

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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MEMORANDUM

March 13, 2016

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Full Committee Markup of H.R. 2666, “No Rate Regulation of Broadband Internet Access Act,” and H.R. 4725, “Common Sense Savings Act of 2016”

On **Monday, March 14, 2016, at 5:00 p.m. in room 2322 of the Rayburn House Office Building**, the Committee on Energy and Commerce will convene a markup for the purpose of delivering opening statements on H.R. 2666 and H.R. 4725. The Committee will reconvene on **Tuesday, March 15, 2016, at 10:00 a.m. in room 2123 Rayburn House Office Building**.

I. H.R. 2666, THE “NO RATE REGULATION OF BROADBAND INTERNET ACCESS ACT”

A. Background

In February 2015, the Federal Communications Commission (FCC) adopted a new set of net neutrality rules to protect consumers, free expression, and innovation.¹ The FCC rooted its decision in multiple sections of the Communications Act. Following an appeal of the FCC’s Open Internet Order before the D.C. Court of Appeals in *Verizon v. FCC*,² the Commission classified broadband Internet access service as a telecommunications service;

¹ Federal Communications Commission, *Protecting and Promoting the Open Internet*, GN Docket No. 14-28, Report and Order on Remand, Declaratory Ruling, and Order, 30 FCC Rcd. 5601 (2015)[hereinafter *Protecting and Promoting the Open Internet Order*].

² *Verizon v. FCC*, 740 F.3d 623, 649-650 (2014).

telecommunications (and other common carriage) services are regulated under Title II of the Communications Act.³

After carefully reviewing the Court’s remand instructions and reconsidering its own record and numerous policy options, the FCC found that many aspects of Title II are not relevant to modern broadband service. Accordingly, the FCC moved forward to exercise its forbearance authority over broadband Internet access service. It specifically decided not to impose or enforce over 700 Title II regulations, including rate setting, tariffing, and last-mile unbundling regulations.⁴

Despite the FCC’s clear and unequivocal forbearance from regulating broadband access service rates, some have voiced fears that Title II reclassification makes it easier for the FCC to regulate broadband rates in the future. FCC Chairman Wheeler has consistently responded that his intention is not to regulate rates.

B. Summary

As introduced, H.R. 2666, the No Rate Regulation of Broadband Internet Access Act, responds to fears that the FCC will seek to regulate broadband access rates in the future. As such, the bill statutorily precludes the FCC from ever regulating rates charged for broadband Internet access services. The bill imports the definition of “broadband Internet access service” from the FCC’s most recent net neutrality order.

H.R. 2666 does not define what “rate regulation” is or what it constitutes. The term, “rate regulation” is also undefined in the Communications Act or in FCC regulations.

C. Issues Raised by the Bill

The central issue raised by H.R. 2666 is the bill’s failure to define what it is prohibiting. Without defining the term “rate regulation,” experts have asserted that the bill could result in vast unintended consequences.⁵

One particular argument made by many commentators is that H.R. 2666 could undermine the FCC’s ability to enforce consumer protections.⁶ These consumer protections could include cramming, truth in billing, device rental fees, and fraudulent, inaccurate, or contested charges.

³ *Protecting and Promoting the Open Internet Order*, *supra* note 1, at ¶ 306-435.

⁴ *Id.* at 434-543.

⁵ House Committee on Energy and Commerce, Subcommittee on Communications and Technology, Hearing on Four Communications Bills, 114th Cong. (Jan. 12, 2016) (Testimony of the Honorable Robert McDowell).

⁶ House Committee on Energy and Commerce, Subcommittee on Communications and Technology, Hearing on Four Communications Bills, 114th Cong. (Jan. 12, 2016) (Testimony of Mr. Harold Feld) [hereinafter Testimony of Harold Feld].

Additionally, some have raised concerns that H.R. 2666 could preclude the FCC from enforcing its rule against paid prioritization.⁷ Paid prioritization is a financial arrangement in which a content owner pays a broadband provider to give priority to that content owner or where a broadband provider favors its own content. H.R. 2666 could similarly harm the FCC's authority to enforce the general conduct rule it adopted as part of the Open Internet Order—the rule aimed at ensuring Internet service providers (ISPs) do not circumvent the rules in the future.⁸

Other wholly unrelated FCC programs could also be undercut by this bill. Specifically, the bill could weaken the FCC's mandate to ensure that rural consumers have reasonably comparable service provided at reasonably comparable prices.⁹ As a consequence of this bill, the FCC could also lose its authority to take action related to the \$40 billion special access market.¹⁰

D. Subcommittee Consideration of H.R. 2666

The Subcommittee on Communications and Technology held a legislative hearing on H.R. 2666 on January 12, 2016. At the hearing, Democrats raised concerns about a number of the unintended consequences that could stem out of the bill. Nonetheless, Democrats offered to work to improve the bill and reduce these unintended consequences, and they attempted to negotiate an agreement with Republicans to deal with these concerns.

The Subcommittee on Communications and Technology held its markup of H.R. 2666 on February 11, 2016, while discussions were on-going regarding potential modifications to the bill. At the markup, Ranking Member Anna Eshoo (D-CA) offered an amendment that would codify the rate-setting forbearances that the FCC adopted in its Open Internet Order. Had the Eshoo amendment passed and been included in the bill, it would have effectively prevented any future FCC from changing its mind – the main concern expressed by Republicans and the purported intent of H.R. 2666. Ms. Eshoo's amendment was defeated on a party-line vote of 17 nays to 10 yeas.

Representative Doris Matsui (D-CA) offered another amendment that would retain the existing language in H.R. 2666, but provide specific carve-outs to protect the FCC's authority to (1) act in the public interest to regulate discriminatory practices or prevent unfair business practices; (2) act in the public interest to protect consumers; (3) protect universal service; (4) enforce the Open Internet rules; (5) conduct merger reviews and enforce merger conditions; and (6) enforce paid prioritization rules. These are the issues most likely to be adversely affected by the broad prohibition in the underlying text. The Matsui amendment was similarly defeated on a party-line vote of 16 nays to 11 yeas. H.R. 2666 was favorably reported from the subcommittee on a party line vote of 15 yeas to 11 nays.

⁷ 47 C.F.R. § 8.9. *See also* Testimony of Harold Feld, *supra* note 6.

⁸ 47 C.F.R. § 8.11.

⁹ 47 U.S.C. § 254 (b)(3). *See also* Testimony of Harold Feld, *supra* note 6.

¹⁰ Testimony of Harold Feld, *supra* note 6.

II. H.R. 4725, THE “COMMON SENSE SAVINGS ACT OF 2016”

A. Section 2 - Treatment of Lottery Winnings and Other Lump-Sum Income for Purposes of Income Eligibility under Medicaid

Lump-sum income is income that an individual generally receives on a one-time basis, such as insurance or workers’ compensation settlements for physical or emotional injuries, retroactive disability or unemployment compensation payments (to cover months when the individual was eligible but the state or federal agency was still processing their application), and one-time gifts from a friend or relative. Lump sum income can only be an amount that is given one time – if a payment occurs more than once, it will be counted as income.

This section would change how lottery winnings and other lump-sum income is counted for purposes of eligibility for Medicaid. Specifically, effective January 1, 2018, this section would alter Medicaid rules in this area by allowing states to consider lump sums of \$60,000 or more as if it were obtained over multiple months. The winnings would be counted in equal monthly installments over a specified period of months depending on the income received, not to exceed 120 months for winnings or income over \$1,240,000.

This section applies to more than just lottery winnings; it also includes damages received from certain causes of action or income received from an estate. Additionally, Medicaid eligibility is calculated by household income—although it must be noted that the majority of actual Medicaid enrollees are children, the elderly and disabled. In fact, one in every three children is covered under Medicaid. So, this means that if a parent of a Medicaid child were to receive lump sum income, under this legislation, it would be the child that would lose the coverage.

Additionally, this provision would change the streamlined approach to determining eligibility for Medicaid, the Children’s Health Insurance Program (CHIP), and both the premium tax credits (PTCs) and cost-sharing subsidies (CSRs) that help people afford coverage created under the Affordable Care Act (ACA). This approach was designed to ensure that people can qualify for the appropriate program without gaps in or duplication of coverage, and that they can readily move between health insurance programs when their incomes change and they lose eligibility for one form of coverage and gain it for another.

Finally, it is important to note that the ACA’s income accounting system has several checks in place for detecting when and which individuals have received higher incomes for a period of time. Pursuant to the ACA, states transitioned to a new countable income rule based on Modified Adjusted Gross Income (MAGI). Under the new rule, a lump sum payment is counted in Medicaid as income in the month in which it is received (and as an asset for Medicaid beneficiaries subject to an asset test, such as most elderly and disabled beneficiaries). Then, because the ACA’s premium tax credits are based on annual rather than monthly income, taxable lump sum income is included in a tax filer’s annual income level, which is used to calculate the filer’s eligibility for a premium tax credit. In the hypothetical case where payments of a lump

sum are made in installments, said installments would automatically count as income. If the payment is in fact a lump sum, it is counted in the month received, but any savings, interest or investment from the sum would be counted as income thereafter.

Moreover, CMS requires that enrollees notify the state Medicaid agency immediately if they have a change of circumstance that affects their eligibility for Medicaid coverage.¹¹ Furthermore, states are required annually to re-determine Medicaid eligibility; as part of that process, states may “adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income.”¹²

B. Section 3 - Eliminating the ACA Medicaid Expansion FMAP for Prisoners

Federal law prohibits states from obtaining federal Medicaid matching funds for health care services provided to inmates with the exception of when inmates are inpatients in medical institutions.¹³ Under this exception, prisoners must have been admitted to an inpatient facility for at least 24 hours, and only inpatient services are allowable for reimbursement. This exception ensures that emergency medical care that is outside the scope of the health expertise available by state and local correctional facilities is provided to inmates.¹⁴ Historically, Medicaid eligibility for adults has been limited to certain categories of low-income individuals—such as pregnant women and those who are aged or disabled. Today, 31 states have expanded Medicaid to low-income adults, some of whom cycle through incarceration. Under current law the Federal government is financing 100 percent of the costs for this expansion population through 2016, with the match drawing down to 90 percent from 2020 onwards.

This section would eliminate the enhanced federal Medicaid matching rate for this population when seeking emergency treatment, and replace it with the state’s regular matching rate, effectively shifting the cost of caring to this population more fully onto states.

C. Section 4 - Extending Previous Medicaid Threshold Applied for Determining Acceptable Provider Taxes

Since the enactment of Medicaid in 1965, the program has been a partnership between the states and the federal government in which both share in the cost of providing health and long-term care services to low income Americans. States that elect to participate in Medicaid, as

¹¹ See “Periodic Redeterminations of Medicaid Eligibility” §435.916.

¹² See *id.*

¹³ 42 U.S.C. § 1396d(a)(29)(A).

¹⁴ The U.S. Supreme Court has determined that state and local correctional facilities are required to provide health care services to inmates in accordance with the Eighth Amendment of the Constitution. See, e.g., *Estelle, et al. v. Gamble*, 429 U.S. 97 (1976), *Brown, et al. v. Plata, et al.*, 131 S. Ct. 1910 (2011).

all now do, are guaranteed that the federal government will pay at least half of the costs of the program. States have discretion as to the source of the state's share of program costs. Current law allows states to use revenue from provider taxes to help make up the state share of Medicaid; however the state must follow federal rules in designing their provider tax.¹⁵ Frequently, these taxes are used to finance enhanced payments to providers such as nursing homes and hospitals. All states, with the exception of Alaska, use some level of provider taxes to help finance the state share of the Medicaid program, and a number of states currently have in place allowable taxes of up to 6 percent of provider revenue for some or all allowable providers.¹⁶

In 1991, Congress enacted federal rules circumscribing allowable state provider taxes for the purposes of Medicaid financing.¹⁷ According to these rules, taxes must be broad-based (i.e., imposed on all health care items or services in a class); must be uniformly imposed (i.e., the same amount or rate for each provider in the class); and cannot hold the provider harmless (i.e., cannot vary based only on the amount of tax paid by each provider or provide a separate payment to offset the cost of the tax). Current law provides that any tax that is less than 6% of total provider revenue in a state is considered to meet the broad-based, uniform, and hold harmless test, and is, therefore, allowable.

In 2006, Congress reduced the 6 percent provider tax test to 5.5 percent from FY 2008 through FY 2012 in order to offset partially the cost of a temporary fix to the Medicare physician sustainable growth rate (SGR).¹⁸ This reduction caused a number of states to have to modify state provider taxes and search for other revenue sources for Medicaid. As of October 2011, the allowable rate returned to 6 percent.

This section would prohibit states from having taxes above 5.5 percent. This would impose new federal restrictions on states' ability to raise revenue to finance their Medicaid programs. It would require a number of states to forgo currently allowable sources of revenue in less than a year, thus leaving a budget hole for financing care for vulnerable populations.

D. Section 5 - Sunsetting the ACA Increase in Enhanced FMAP under CHIP

Under the ACA, the federal matching rate for each state was temporarily increased by 23 percentage points starting in fiscal year 2016,¹⁹ commonly referred to as the “23% Bump.” This means that the federal government currently picks up, on average, 93 percent of the cost of state CHIP programs (up from 70 percent, on average). This increased matching rate was reaffirmed

¹⁵ Kaiser Commission on Medicaid and the Uninsured, *Medicaid Financing Issues: Provider Taxes* (May 2011).

¹⁶ See Health Provider and Industry State Taxes and Fees (Feb 1, 2016) (online at <http://www.ncsl.org/research/health/health-provider-and-industry-state-taxes-and-fees.aspx>).

¹⁷ Medicaid Voluntary Contribution and Provider-Specific Tax Amendments, Pub. L. No 102-234.

¹⁸ Tax Relief and Health Care Act of 2006, Pub. L. No. 109-432.

¹⁹ Patient Protection and Affordable Care Act of 2010. P.L. 111-148

when CHIP was reauthorized for two years (through FY 2019) in the Medicare Access and CHIP Reauthorization Act (MACRA), and will be in effect through fiscal year 2019.²⁰

States have used the increased federal funding to expand and improve children's health coverage as well as to sustain their overall CHIP programs. It is important to note that states are already three-quarters of their way through this fiscal year (with their budgets including the 23 percentage point match increase) and are already considering their upcoming 2017 budgets.

This section would eliminate the temporary 23 percentage point match increase as of the end of this month, thus reducing the amount of federal funds states receive to cover low-income children through their CHIP programs.

E. Section 6 - Repeal of Prevention and Public Health Fund

This section would repeal the Prevention and Public Health Fund (Prevention Fund) created by the ACA and eliminate any unobligated amounts. That means the \$15.5 billion for the period FY 2016 through FY 2025 (not taking into account any sequestration requirements) would be rescinded.

1. Overview of the Prevention Fund

The Prevention Fund is the federal government's only dedicated investment in prevention and the nation's largest single investment in prevention.²¹ The Prevention Fund was enacted in response to overwhelmingly bipartisan support for prevention efforts and recognition of the lack of a targeted and sustained federal initiative to address chronic and costly illnesses. The Prevention Fund is intended to provide resources to address the perpetual underfunding of prevention activities.

Most Prevention Fund dollars have gone directly to states, communities, and tribal and community organizations to improve the health and wellness of Americans.²² Indeed, the Prevention Fund supports efforts to reduce tobacco use, increase physical activity, increase immunization, reduce racial and ethnic health disparities, to promote lead poisoning prevention,

²⁰ Medicare Access and CHIP Reauthorization Act of 2015. P.L. 114-10.

²¹ Trust for America's Health, *The Prevention and Public Health Fund: Preventing Chronic Disease and Reducing Long-Term Health Costs* (Feb. 2015) (online at <http://healthyamericans.org/health-issues/wp-content/uploads/2015/06/Fund-Backgrounder-June-2015-Update.pdf>).

²² Trust for America's Health, *The Prevention and Public Health Fund at Work in New Jersey* (Aug. 2015) (online at <http://healthyamericans.org/health-issues/wp-content/uploads/2015/08/NJ-Fund-at-Work.pdf>).

and to enhance the ability of state, local, and territorial officials to detect and respond to infectious diseases and other public health threats.²³

Chronic disease accounts for 86 percent of U.S. health care costs.²⁴ A Trust for America's Health report concluded that investments in proven community-based interventions increase physical activity, improve nutrition, and prevent smoking – the very programs supported by the Prevention Fund – generate a return of \$5.60 for every \$1 spent.²⁵ Another Trust for America's Health report found that a reduction of body mass index rates nationwide by 5 percent would save over \$158 billion in 10 years and almost \$612 billion in 20 years.²⁶

2. *Mandatory Funding for the Prevention Fund*

The Prevention Fund was created through the ACA “to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.”²⁷ This funding was intended to supplement and not supplant the pre-existing federal funding levels for public health programs. The ACA requires the Secretary of the Department of Health and Human Services (HHS) to transfer amounts in the Prevention Fund to accounts within HHS to increase funding over the FY 2008 level, for prevention, wellness, and public health activities.

The ACA initially provided \$500 million for the Prevention Fund in FY 2010 and steadily increased the funding until it reached \$2 billion in FY 2015 and each fiscal year thereafter.²⁸ Thus the ACA provided \$5 billion in mandatory funding for these activities over the period FY 2010 through FY 2014 and \$2 billion in mandatory funding each fiscal year thereafter (for a total of \$15 billion for FY 2010 through 2019, and \$20 billion for FY 2015 through 2024).²⁹

However, subsequent legislation reduced funding for the Prevention Fund. The Middle Class Tax Relief and Job Creation Act of 2012, reduced the mandatory funding levels by \$6.25

²³ Department of Health and Human Services, *Prevention and Public Health Fund* (online at <http://www.hhs.gov/open/prevention/index.html>).

²⁴ Centers for Disease Control and Prevention, *Chronic Disease Prevention and Health Promotion* (online at <http://www.cdc.gov/chronicdisease/>).

²⁵ Trust for America's Health, *Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities* (Feb. 2009) (online at <http://healthyamericans.org/reports/prevention08/Prevention08.pdf>).

²⁶ Trust for America's Health, *Bending the Obesity Cost Curve* (Feb. 2012) (online at <http://healthyamericans.org/report/93/>).

²⁷ Patient Protection and Affordable Care Act, Public Law No. 111-148.

²⁸ *Id.*

²⁹ *Id.*

billion for FY 2012 through FY 2021.³⁰ This was achieved by slowing the increase in funding such that the \$2 billion in annual funding would not be reached until FY 2022. The Budget Control Act of 2011, which applied sequestration to the Prevention Fund, among other programs, resulted in a reduction in funding of \$264 million in FY 2013 through FY 2016.³¹ Under current law, funding from the Prevention Fund would be reduced by \$69 million in FY 2017 – from \$1 billion down to \$931 million – due to a 6.9 percent sequestration reduction.³²

3. *Transparency and Control of Funding Allocation for the Prevention Fund*

As discussed above, the ACA requires the Secretary to transfer funds from the Prevention Fund to accounts within HHS. Additionally, the Consolidated Appropriations Act of 2012 required HHS to establish a website to report the uses of funds made available through the Prevention Fund and the Consolidated Appropriations Act of 2016 required HHS to provide information on activities and programs supported by the Prevention Fund. The website, www.hhs.gov/open/prevention, provides an overview of the funding distribution of the Prevention Fund for FY 2012 through FY 2016 as well as includes a database that provides information on funding opportunity announcements, requests for proposals, other funding solicitations, and awards for activities funded from the Prevention Fund.

The ACA also granted the House and Senate Appropriations Committees transfer authority to determine the distribution of Prevention Funds for prevention, wellness, and public health activities. Beginning in FY 2014, the House and Senate Appropriations Committee have used that authority to direct the funding allocation of the Prevention Fund. The FY 2014, FY 2015, and FY 2016 Omnibus appropriations bills included bill language to allocate PPH funding “to the accounts specified, in the amounts specified, and for the activities specified” in a table in the accompanying explanatory statement. Furthermore, the appropriations bills specify that “the Secretary may not further transfer these amounts.”

Because Congress allocates every dollar from the Prevention Fund, any suggestion that the Prevention Fund is a “slush fund” for the HHS Secretary is inaccurate.

³⁰ Middle Class Tax Relief and Job Creation Act of 2012, Public Law No. 112-96.

³¹ *Supra* note 2121, Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2016* (online at https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/2016_jc_sequestration_report_speaker.pdf). See Budget Control Act of 2011, P.L. No. 112-25.

³² Office of Management and Budget, *OMB Report to the Congress on the Joint Committee Reductions for Fiscal Year 2017* (online at https://www.whitehouse.gov/sites/default/files/omb/assets/legislative_reports/sequestration/jc_sequestration_report_2017_house.pdf).