all programs at HHS, sequestration reduced funding for LIHEAP, Head Start, and Child Care under the Child Care and Development Block Grant by approximately 5 percent. HHS is working with States and grantees as they make decisions about how to administer programs in light of the reduced funding level, and in many cases, the full impact of sequestration will not be known until the fiscal year has ended.

In the case of Head Start, the impact of reduced funding is being felt across the Nation, with community and faith-based organizations, small businesses, local governments and school systems facing potential layoffs for teachers, teacher assistants, and other staff who work in Head Start programs. Services for children and families are being disrupted, with some Head Start centers shortening their service days, closing their classrooms early this school year, or reopening their programs later in the fall.

We expect that some programs are choosing not to fill openings as children age out of the program, and reducing the number of children and classrooms through attrition. Working families participating in Head Start rely on a regular school calendar in planning their work schedules, and early closures could impact parents' ability to retain jobs.

Question. Because the sequester impacts every program and activity the same amount, can you describe how cuts will impact CDC grants to State and local communities, NIH-funded research, Community Health Centers, the National Health Service Corps, and AHRQ Institutional Training Grants? Will some communities be hit harder than others, and in what areas?

Answer. The cuts mandated by sequestration will have a significant impact on States and local communities across the country, leading to lower investment in public health system and biomedical research. Because the law mandates that most programs be reduced proportionately, programs that serve vulnerable and underserved populations will see decreased funding, impacting communities across the country.

At the Centers for Disease Control and Prevention (CDC), the cuts will result in less funding to State and local communities and research institutions, leading to reduced technical assistance and surveillance activities within States. For example, each State's funding for HIV testing will also be cut, which could result in increased future HIV transmissions, costs in healthcare and leave vulnerable communities at risk.

The National Institutes of Health (NIH) sequester was applied evenly across all programs, projects, and activities (PPAs), which are primarily the Institutes and Centers. This affects every area of medical research. Approximately 700 fewer research project grants (RPGs) will be awarded compared to fiscal year 2012 and existing grants will be reduced by 4.7 percent, on average. These cuts will delay medical research progress in all disease areas and the development of more effective treatments for common and rare diseases affecting millions of Americans. In addition, while patients currently participating in research protocols at the NIH Clinical Center will continue to receive care, about 750 fewer new patients are anticipated to be admitted to the Clinical Center for the remainder of the fiscal year due to these reductions.

Approximately 176 fewer awards for loan repayment and scholarships will be provided to National Health Service Corps (NHSC) clinicians who are integral to building healthy communities by providing primary healthcare services in federally designated Health Professional Shortage Areas throughout the Nation.

In the case of the impacts of sequestration on Institutional Training Grants funded by the Agency for Healthcare Research and Quality (AHRQ), Congress funds AHRQ using Public Health Service Act authority that is not reduced by this sequester, so no reductions were taken to these grants.

Question. Unlike premium assistance subsidies, cost-sharing subsidies are not provided to individual taxpayers, but paid directly to insurers. As such, they appear to be subject to sequestration. How will sequestration affect the ability to protect lower income people from high out-of-pocket costs at the point of service, as intended by the Affordable Care Act?

Answer. We share your concern about the potential adverse impacts of the payment cuts mandated by sequestration, both with regard to low-income individuals, and more broadly across all government programs. That is why the Administration has indicated that we stand ready to work with Congress on balanced approaches to replace sequestration to avoid its adverse impacts.

REPRODUCTIVE HEALTH

Question. Accessible and affordable family planning services have helped reduce the rates of unintended pregnancy and abortion in the United States. CDC has even included family planning on its list of the top 10 most valuable public-health achievements of the 20th century—along with childhood vaccinations and fluoridation of drinking water. More recently, a panel of women's health experts convened by the Institute of Medicine agreed that family planning is basic preventive healthcare for women that should be covered at no extra cost in the new health system. Do you agree that family planning improves public health, and if so, how?

Answer. Yes, family planning is an integral component in public health and healthcare service delivery. As you have indicated, family planning has had a significant impact in improving the public's health, from allowing women the ability to safely space their pregnancies—improving their children's physical and cognitive development, improving access to screening for diseases and cancers of the reproductive tract to increasing access to other related preventive health screening. Ensuring access to preventive health services, including family planning, as the Institute of Medicine's 2011 Report on Clinical Preventive Services for Women recommended, is of great benefit to the health of men and women of all ages.

Family planning clinicians provide information, counseling and clinical services to women and men of reproductive age to ultimately assist in maintaining healthy re-