FIRST FOCUS
CAMPAIGN FOR CHILDREN

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March 21, 2017

The Honorable Paul Ryan
Speaker of the House
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Greg Walden
Chairman
Energy and Commerce Committee
Washington, D.C. 20515

The Honorable Frank Pallone
Ranking Member
Energy and Commerce Committee
Washington, D.C. 20515

The Honorable Kevin Brady
Chairman
Ways and Means Committee
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
Ways and Means Committee
Washington, D.C. 20515

Dear Speaker Ryan, Minority Leader Pelosi, Chairmen Walden and Brady, and Ranking Members Pallone and Neal:

I am writing on behalf of First Focus Campaign for Children, a national bipartisan advocacy organization in support of our nation's children, to provide our comments to the American Health Care Act (AHCA) that passed out of the House Ways and Means and Energy and Commerce Committees on March 9, 2017. We apologize for the delay in providing the Congress our full comments, as this is a complicated piece of legislation that makes changes to health coverage for children in ways that are far more expansion than "repealing and replacing" the Affordable Care Act (ACA).

Based on the language in the bill that passed the two committees in the House of Representatives and the Manager's amendment offered to the bill late Monday evening, we strongly oppose the legislation. Congress should, at the very least, "do no harm" to the health coverage of children, but this legislation has the potential to negatively impact the health coverage for half of our nation's children and other systems of care and support for kids.

We would urge hearings to address a number of concerns and unanswered questions as to how the bill would impact the health and well-being of children in order to make necessary modifications to make sure children are, at the very least, not left worse off by the bill.

The biggest concern we have has to do with the legislation's imposition of Medicaid per capita caps upon the states and the block grant option. These provisions in the bill would have troubling consequences for the nearly 35 million children who make up nearly half of the Medicaid

population, as it would undoubtedly lead to reductions in coverage, benefits, affordability, or access to care to many of our nation's most vulnerable children.

According to the Congressional Budget Office (CBO) score released on March 13, 2017 (and which does not include an analysis of the Manager's Amendment that would potentially make these numbers worse), AHCA would reduce federal outlays in Medicaid by an astounding $880 billion over the 2017-2026 period and increase the uninsured rate in this country from 28 million to 52 million, a shocking 86 percent increase in the nation's uninsured rate, by 2026.

Although we do not know how many of the 24 million newly uninsured citizens would be children under the bill, since CBO completely and surprisingly left children out of both Table 4 and Figure 2 in its analysis, we do know that any increase in the uninsured rate is counter to the significant gains that our nation has made in improving health coverage rates for children over the last two decades. In fact, the percentage of health insurance coverage for children has never been higher than today, as over 95 percent of children have insurance, because of the combination of private sector coverage, Medicaid, the Children's Health Insurance Program (CHIP), and the ACA.

Since 1997, when CHIP was created to work in tandem with Medicaid, the uninsurance rate for children has dropped from 14.9 percent to 4.8 percent, a 68 percent reduction in the uninsured rate for kids. Clearly, Medicaid and CHIP are critically important to millions of children and their families and now is not the time to backtrack on these critically important gains.

Consequently, we urge you to reject this legislation and, as Congress works on changes to our nation's health care system, we ask you to adopt a simple "do no harm" standard when it comes to the health coverage of children. Any effort to "repeal and replace" the ACA, modify the Medicaid program, and reauthorize CHIP should ensure that children are not harmed, even if that harm would be unintentional. Before Members of Congress proceed, they should ask themselves one key question: "Is it good for the children?"

Unfortunately, the AHCA does not meet those two simple, and yet, fundamental standards for children, and so, we urge you to reject the bill until changes made allow you to affirmatively answer "yes" to those critical and relatively simple tests for our children.

It should be also noted that the children covered by Medicaid have nothing whatsoever to do with the ACA, and yet, the care of millions of children is being put at risk by the House bill.

Negative Consequences of Per Capita Caps to Vulnerable Children

We are wholeheartedly opposed to the provisions in the bill that caused CBO to estimate that it cuts Medicaid by $880 billion over 10 years and drops 14 million people from Medicaid coverage.

First and foremost, our biggest concern is due to the imposition of a per capita cap upon Medicaid. The legislation creates 255 separate "per capita caps" that would be inflicted unilaterally upon state Medicaid programs. According to the summary of the legislation, the newly imposed Medicaid per capita caps "would use each State's spending in FY2016 as the base year to set targeted spending for

each enrollee category (elderly, blind and disabled, children, non-expansion adults, and expansion adults) in FY2019 and subsequent years for that State."

This is a fundamental and radical change to the financing of Medicaid—with the goal of slashing hundreds of billions of dollars out of the program. The change represents a fundamental abdication of the federal government's shared responsibility with states that it has shared throughout the 52-year history of the Medicaid program to provide health coverage to our nation's low-income children, people with disabilities, and senior citizens.

Unfortunately, the consequences will be immense. As CBO says, "With less federal reimbursement for Medicaid, states would need to decide whether to commit more of their own resources to finance the program at current-law levels or whether to reduce spending by cutting payments to health care providers and health plans, eliminating optional services, restricting eligibility for enrollment, or (to the extend feasible) arriving at more efficient methods for delivering services. CBO anticipates that states would adopt a mix of these approaches. . . ."

In other words, states are likely to respond to the hundreds of billions of dollars in federal cuts in a manner that would likely weaken the coverage, benefits, and affordability that Medicaid provides many of our nation's most vulnerable and fragile children. We are talking about children in poverty, children who have been sexually or physically abused and neglected in foster care, newborns, kids in need of an organ transplant, and children with cancer, cystic fibrosis, asthma, mental and behavioral health needs, oral health care, spina bifida, Rett's Syndrome, Fragile X Syndrome, traumatic brain injury, heart problems, bleeding disorders, genetic birth defects, etc.

Operationally, the bill sets in motion a procedure for the Department of Health and Human Services (HHS) to unilaterally establish an arbitrary and limited block of money – estimated by the Urban Institute in a September 2016 report to be either an average of $2,002 per child or $13,084 per person with a disability – to give to states and the District of Columbia for health care services that can run up into hundreds of thousands of dollars in the case of medically fragile children.

CBO also notes that the inflation factor included in the bill would also likely shortchange states by a compounding 0.7 percent annually. In the end, according to CBO, "By 2026, Medicaid spending would be about 25 percent less than what CBO projects under current law."

In the Manager's Amendment, this was modified to give an annual update that is a full percentage point higher for senior citizens and people with disabilities than for children and adults. According to a summary by the House Ways and Means Committee, the intent of the change is to "recognize the unique needs of the elderly and the disabled, the amendment increases the inflation rate for the elderly and the disabled populations. This ensures that Medicaid spending on our most vulnerable more accurately reflects shifting demographics due to the aging of the Baby Boomers and the practical challenges of high-fixed costs for this vulnerable population."

The Manager's Amendment, however, fails to recognize that the growth in children's spending per enrollee has historically been lower because the use of managed care, care coordination, and other cost containment techniques have been employed longer and more extensively with children than other populations in Medicaid. Those savings made over the years and are partially responsible for

the wide gap in spending on children versus other populations. However, in recent years, due to new technologies and treatment options that save the lives of newborns and improve the care and well-being of children with special health care needs, spending on children no longer grows at a slower rate.

In fact, the House Manager's Amendment provides senior citizens and the disabled an inflation rate that is 1.0 percent higher than children under the per capita cap, despite projections by the Medicaid and CHIP Payment and Access Commission (MACPAC) (*Report to Congress on Medicaid and CHIP*, June 2016, see Figure 1-8) that spending per enrollee for children would grow by 4.8 percent annually between FY 2014-2023, 0.5 percent higher than that projected growth in spending for the elderly (4.3 percent) and disabled (4.2 percent).

The Centers for Medicare and Medicaid Services (CMS) also projects much higher enrollee growth rates for children than for all other populations between 2013-2025 (see Table 19 in the *2016 Actuarial Report on the Financial Outlook for Medicaid* from the Office of the Actuary).

In short, the House bill would impose a per capita cap with a lower annual inflation rate more heavily on children (more than a full percentage point annually below projections) than other populations, despite the evidence showing that children will need a faster growth rate in the future. Thus, the House bill would cause children to disproportionately bear the brunt of the cuts that states would need to impose in order to meet the per capita limits. And yet, the techniques available to states in which to do so, such as managed care and care coordination, have already been more aggressively applied to children in the past.

Consequently, shortchanging children with special health care needs for the costs of their care would undermine coverage, benefits, affordability, and access to care for our nation's most vulnerable citizens – our children.

Unfortunately, that is not the limit to the possible harm to children under the per capita cap, as HHS would then sum up the amounts from the five different caps to establish an "aggregate" amount – or a block granted total. Thus, even if a state were to make the necessary cuts or ration care in a manner to stay below both the individual "children" and "blind and disabled" caps imposed by the bill in a given year, the health of children could still be threatened if that state has costs that exceed the two "adult" categories, the other "blind and disabled" enrollees, or "the elderly" category, and thereby, the aggregate limit.

To stay under this secondary aggregate or block granted cap imposed upon the states (much like the prescription drug clawback is unilaterally imposed upon state Medicaid programs by the 2003 Medicare prescription drug bill, but in that case the federal government imposed double-digit inflation increases upon the states in the past two years), state policymakers and agency heads would have to decide whether or how to impose yet another round of cuts to children, people with disabilities, adults, or senior citizens.

As Republican Senator and former Governor John Chafee said in opposition to Medicaid caps in 1995, "As states are forced to ration finite resources under a block grant, governors and legislators would be forced to choose among three very compelling groups of beneficiaries. Who are they?

Children, the elderly, and the disabled. They are the groups that primarily they would have to choose amongst. Unfortunately, I suspect that children would be the ones that would lose out."

This legislation, in fact, proves Senator Chafee's point, as it imposes a lower inflation rate upon children and singles out children as the primary optional population to move into a block grant (more on that below).

In addition, per capita caps would result in cuts to providers that would undermine the health care system and the providers serving children, including hospitals, doctors, nurses, clinics, school nurses, and other health professionals. Without a strong pediatric safety net, the access to care for millions of our nation's children would be threatened – both inside and outside of Medicaid.

For example, if benefits and services for children are cut out of Medicaid, those costs will increasingly be picked up by other areas, such as our nation's schools, foster care, and juvenile justice systems. This is not an appropriate cost-shift and would negatively impact those systems and services for children. And we must recognize that some services will be lost completely and not picked up by the states at all. Kids will lose ground and go without needed services.

Moreover, if a state decided to fully or partially finance the federally-imposed shortfalls caused by the per capita cap, children may still be put at risk if states are forced to make cuts to other areas of their state budgets that are important to children, including education, early childhood, foster care, family housing, and juvenile justice programs.

Whether intentional or not, per capita caps, by themselves, create a triple-threat of possible cuts to children.

The Medicaid per capita caps raise a number of questions:

- Of the 14 million that CBO estimates will lose Medicaid coverage under the bill, how many are children?
- Of the $880 billion in Medicaid cuts and the fact that children represent nearly half of Medicaid enrollees, how much of those cuts will fall on children and the providers that now treat them?
- If there were a natural disaster or an epidemic of some type and costs were to rise, how will states be able to respond to such crises under a per capita cap?
- The Urban Institute estimates a nearly 3-to-1 difference in the caps that will be imposed upon states for children under a per capita cap – from a high in Vermont to a low in Wisconsin. Are those differences justified and should they be locked into place for years, if not decades, to come?
- Would the per capita caps more negatively impact some states, such as historically low-spending states, or patient populations, such as children with cancer, or certain regions of the country more than others?
- On a bipartisan basis, Congress passed the 21st Century Cures Act last year to "expedite the discovery, development, and delivery of new treatments and cures and maintain America's global status as the leader in biomedical innovation." If the Cures bill is successful and there are new treatments, cures, and therapies but state Medicaid programs are struggling to deal

with $880 billion in Medicaid cuts, would some of the very people that need these cures by denied access to them?
- Will children's hospitals and other centers of excellence for children be able to continue to serve their all children in their communities?

Tragic Consequences to Children from the Medicaid Block Grant Option

The Manager's Amendment also creates a new option for states to shift children and adults (but not senior citizens and people with disabilities) to a new block grant. The block grant period is for 10 years and gives states flexibility to make significant changes to the coverage, pediatric benefits, and cost sharing for millions of children. For a bill that was touted as a "repeal and replace" for Obamacare, this represents a significant and radical departure from such an effort to a threat to the health coverage for 35 million children across this country.

This provision is significantly worse than even the per capita cap for children, as the inflation update is lower than under the per capita cap and, as the summary reads, "will not adjust for changes in population." Thus, if a state were to choose this option and it experiences an increase in its population of children living in poverty due to a recession or population growth, a natural disaster, an epidemic, or an increase in eligible children due to other changes in the legislation (such as CBO's estimate that there will be a decline in employer-sponsored health coverage caused by the bill), there would be additional dollars per person made available for people with disabilities to deal with the crisis *but not for children*.

As for the practical implementation of this provision, would some children be exposed to the block grant and children with disabilities be subjected to the per capita cap? Could some children move back-and-forth between the two different financing systems from year-to-year or within a year? Would a state operate two different systems of care for children?

The Manager's Amendment also provides for a "matching rate" (if even that) for states that would require them to contribute 30 percent less (at the regular CHIP matching rate) than under current Medicaid law. This combination would be an outright disaster for children.

First, the federal contribution would be capped, there would be no adjustment for population growth, and the inflation factor would be well below need. And second, the state's contribution would decline by 30 percent or even more under the language. This combination would be be incredibly harmful for children, threatening the health coverage of 35 million children.

We also have some real world examples of Medicaid block grants, as Puerto Rico and the territories already have Medicaid block grants imposed upon them. In Puerto Rico's case, the federally-imposed block grant radically under finances the Commonwealth's health system.

According to David Thomsen of the National Council of La Raza, Puerto Rico has nearly the same population as Oklahoma and far greater poverty, but only receive one-tenth of the support from Medicaid that Oklahoma does. This has created severe problems with Puerto Rico's health care system, but it has also become a major factor in the Commonwealth's debt crisis.

Dr. Johnny Rullán, Puerto Rico's former Secretary of Health and Secretary of the Puerto Rico Healthcare Crisis Coalition, points out, ". . .more than 40 percent of the island's debt is due to health care and the lack of funding from Medicaid in particular. This chronic underfunding has caused cutbacks in services, a major physician exodus, life-threatening delays in getting appointments and huge delays in payments to hospitals and other medical providers. Patients are suffering and the system is crumbling."

We must do better for Puerto Rico and also not impose such a system on our nation's children.

Questions About Medicaid Coverage for Current and Former Foster Youth

First Focus Campaign for Children opposes the imposition of the per capita cap in Medicaid for all children. We have some specific questions, however, as to how the bill would address foster youth, former foster youth, and the children of veterans and those in military service, who could also be viewed as either special populations or "partial-benefit" enrollees under the bill.

By definition, foster youth have been sexually or physically abused or neglected and have been removed from their families. If we want these children to overcome the trauma and abuse that they have been subjected to, it does not make sense to impose an arbitrary cap on their care.

As the Center for Health Care Strategies (CHCS) has pointed out, ""These children face myriad challenges – from placement instability, to emotional, behavioral, and educational difficulties, to juvenile justice involvement – that threaten their health and well-being. Because they are often at the intersection of multiple public systems including behavioral health, child welfare, education, juvenile justice, and primary care, it is critical for these systems to work collaboratively to meet their health needs." These children clearly have health care needs that extend well beyond the Medicaid program and caps imposed on that care would impact these other systems.

First Focus Campaign for Children and over 240 other organizations from across the country signed on to a letter urging Congress to maintain the provision in the ACA that ensure that youth who age out of foster care can keep Medicaid coverage until they turn 26, in parity with their peers who can stay on their parent's health insurance until the age of 26. We were pleased that the House bill left that provision intact.

However, if former foster youth were subjected to the per capita caps, would they be included in the child, blind and disabled, non-expansion adults, or expansion adults cap? Also, what would be the implications for their coverage and the incentives on states for their care?

We are also deeply concerned with the language in the Manager's Amendment relating to work requirements and are concerned that this language could have negative implications for former foster youth, including their ability to attend higher education. These young adults should not have to choose between their health care and getting a college degree.

We are also uncertain as to the consequences of the language that modified presumptive eligibility for these children through the Medicaid program. Why does the language strike the language for former foster youth (referenced under section 1902(a)(10)(A)(i)(IX)) and then reinsert them into

the presumptive eligibility section? Does this new language create a sunset for presumptive eligibility for them? Different attorneys have interpreted this language in different ways.

Finally, as noted before, with the Manager's Amendment giving states the option to choose a block grant for children and adults, this could have enormous negative implications on foster children and former foster youth. For example, as CHCS has found, "Children in foster care represented three percent of the Medicaid child population, but accounted for 15 percent of those using behavioral health services and 29 percent of total behavioral health spending for children." What happens to these health services for children in foster care? And, although these numbers are for foster youth, many of these issues persist into adulthood.

In addition, the questions raised earlier about whether children in foster care might move between the per capita cap (disabled) and a block grant (children/adults) in certain states also apply here.

Regardless, we strongly believe that the imposition of per capita caps or block grants on children in foster care would be detrimental to their health and well-being and represents an abdication of a societal responsibility to them.

Other Medicaid Changes Compound the Problems for Children

First Focus Campaign for Children shares the concerns of other groups as to the sunsetting of provisions related to the Medicaid expansion population in the ACA because, as the American Academy of Pediatrics writes, it will "increase uninsurance among young adults and parents, negatively impacting family health and stability." As examples, children and newborns are negatively impacted if their parents lack insurance and go untreated for things like pregnancy-related care, mental illness, or substance abuse. Ohio Governor John Kasich (R-OH) has repeatedly cited the importance of coverage of adults under the Medicaid expansion to combat the opioid epidemic. It is unclear how much of the $880 billion in Medicaid cuts are attributable to this provision.

We are also extremely concerned about these two other provisions in the legislation that CBO estimates would cut Medicaid funding. According to CBO, these include:

- "Decreasing the period when Medicaid benefits may be covered retroactively from up to three months before a recipient's application to the first of the month in which a recipient makes an application;" and,

- "Eliminating federal payments to states for Medicaid services provided to applicants who did not provide satisfactory evidence of citizenship or nationality during a reasonable opportunity period."

The first provision undermines a current provision in Medicaid intended to prevent medical bankruptcy in patients and families and reimburses providers for the costs of services delivered to low-income patients. For children, previous studies of medical bankruptcy indicate that families with children under the age of 1 have a significantly higher rate of medical bankruptcy filings than the general public.

The second provision would result in the delay of coverage and enrollment of low-income people on Medicaid, and that could have tragic consequences, just as the delay in coverage for 12-year-old Deamonte Driver lead to his tragic death in Maryland when untreated dental disease resulted in the spread of a lethal bacteria to his brain.

Concerns Related to Changes in Family and Dependent Care Under the Tax Credits

We were pleased that AHCA leaves in place important patient protections, including the ban on lifetime and annual limits, mandated coverage of essential health benefits important to children, coverage of dependents in family coverage up to age 26, the elimination of cost-sharing for preventive services, including well-child visits and vaccinations, and the catastrophic limits.

According to CBO's analysis of the bill, there are questions as to how changes in the tax credit structure under the AHCA would impact the affordability of health coverage to children in the nongroup market. CBO believes "the average subsidy under the legislation [to] be about 50 percent of the average subsidy under current law" by 2026 and that actuarial values of plans in the nongroup market will be lower. As a result, CBO and JCT "expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law."

CBO asserts, "Because of plans' lower average actuarial values, CBO and JCT expect that individuals' cost-sharing payments, including deductibles, in the nongroup market would tend to be higher than those anticipated under current law. In addition, cost-sharing subsidies would be repealed in 2020, significantly increasing out-of-pocket costs for nongroup insurance for many lower-income enrollees."

The bill also denies tax credits to those who have the offer of employer coverage, even if that coverage were to be "unaffordable" for families. Thus, the ACA problems with covering dependents due to the bill's "family glitch" would be even worse under the AHCA. According to a recent Kaiser Family Foundation and Health Research and Education Trust (HRET) report of firms that offer family coverage, "45 percent of small firms and 18 percent of large firms provide the same dollar contribution for single and family coverage, which means that employees must pay the full additional premium cost to enroll family members in their plan. . . ."

According to Kaiser/HRET, the average annual employee share of health care premiums was $1,129 for single coverage and $5,277 for family coverage in 2016, or 367 percent more for family plans. In 15 percent of family plans, the employee has to pay more than half of the total premium compared to just 2 percent of those in single coverage plans. Under the House bill, families would be unable to access to credit even if an employer offers but does not subsidize family coverage at all or if such coverage is unaffordable.

The House bill also inexplicably caps the cumulative credits that a family could receive at $14,000 in 2020. It is important to note that the same cap is not applied to the tax deductibility for those in employer coverage. Also, this arbitrary cap would discriminate against those in large families.

Furthermore, experts believe that the average family plan premium will soon exceed $20,000 annually, and that doesn't take into account the costs of deductibles, coinsurance, and copayments that families incur to pay for their health care.

Unfortunately, the CBO score for the bill provides little insight on the possible impact of these provisions. The entire analysis of the credits is focused exclusively on the individual coverage.

However, the analysis estimates that "roughly 9 million fewer people, on net, would obtain coverage through the nongroup market in 2020 [and] that umber would fall to 2 million in 2026" under the AHCA.

Concerns Related to Changes the Bill Creates for Children Under Employer or Private Coverage

According to CBO, they believe that employer coverage would decline under the bill. As the score read, "CBO and JCT estimate that, over time, fewer employers would offer health insurance because the legislation would charge their incentives to do so. First, the mandate penalties would be eliminated. Second, the tax credits under the legislation, for which people would be ineligible if they had any off of employment-based insurance, would be available to people with a broader range of incomes than the current tax credits are. That change could make nongroup coverage more attractive to a larger share of employers. Consequently, in CBO and JCT's estimation, some employers would choose not to offer coverage. . . ."

According to the score, CBO and JTC estimate that, by 2026, "roughly 7 million" fewer people would be enrolled in employment-based coverage under the AHCA.

Again, unfortunately the CBO estimate did not address the impact of the bill to children specifically. However, if employers were to drop coverage, it would be likely that the first to be cut would be dependents. Unfortunately, CBO and JCT did not mention dependent or family coverage in their analysis of the bill and this is another question on which we urge you to seek clarification from CBO.

Finally, we support the provision in the AHCA that pushes implementation of the Cadillac Tax back to 2025. As we wrote in our letter of support for the Kelly/Courtney "Middle Class Health Benefits Tax Repeal Act of 2007" (H.R. 173), "The threshold was set but is not adjusted for regional differences in health care costs or family health plan expenses. For example, the 'Cadillac Tax' sets the threshold for family plans at 2.69 times the expense of that for individuals. However, according to a recent report by the Kaiser Family Foundation and Health Research and Education Trust (HRET), the average premium cost for family coverage is 2.82 times greater than individual coverage. Thus, the excise tax will more heavily fall upon family plans, and thereby, children."

Eliminating the Prevention and Public Health Fund Would Also Harm Children

AHCA also repeals the ACA provision that established the Prevention and Public Health Fund – a source of funding that has proven to be important to state public health programs and efforts to promote prevention and wellness. CBO estimates "eliminating that funding would reduce direct spending by $9 billion over the 2017-2026 period."

Conclusion

Through the bipartisan leadership of past presidents, Congresses, our nation's governors, and state legislatures over the past 20 years, the country has made enormous strides in reducing the uninsured rate for our nation's children. Today, over 95 percent of our nation's children have health insurance coverage – a historic record. Since the passage of CHIP in 1997, the uninsured rate for children has been cut by 68 percent. Now is not the time to retreat from two decades of progress and undermine the health and well-being of our nation's children.

Consequently, we urge you to reject the AHCA as currently written, as it would impose $880 billion in Medicaid cuts and a per capita cap or block grant upon the states. Such cuts would undoubtedly do harm to the health of children, but also threaten support for education, early childhood, child welfare, public health, and social services programs of importance to children in states, as their budgets will be squeezed to make up for the federal shortfall.

Children are about one-quarter of our population but all of our future. The decisions we make today will determine their tomorrow. We urge you to commit to "do no harm" to the health and well-being of children, and thus, to reject the AHCA, as currently drafted.

We apologize for the length of the letter. However, the legislation has an impact on the health of more than half of the nation's children. Thank you for your consideration of our comments and the questions we have raised on behalf of millions of our nation's children.

Sincerely,

Bruce Lesley
President

xc: Members of the House of Representatives
Members of the United States Senate