

**PRESIDENT'S FISCAL YEAR 2018
HEALTH CARE PROPOSALS**

HEARING
BEFORE THE
COMMITTEE ON FINANCE
UNITED STATES SENATE
ONE HUNDRED FIFTEENTH CONGRESS
FIRST SESSION

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JUNE 8, 2017
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PRESIDENT'S FISCAL YEAR 2018 HEALTH CARE PROPOSALS

THURSDAY, JUNE 8, 2017

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:54 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Roberts, Thune, Isakson, Toomey, Heller, Scott, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Brown, Bennet, Casey, and McCaskill.

Also present: Republican Staff: Chris Campbell, Staff Director; Brett Baker, Health Policy Advisor; Kimberly Brandt, Chief Health-care Investigative Counsel; Jay Khosla, Chief Health Counsel and Policy Director; Jennifer Kuskowski, Health Policy Advisor; and Preston Rutledge, Tax Counsel. Democratic Staff: Joshua Sheinkman, Staff Director; Laura Berntsen, Senior Advisor for Health and Human Services; Anne Dwyer, Health-care Counsel; and Elizabeth Jurinka, Chief Health Counsel.

The CHAIRMAN. The committee will come to order. We are going to first listen to the distinguished Senator from Oregon, who has to go to another committee hearing, so I will show that deference to him.

I welcome everybody to this morning's hearing on the President's proposed budget for fiscal year 2018 with specific attention to the Department of Health and Human Services.

I want to thank Secretary Price for being here. These hearings are an annual event for the Finance Committee. Secretary Price, since this is your first time around, I will just warn you that these hearings can be a little grueling, so—of course, you already know that.

I am grateful that the President and HHS are eager to work with Congress to fix our health-care system in order to ensure Americans are able to access affordable health coverage.

With that, I am going to turn to the ranking member, who needs to get to another hearing, and we will show that deference.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Mr. Chairman, thank you very much for this courtesy. And I know this is a busy morning, and I am very grateful to you for doing this.

I also want to say “thank you” to Senator Stabenow, who in my absence is going to do an excellent job, as she always does.

This administration from day one has preferred “alternative facts” and convenient spin to the truth. One of the most recent examples was its budget proposal which double-counted \$2 trillion to maintain some whiff of fiscal responsibility while it slashed health programs and protections for basic and essential needs.

The budget math is fake, but the extreme agenda that would deprive millions of Americans of access to health care and wipe out living standards is not. Unfortunately, this morning I am going to be splitting my time between the Finance Committee and the Intelligence Committee, so I will be brief.

There are several issues in the budget and the administration’s agenda that I am going to touch on. First is Medicaid. Secretary Price is the captain of the President’s health-care team. He has been the premier advocate for Trumpcare, a bill that cuts Medicaid by \$834 billion in order to pay for massive tax breaks for the wealthy.

Fourteen million Americans would lose coverage, and millions more would see caps on their care. And if that was not enough of a cut, the budget proposal that came out a few weeks ago goes even further.

It slashes hundreds of billions more from Medicaid. In a program that covers nearly half of all births, 37 million kids, millions of working families and people with disabilities, and two out of three nursing home beds in America, these cuts would be a staggering blow to Americans of all generations.

These facts and figures have been met by a wave of the hand from Secretary Price. When asked if his proposed cuts would result in millions of Americans losing access to Medicaid, he responded, “Absolutely not.” He went further, claiming “there are no cuts to the Medicaid program,” and he also said, “nobody will be worse off financially.”

I have heard Secretary Price and others make the baffling argument that people are actually worse off when they have Medicaid coverage—that their health does not improve as a result of Medicaid coverage. Often this argument is based on a brief and outdated study performed in my home State.

Here is the bottom line on Medicaid. Seventy-four million Americans rely on this program for basic health needs—parents with sick kids, people with disabilities, seniors in nursing homes who have nobody to turn to for help if their benefits disappear, and in addition, thousands of Oregonians who are healthy under my home State’s model.

It would be a tough sell to convince those people they are worse off being enrolled in Medicaid, or that the program needs more than a trillion dollars in cuts. And public opinion is very clear: two out of three enrollees are happy with the program. Seven out of ten Americans say Congress ought to leave it as it is—no block grants, no per-capita caps.

Fortunately, the budget proposal hit the wall here in the Congress, and there is a lot of debate left to be had on Trumpcare. But right now, the administration is causing turmoil in the insurance

markets, and it is already having disastrous effects for millions of families.

The President issued a day-one executive order undermining the Affordable Care Act, and nobody on the Trump team can give a straight answer about whether the administration will continue making cost-sharing reduction payments that are key to making insurance affordable for working families. Because of this sabotage, insurers are pulling out of the markets, and people are left without plans to choose from.

You do not have to take my word for it. The insurers are very clear about why they are making these decisions.

Furthermore, on the campaign trail, the President said he would not cut Medicare. The Trumpcare bill shrinks the life of Medicare, and the budget proposal extends the mandatory cuts under the budget sequester by more than \$30 billion. The Food and Drug Administration, the Centers for Disease Control, and the National Institutes of Health are all slashed in the budget. The same is true of programs aimed at basic human needs, programs that fund Meals on Wheels, child care, and foster care. This is the budget you write if you think seniors and working families have it too easy.

I want to thank the Secretary for joining the committee. I apologize again for the hectic schedule. It is never an easy appointment for a Cabinet Secretary, and I think he knows there is going to be some vigorous discussion this morning.

I also again want to express my thanks to the chairman for his very gracious and ongoing courtesies on these kinds of matters. Thanks, Senator Stabenow, for being willing to fill in, and I look forward to returning with our colleagues, and again, I thank the chair.

The CHAIRMAN. Well, thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. Let me just say I am grateful that the President and HHS are, in essence, working on this effort, and are, in essence, eager to work with Congress to fix our health-care system in order to ensure Americans are able to access affordable health coverage.

This may not be something that is going to be that easy to do. And as we know, time is of the essence in regard to this effort.

Earlier this week, we received word that Anthem is pulling out of Ohio's Obamacare marketplace, potentially leaving more than 10,000 patients and consumers in 20 counties without any insurance options on Ohio's exchange for 2018. Now, this news is particularly frightening as we expect to hear similar notices from Anthem as they reevaluate their participation in Obamacare exchanges throughout the United States, our whole country.

Now, this recent story is just the latest in a long line of failures, but my colleagues on the other side seem to want to continue under the guise that this is working. It is not working. All of these failures demonstrate the need to move forward with repealing Obamacare and replacing it with a more workable approach, one that will

take seriously the ballooning health-care costs impacting every American family.

Let me talk for a few minutes about the specifics of the President's budget. The budget assumes \$250 billion in total savings from the repeal and the replacement of Obamacare.

Despite some insinuations to the contrary, the budget does not incorporate the specific legislative proposal, the American Health Care Act, that is before Congress right now. Therefore, it is not accurate to associate the specific Medicaid savings the CBO has estimated from enactment of the AHCA with the President's budget. To do so would assume a level of specificity that, for obvious reasons, is just not there.

Moreover, the President's budget does not cut \$1.5 trillion from Medicaid. Nor does it assume that the specific Medicaid-reform proposals from the AHCA will be enacted into law. I am quite certain that we will hear a lot about that today, but any attempt to make that connection is simply unfounded. And any Senator who harps on the AHCA Medicaid numbers here today either does not understand the explicit language and estimates provided in the President's budget, or they are simply attempting to muddy the waters in order to scare Americans who rely on Medicaid for health-care coverage.

Ultimately, the President's budget appears to accept the reality that the Senate will need to come up with its own health-care reform proposal that includes a fundamental fix to Medicaid, which is, quite frankly, long overdue. And anybody who does not agree with that just is not living in the real world.

In addition to the savings assumed from the repeal of Obamacare, the budget also explicitly assumes \$610 billion in savings from putting Medicare on a sustainable fiscal path by capping funding in fiscal year 2020 through per capita caps or block grants at the States' option.

All told, most of the budget's overall Medicaid savings would be achieved by returning the focus of Medicaid to serving those with the greatest needs—the elderly, the disabled, and needy mothers and children—and by giving States more flexibility to run their own Medicaid programs.

Any Senator who would like to argue that the Federal Government should spend more Medicaid dollars to provide coverage for non-disabled, childless adults at the expense of disabled patients who remain on waiting lists should explain why. Furthermore, any Senator who would like to argue that the States are ill-equipped to handle their Medicaid programs should explain why that is the case, given that the overwhelming consensus we have heard from Governors nationwide over the last several years is that States want more independence and flexibility to tailor the Medicaid program.

Washington needs to stop measuring the success of a Federal program by how much money it spends, or how many other programs are a part of it. Instead, Washington needs to focus on how well a Federal program helps those it is intended to serve and how efficient the program is at fulfilling its mandate.

Long story short, we need to stop focusing on spending and pay more attention to outcomes, because we may not be able to spend

more. It does not appear that we are going to be able to. The rate things are going right now under the current system, it is a national tragedy.

I think the President's budget, while it is by no means flawless, largely recognizes this reality, and the President and the administration deserve credit for that. Now, I look forward to having an open and frank discussion with Secretary Price about his thoughts on these and other matters.

[The prepared statement of Chairman Hatch appears in the appendix.]

The CHAIRMAN. But before we get to that, I would like to say today that we have the pleasure of being joined by Secretary Thomas E. Price.

Secretary Price, I want to thank you for coming. Secretary Price was sworn in as the 23rd Secretary of Health and Human Services on February 10, 2017.

As a policymaker and a physician—a surgeon, in particular—he brings to the Department a lifetime of service and dedication to advancing the quality of health care in America.

Secretary Price first began his career in care for patients as an orthopaedic surgeon. He followed in the footsteps of his father and grandfather, and began a solo medical practice in Atlanta, GA. Since its founding, that practice has grown to be one of the largest non-academic orthopaedic practices in the country.

Hoping to make a different type of impact on health care, Secretary Price ran for public office and was elected to four terms in the Georgia State Senate, and I believe would have continued on forever if he wanted to. During his tenure there, Secretary Price served as Minority Whip and later as the first Republican Senate Majority Leader in the history of Georgia.

Most recently, Secretary Price served as U.S. Representative for Georgia's sixth congressional district from 2005 to 2017. During his time in the House, Secretary Price served in various roles, including chairman of the House Budget Committee, chairman of the House Republican Policy Committee, and chairman of the Republican Study Committee.

Secretary Price received his bachelor and doctorate of medicine degrees from the University of Michigan, after which he completed his orthopaedic surgery residency at Emory University.

Now, Secretary Price, we are grateful to have you here and will be happy to have you proceed with your testimony here today.

STATEMENT OF HON. THOMAS E. PRICE, M.D., SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary PRICE. Thank you so much, Mr. Chairman and Ranking Member Stabenow and members of the committee. I want to thank you for inviting me today to discuss the President's budget for the Department of Health and Human Services for fiscal year 2018. It truly is an honor to be with you.

Whenever a budget is released, the most common question in this town, in Washington, is "how much?" How much does the budget spend on this program, how much does it cut from the other program?

And as a former legislator, I understand the importance of this question. But too often, it is treated as the only question that is worth asking as it relates to the budget, as if how much a program spends is more important, or somehow more indicative of whether the program actually works.

President Trump's budget request does not confuse government spending with government success. The President understands that setting a budget is about more than establishing topline spending levels. Done properly, the budgeting process is an exercise in reforming our Federal programs to make sure that they do their job and use tax dollars wisely.

The problem with many of our Federal programs is not that they are too expensive or too underfunded. The real problem is that many of them simply do not work. Fixing a broken government program requires redesigning its structure and refocusing taxpayer resources to better serve those most in need. And that is exactly what President Trump's budget will do at HHS and across the government. Consider Medicaid, which has been discussed, the primary source of medical coverage for millions of low-income American families and seniors facing challenging health circumstances.

If the amount of government spending were truly a measure of success, Medicaid would be hailed as one of the most successful programs in history. Twenty years ago, actual spending on Medicaid was less than \$200 billion. Within the next decade, it is estimated to top \$1 trillion a year.

Despite these significant investments, one-third of physicians who ought to be seeing new Medicaid patients do not. Some research shows that enrolling in Medicaid does not necessarily improve your health outcomes for the newly eligible Medicaid population.

This suggests that we need structural reforms that empower States to serve their unique Medicaid populations in a way that is both compassionate and sustainable. Now under current law, Federal rules prevent States from focusing on their most vulnerable communities and from testing new ideas to improve health outcomes and access to care. This budget changes that.

HHS's mission of protecting the health of the American people involves far more than overseeing the Nation's health care and insurance programs. HHS is the world's leader in helping the health-care sector prepare for cyber-threats and responding to and protecting against public health emergencies.

Recently, I witnessed this important work firsthand visiting Ebola survivors in Liberia and representing the United States at the G20 Health Ministerial Meeting in Berlin and the World Health Assembly in Geneva. To support HHS's unique Federal role in public health emergencies, preparedness, and response, the President's budget provides \$4.3 billion for disaster services coordination and response planning, biodefense and emerging infectious disease research, and development and stockpiling of critical medical countermeasures.

In addition, today America faces a new set of public health crises that we have been far less successful in resolving. Those are serious mental illness, the opioid crisis, and childhood obesity.

As Secretary, I am committed to leading HHS to address each of these three challenges, and the President's budget calls for investments in policy reforms that will enable us to do that. The budget calls for investments in high-priority mental health initiatives for psychiatric care, suicide and homeless prevention, and children's mental health, focusing especially on those suffering from severe mental illness.

In 2015, over 52,000 Americans died of overdose, most of them from opioids. This budget calls for \$811 million to support the department's five-point strategy to fight this epidemic.

To invest in the health of the next generation and help nearly the 20 percent of school-aged children who are obese lead healthy and happier lives, the President's budget establishes a new \$500 million America's Health Block Grant.

Additionally, the President's budget prioritizes women's health programs by investing in research to improve health outcomes for women and increasing funding for the Maternal and Child Health Block Grant and Healthy Start. Across HHS, funding is maintained for vital programs serving women, including community health centers, domestic violence programs, women's cancer screenings and support, mother and infant programs, and the Office of Women's Health. This budget demands some tough choices, and in this challenging fiscal environment, there are no easy answers. With this budget, however, the new administration charts a path toward a sustainable fiscal future and ensures the dedicated resources provided enhance and protect the health and well-being of the American people.

Members of the committee, I want to thank you for the opportunity to be with you today and your continued support of the Department of Health and Human Services. It is my incredible privilege to serve as its Secretary.

[The prepared statement of Secretary Price appears in the appendix.]

The CHAIRMAN. We are proud of you, and we know that you were an excellent member of the House. And so far, it looks to me like you are getting on top of what these problems are, although you were pretty well on top of them before as a member of the House.

The opioid crisis seems to be spreading across the country, affecting families and communities in unprecedented ways. In fact, *The New York Times* reported earlier this week that overdose deaths are at an all-time high. Tackling this crisis is a priority for you and for President Trump. So can you describe the efforts HHS is undertaking to address the ongoing opioid epidemic in the United States?

Secretary PRICE. Mr. Chairman, this is one of the scourges across the Nation that tears your heart out. In 2015, 52,000—as I mentioned—fellow Americans died of an overdose, 33,000 of those of an opioid overdose. We hear this day after day after day. What the Department has done is put in place a five-part strategy to make certain that we are identifying the kind of treatment and recovery efforts that work in assisting the States.

We want to make certain that we have the overdose-reversing drugs available wherever they need to be available and know that we are trying to surveil and make certain that we know prior about

strong drugs getting to the street, from a law-enforcement standpoint.

There is a public health aspect to this, obviously, to try to determine what the heck is going on. Why is this scourge as large as it is? And we are putting resources into that.

In addition, we want to make certain we are doing the highest level of research to try to identify those pain treatments that are able to make it so that there is not a need for individuals to seek pain medication for its euphoric effect.

And then finally, fifth, it is important to look at how we manage pain in this Nation. Twenty years ago, we started down this road of measuring pain as a fifth vital sign. Let me suggest to you that that has resulted in significantly greater use of opioids and prescription medication than would have otherwise been the case.

So we have this five-part strategy. You have been incredibly helpful, Congress has been incredibly helpful, to make certain, through 21st Century Cures and otherwise, to provide resources so that we can allow the States to identify, again, those evidence-based programs that they have in place that can help mitigate this challenge.

But we continue to move in the wrong direction, Mr. Chairman, and we will not rest at the Department or in the administration until we bend that curve in the other direction.

The CHAIRMAN. Well, thank you so much.

HHS recently published a report using the previous administration's data showing just how much health insurance premiums in the individual market have increased since 2013. Could you tell us what are the principle findings of that report?

Secretary PRICE. Well, thank you so much.

I know that when I visited with folks in my previous position, and then since I have been privileged to serve as Secretary, I hear over and over again how folks are just so terribly concerned about the cost of health coverage for them and their family. And there was this disconnect—you are going to have the individuals talking about the wonders of the program that was in place, but then you had all of these individuals who were so concerned because they did not have the ability to afford the coverage, or they did not have the ability to get the care.

So this study that we undertook, that was undertaken at the Assistant Secretary for Planning and Evaluation group within HHS, identified that the average premium increase over the last 4 years has been over 100 percent. It was 105 percent, so more than double, across the country. In fact, in three States, the increases were tripled—in Alaska, in Alabama, and in Oklahoma.

And what that means is that there are individuals who (1) cannot afford the coverage, and (2) even when they can afford the coverage, the deductibles have increased to a significant degree so that they may have an insurance card, but they do not have any care, because they cannot afford the deductible.

So that is the challenge that we are trying to address and make certain that Congress addresses so that individuals are able to afford the kind of coverage that folks want for themselves and for their families.

The CHAIRMAN. Well, as you may be well aware, this committee has for several years now been keenly interested in the large backlog of Medicare claims under appeal at HHS. The most recent reports we have heard indicate that the backlog has been reduced from a high of nearly 1 million claims to a current number closer to 750,000 claims. Now, that number is still unacceptably high.

Can you tell me what HHS is doing to address the unnecessary backlog of Medicare claims?

Secretary PRICE. Yes. These are appeals where providers have said that they do not believe that the Federal Government is providing the kind of resources necessary for them to be able to care for their patients. And as you mentioned, the numbers are staggering: nearly a million claims. We are down to about 700,000 now.

We can take care of somewhere around 20,000—up until recently—a year. What we have done is met with the individuals, and they are high-quality folks. These are folks just trying to get these appeals through the process and trying to make the right decision.

We put a focus on that. We have encouraged them to talk to the stakeholders, talk to the individuals out there about why we have this increase in claims. There is a problem there. It means that the system is not working to the degree that it should to allow those individuals to care for those patients and be compensated for that care.

We have identified the opportunity for the administrative law judges to be able to review higher claims and move in the direction of having magistrate judges review lower claims so that we can hopefully get through a larger volume of claims on an annual basis.

And then we have tried to decrease the burden of reporting. We are working on trying to decrease the burden of reporting for the providers so that there is a less likely possibility that they would feel the need or desire to file a claim.

So this is a major problem. We are working through it, and we are committed to getting that number down to a reasonable number.

The CHAIRMAN. Well, I am happy to listen to you. You have inherited a tremendous number of problems, and I know that you are fully capable of solving those problems. I think you are well on your way.

The distinguished ranking member has agreed with me to allow Senator Isakson to go next.

Senator ISAKSON. Thank you, Mr. Chairman.

Dr. Price, welcome back. The last time you were here, we were confirming you, and now we are getting a lecture from you on what we need to do to help you. And we are here to help you.

Secretary PRICE. Thank you.

Senator ISAKSON. All of the Georgians are proud of you and your service to our State.

You just returned from your first trip overseas as Secretary, and you began that in Liberia, if I am not mistaken.

Secretary PRICE. I did.

Senator ISAKSON. What did you learn, particularly with respect to our response to the Ebola outbreak, which ground zero, I think, was Liberia?

Secretary PRICE. It was indeed, Senator. Thank you so much. I appreciate your support and your service to our great State.

My first trip overseas was—we stopped first in Liberia. I wanted to do that, because I wanted to express our appreciation to the Americans who were working over there, especially during that Ebola crisis, and to also demonstrate our continued commitment for global health security and to thank the Liberian government for what they had done to elevate and increase their ability in the area of infectious disease.

What I saw was incredibly inspiring. And you all would be so remarkably proud of the American people who are forward deployed—if you will—in global health, individuals from the CDC, from the NIH, from HRSA, who are doing all that they can to make certain that we address the health challenges that exist around the world, especially around infectious disease.

It paid off in absolutely remarkable benefits, and we saw that because of the most recent outbreak of meningitis that occurred in Liberia, and that outbreak—the surveillance that was done, the detection that was done, the prevention of spread that was done, and the treatment that was done, was only possible because of the work that had been done in Liberia since the Ebola outbreak and since that challenge was resolved.

So I was just uplifted and inspired by the incredible work of the American people who are dedicating their lives to assisting the health of individuals overseas.

Senator ISAKSON. Well, CDC did a phenomenal job, as did HHS.

Secretary PRICE. Absolutely.

Senator ISAKSON. I want to point out that the President's budget cuts by \$136 million the Preparedness Fund, a lot of which went to the initial response to Ebola in Africa, along with a partnership with Emory University to have the first place we could actually bring some of those victims to the States. We need to work to see to it that the funding is there so we can have the same type of response the next time an outbreak takes place, wherever it is in the world, because we are the world's clinic, if you will, for emergencies and disasters like that.

Secretary PRICE. Yes.

Senator ISAKSON. Secondly, you had a partner by the name of John Knox, if I am not mistaken. Is that right?

Secretary PRICE. I did.

Senator ISAKSON. You may remember, John operated on my son, Kevin, 30 years ago and saved his leg from a terrible injury and a terrible accident. It took him 9 months to recover. Eight of those months he recovered at home.

My wife and I went to school. We took lessons in how to clean ports and put the antibiotic drips into him so he could fight infection in his bone marrow while he recovered at home.

Since 1989 when that accident took place, over time reimbursement for antibiotics and home infusion went away. In fact, there was a push to drive everybody into the hospital to recover and not as much reimbursement to encourage people to stay home.

Fortunately, Senator Warner worked closely with us to see to it that we began focusing on reimbursement for durable medical equipment in the 21st Century Cures Act. I hope you will work

with us to see to it we can expand coverage to get home infusion, wherever practical and possible, covered as a benefit so that we can have more people recovering in a less expensive, more hospitable environment than in hospitals and hospital facilities.

Secretary PRICE. This is really important, Senator, because what we find—health care and medicine are dynamic. They change all the time. So what used to be able to be done only in a hospital, now can oftentimes be done as an outpatient or, in the instance of recovery, oftentimes at home. And home- and community-based services are absolutely imperative for us to have the flexibility to be able to do that.

So that is one of the things that we are trying to concentrate on from a waiver standpoint in many different programs, as well as trying to incent the flexibility within existing programs so we can cover those kinds of treatments, not necessarily just in the venue that was previously selected when that was the standard of care, but in a new venue because it works better for the patient.

Senator ISAKSON. Lastly, I just want to underscore what you said about experimenting to have our Medicaid coverage available and robust for our citizens. Your State and my State, Georgia, we have 1.9 million people on Medicaid—1.3 million of them are children. Fifty percent of all the live births in Georgia are paid for by Medicaid.

So, as we go through the reforms that are necessary in Medicaid, we have to remember that we are talking about, first and foremost in our State—and I think in most others—children who benefit from those programs being robust or are hurt if they are cut. I look forward to working with you to see to it that we continue to provide the coverage that is necessary and experiment with ways to incentivize the program to meet the needs for our children in Georgia.

Secretary PRICE. Thank you, Senator. Thank you for your leadership.

Senator ISAKSON. Thank you, Mr. Secretary.

The CHAIRMAN. Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman.

Welcome, Secretary Price. There are so many things that I would like to talk to you about and actually debate with you in terms of what has been said and the positions of the administration. But I want to start with, I think, a very important basic assumption that you have made, and that is that the Affordable Care Act is falling apart. “Oh my gosh, look what is happening. We have to dismantle it. Do something different, because it is falling apart.”

And yet we know—to me it is like pulling the rug out from under somebody and saying, “Oh my gosh they fell down.” We have seen consistent moves by the administration, whether it was cutting in half the number of days that citizens have to sign up for insurance, whether it is no longer aggressively doing outreach to younger, healthier people, making sure everybody is in the pool so that costs do not go up, or whether it is doing what has been done to take away the commitments made to the insurance industry to make sure that they would be covering pre-existing conditions and have no caps on services, and so on.

And it is laid out this morning in *The Washington Post*, when we look at the question of whether or not the White House is going to let the health-care system die. I want to just quote a little bit from there, because this is coming from the industry. The biggest source of industry anxiety right now is whether the administration and Congress will continue to fund cost-sharing subsidies that help 7 million Americans with ACA plans afford deductibles and copays, and, “Absent that funding, I don’t know if we are going to have much participation in the exchange market in 2018,” said Tennessee Insurance Commissioner Julie Mix McPeak, a Republican who also serves as president-elect of the National Association of Insurance Commissioners.

The uncertainty—the uncertainty is one of the top reasons insurers have cited when explaining why they are posting higher rates for the next year or withdrawing from markets altogether. Two weeks ago Blue Cross Blue Shield of North Carolina filed a rate increase of 22.9 percent. They said it would have been 8.8 percent, not 22.9 percent, if the administration had committed to paying and basically keeping the commitments that were passed as part of health reform.

And then finally, on Tuesday Anthem Blue Cross Blue Shield announced it was pulling out of the Federal exchange. You have mentioned that in Ohio. The President seemed to cheer that yesterday. I do not know why we are cheering that people are going to have less opportunity to have health care.

If we spent a tenth of the time that has been spent undermining the health-care system working to make it better, we would be making terrific strides to lower costs for people.

But here is what was said by Brad Wilson, the North Carolina chief executive of Blue Cross Blue Shield. “We have to take a snapshot in time, which is right now. A lack of action by the administration,” he added, “yields a result we are currently seeing, higher premiums rather than lower premiums.”

And so my question, Mr. Secretary, is, why do you believe it is in the best interest of American families to sabotage the health-care system that is today allowing American parents to take their children to the doctor?

Secretary PRICE. Thank you, Senator.

Well, let me just correct a few statements. Nobody is interested in the system dying. What we are interested in is making certain that the system works for patients and families and doctors. Nobody—

Senator STABENOW. Then why are you not willing to—excuse me, but why are you not willing, then, to indicate that as long as we have the system we have, you are going to keep the commitments and reimburse the insurance companies so they have certainty?

Secretary PRICE. Nobody is interested in sabotaging the system. Nobody is cheering the challenges that we have in the system.

In your State alone, premiums were up 90 percent before this President came into office. The number of insurers was down before this President came into office. In your State, so—

Senator STABENOW. Well, I can assure you, after meeting with the head of Blue Cross and Blue Shield of Michigan, they are going to file two rates when they file their rates: one if the administra-

tion keeps their commitments, and one if they do not. And if they do not, they are going to be much higher.

So I think the question is, why would you not keep the commitments made? I understand you have a different view in terms of what the system should look like, which I disagree with. But in the meantime you have insurers—insurers—that are saying the reason the rates are going up is because of uncertainty and instability created by the administration. Why is that a good idea?

Secretary PRICE. Actually, Senator, if you read further in that article, it talks about the increase in costs and decreasing insurance availability for individuals across this country before this administration came into office.

So what we are trying to do is to fix the challenges that we have—

Senator STABENOW. Well, let us start by keeping our commitments. I have more questions for another round, but let us start by making sure that the administration is keeping the current commitments, following the current law while we debate what should happen next.

Thank you, Mr. Chairman.

The CHAIRMAN. Did you have enough time to answer that question?

Secretary PRICE. Yes, sir.

The CHAIRMAN. Do you need more time?

Secretary PRICE. No, I am fine. Thanks.

The CHAIRMAN. Okay.

Then we will turn now to Senator Cassidy.

Senator CASSIDY. Hello, Dr. Price.

Secretary PRICE. Hello.

Senator CASSIDY. There are a couple of things I am encouraged by in your budget. Senator Cantwell and I last year put in a bill regarding direct primary care. For those unfamiliar with it, as physicians you and I know the way you lower cost is to empower the patient/physician relationship so that if the patient has a problem, instead of going to the ER, she can call her physician, and her physician can give her the advice.

Direct primary care is a contractual relationship, and so there is more investment, perhaps, than in the other relationships that are out there, say an urgent care center where you might see the person once and never see them again.

So Senator Cantwell and I put that together. And I like it, because it can decrease utilization. And by decreasing utilization, you decrease health-care costs, and ultimately we do not decrease the cost of insurance unless we decrease both utilization and the costs of health care.

Secretary PRICE. Absolutely.

Senator CASSIDY. Do you have any comments on that direct primary care model and how robust you all plan to make that?

Secretary PRICE. Well, it is an incredibly helpful program, and it gets to the point of the dynamism of health care.

The opportunity that individuals may have to be able to have a personal physician, a primary care physician in all settings across our health system, would be, I think, absolutely beneficial to the

ability for that patient, that individual patient, to get the kind of care that he or she needs.

Right now, you cannot do that. So what we want to do is move toward a system that allows for more personalized care, and the DPC model—the direct primary care model—is one that I think holds great promise.

Senator CASSIDY. Now, if you will, it aligns the incentive between the patient and the physician.

Secretary PRICE. Absolutely.

Senator CASSIDY. Let me talk a little bit about the per capita cap or, as I prefer to call it, the per beneficiary payment. And just a little history for those who may not know, it was first introduced by President Clinton as a concept, and Senators Phil Gramm and Rick Santorum simultaneously, as a way to align incentives between the patient, the State, and the Federal Government.

I think we are actually seeing almost a modified version of that now as States are going to Medicaid managed care, aligning the incentive between the State as a payer with the Medicaid managed care company, and then the patient. I guess the way I look at the per beneficiary payment—because as you know, I introduced a bill in 2010; I do not know when it was, 112th Congress—which kind of brushed off the Phil Gramm-Bill Clinton proposal and updated it, if you will. It will align the incentive between the Federal and the State government.

Secretary PRICE. Exactly, and it is so important because, as you know, having taken care of—as I did—Medicaid patients in our practices, the Medicaid population is not a monolithic population. There are individuals in the Medicaid population who are, as Senator Isakson said, healthy moms and kids. There are also individuals in the Medicaid population who are seniors, low-income seniors, and disabled, blind and disabled individuals.

All of those individuals need to be treated uniquely, because they are unique individuals. And what we do as a system, by and large, is say, you have to take care of every one of those people exactly the same way, which does not allow for that kind of dynamism and flexibility in the program so that States can tailor their Medicaid programs to suit their Medicaid population.

Senator CASSIDY. And let me just say again I do not know if this is in the House bill, because the way we do the per beneficiary payment is a little bit different, is somewhat different than what the House does.

But as an example of aligning incentives, as we know right now, if States recover waste, fraud, and abuse, they have to give back to the Federal Government the portion that the Federal taxpayer put in. So if it is a 60-percent State—40-percent State, 60-percent Federal Government—60 percent of that recovery goes back to the Federal Government.

That works to disincentivize the State to go after waste, fraud, and abuse, because they have to kick it back. Under the per beneficiary model that we put forward, the State would keep 100 percent of recovered waste, fraud, and abuse, if you will, aligning the incentive for them to wring out that waste, fraud, and abuse.

Secretary PRICE. It is those kinds of modifications and improvements to a system that I believe we all ought to be embracing, be-

cause it is those kinds of things that will then allow us to align the incentives, as you suggested, but also make certain that every individual in that interaction is working for the benefit of the patient, making certain that there is not the fraud and abuse, making certain that the patient is able to see the physician that he or she wants to see, making certain that the patient is able to have the kind of treatment that he or she desires.

Senator CASSIDY. Let me also point out that under the Medicaid Accountability and Care Act which I introduced, and then again in the Cassidy-Collins plan or the Patient Freedom Act, we have incorporated—States like California actually get more money, and some big blue States actually do well. Florida does better in terms of having more dollars for certain categories of patients in order to improve health care.

So when I hear folks condemn it without understanding it, I feel like this could be an incredible missed opportunity to align those incentives to improve patient care, but also to protect the Federal and the State taxpayer.

I look forward to working with you, and hopefully you will have folks on the other side of the aisle.

I yield back.

The CHAIRMAN. Okay.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman.

I want to take a moment just to began, if I could, Mr. Chairman, to commend you and Senator Grassley for something you did—gosh, I want to say 24 years ago. And what you did is, you cosponsored legislation authored by Senator John Chafee that called for creating in every State marketplaces, exchanges. You called for not only establishing the exchanges and marketplaces in every State, but to also say that, in order to make sure that the insurance companies had a healthy pool of people to insure, there would be an individual mandate, that people had to get coverage. You cannot force people to get coverage, but you say, you have to get coverage and fine them somehow if they do not, incentivize them to get the coverage.

I want to congratulate you on cosponsoring legislation that provided for an employer mandate and that also provided for the idea that insurance cannot deny coverage to people who have a pre-existing condition.

All those ideas are a part of Romneycare in Massachusetts. And frankly, all of those are a part of the Affordable Care Act.

And the parts of the Affordable Care Act that the Republican Congress seem to like the least are those ideas. I think there is a real irony in all this. I like those ideas. I studied economics at Ohio State. I was a Navy midshipman. I like market forces. I like trying to harness market forces and make them work.

You came up with a good idea in 1993. And I just wish to heck that you would work with us to try to make sure that those good ideas have a chance of working. And the reason why the marketplaces are failing in places like you mentioned, in Ohio, in your statement, Mr. Chairman—the reason why they are not working is, we have basically undermined the individual mandate so that peo-

ple know they do not really have to get coverage. The young people are not.

We have taken off the training wheels, so to stabilize the marketplaces and insurance companies—they lost their shirts in 2014 because of it. They lost less money in 2015. It got better. They raised their premiums, they raised their copays, they raised their deductibles, and they did better.

A Standard and Poor's column said, rather than the marketplaces being in a death spiral at the end of 2016, they were actually recovering until our new administration came in and said, well we are not sure if we are going to enforce the individual mandate, and by the way, we do not know for sure whether we are going to extend the cost-sharing arrangements.

That provides unpredictability, lack of certainty for the insurance companies. What do they do? They say, we are going to raise our premiums more. Well, you are destabilizing the very idea that these guys came up with 24 years ago.

The CHAIRMAN. Well, if I could just interrupt for a second.

Those were ideas that were against—it was part of the anti-Hillarycare bill.

Senator CARPER. They were good ideas. I commend you for them. If my life depended on it, I could not tell you what Hillarycare did. I could not tell you, but I know what your bill did. And frankly, they were good ideas.

And now we are undermining, undercutting them. Why? Dr. Price, why?

Secretary PRICE. Senator, I appreciate the observation. I would add to that that there are significant challenges out there, and there were before this administration started. In your State alone, premiums were up 108 percent before this administration started. In your State alone, there were fewer insurance companies offering coverage on the exchange before this administration started.

So what we are trying to do is address, especially, that individual and small group market that is seeing significant increases in premiums, increases in deductions—

Senator CARPER. What are you doing? What are you doing to do that? How are you stabilizing the marketplaces? There are some good ideas. The three Rs, what are you doing on those—reinsurance, risk adjustment, risk—what are you doing there?

Secretary PRICE. We passed—we put in place a market stabilization rule earlier this year that identified the special enrollment periods and the grace periods to make certain that they were more workable for both individuals and for insurance companies.

We allowed the States greater flexibility in determining what a qualified health plan was to try to provide greater stability for the market. We put out word to all Governors across this Nation on both 1115 and 1332 waivers with suggestions regarding what they can do to allow for greater market stabilization in their States.

And we look forward to working with you and other Senators to try to make certain that all those individuals, not just in the individual and small group market, but every single American has the opportunity to gain access to the kind of coverage that works for them and their families.

Senator CARPER. Let me just mention Medicaid. When I came to the Congress a long time ago before I was Governor, I used to think that Medicaid was health-care coverage for mostly women with children, poor women and children. You know where we spend most of our money—you know this. Most of the money we spend in Medicaid today is for old people, and they are in nursing homes, and a bunch of them have dementia.

When we talk about cutting \$800 billion out of the program, it is not just the poor women and children who are going to get hurt, it is those old people. And it is a lot of people between the ages of 50 and 65 who are white males who are going to be—so it is a lot of veterans. Their only hope and only chance of getting, in some cases, access to medical care, because they cannot get it—they do not qualify for VA coverage—is through Medicaid.

The last thing I want to say is this. Mr. Chairman, here is an idea. This is—I extend this idea with good intent. I spent 8 years as a Governor. I loved being a Governor. I love being a part of the National Governors Association.

John Engler and I, Governor of Michigan, used to come here. And here in the Ways and Means Committee in the House, we used to testify on welfare reform. And we would say, these are the views of the Governors, Democrat and Republican. This is what we think we ought to do.

This is an issue that cries out for getting Governors to sit at the table and say, here is how this is going to affect us. This is the way the system works or why it does not work. This is why we like the idea of per capita caps and why it does not work.

That is what we ought to be doing. I must say, the 13 folks who have been picked to help figure out a Republican alternative to the House-passed mess—it would be a lot more informative if we could have that kind of hearing. This is fine. I am happy to see you, Dr. Price, but that is actually something that might move us to a principle of compromise and get things done. People want us to get stuff done, and the idea that we are going to do it all Democrat or all Republican is crazy.

Thank you for joining us.

Secretary PRICE. Mr. Chairman, if I may just comment on that, because I think it is important for people to appreciate the work that the Department is doing.

We met with the National Governors Association, met with Governors on both sides of the aisle to try to solicit their input in the kinds of suggestions that they would have regarding 1115 and 1332 waivers, those that affect the Medicaid program and the individual market. So we are doing all that we can to try to make certain that States are able to address the challenges.

Senator CARPER. Dr. Price, just to be clear. When Barack Obama left office—was it a perfect administration? No.

When he left office, there was an insurer in every county of every State in this country. Thank you.

The CHAIRMAN. Senator Cardin?

Senator CARDIN. Secretary Price, thank you very much.

I have heard your commitment to make sure that you will do everything you can to help all people in this country get access to

quality health care. And that is something that we all agree on; that is what we want to get done.

I want to get to some of the practical problems here. I was in Federalsburg on Monday. It is closer to where Senator Carper lives than where I live. It is on the Eastern Shore of Maryland, Caroline County. It is a very rural community.

They do not have the same access to health-care providers that we have in our urban centers. And I visited the Federalsburg Elementary School Wellness Center, where we have the Choptank qualified center that provides direct services to our children within the elementary school.

And they are capable of doing that. This is, for many of these children, their only real ability to get access to primary care and to have someone who can check up on their health. And Choptank is able to do that under current law. But they tell me, as the legislation is passing from the House to the Senate, that that direct reimbursement would be cut off.

They also told me that if they cannot continue their flows through the Medicaid program, they will clearly not be able to continue the services that they are providing today in Caroline County.

So my question to you—I understand your commitment to help all areas. Today our qualified centers are providing lifelines in many communities. They rely upon creative ways to provide care in rural areas, including within school settings. And they depend greatly on the reduced numbers of uninsured and those covered under the Medicaid program for comprehensive reimbursement in order to be able to maintain their presence.

So how do we ensure that, as we go through this transition that the administration is talking about, the children in Caroline County are going to be able to continue to get their health-care needs met?

Secretary PRICE. Well, I appreciate that, Senator. There are significant challenges in the rural areas of our Nation for the provision of health services, and those have been present for a long, long time. And there is a strong commitment on the part of our department, and certainly on the part of the President, to make certain that rural health services are available.

So whether it is through grants to the States, whether it is through an opportunity for various health programs within schools or elsewhere to make certain the children have the kind of health care, and not just coverage, that they need, then we are absolutely committed.

One of the things that our budget includes is something called a New American Health Block Grant, which would provide resources to States to do just this sort of thing, to make certain that folks in rural areas of States have the opportunity to gain the kind of coverage and care that they need.

So I look forward to working with you to make certain that we are able to make that happen.

Senator CARDIN. The other area that I want to cover, you and I talked about in my office during the confirmation process, and I will bring it up again today. I want to know about your commitment to deal with minority health and health disparities.

We have separate agencies today to deal with it. We have an institute at NIH. And as I go around and look at some of the historic discriminations within our health care and recognize that health care is not equally available, and our focus has not been to all communities equally—and we are trying to compensate for that today—I worry about what you are doing, in Medicaid particularly.

Every minority community I go to, they mention to me Medicaid, and that there is no capacity at the State level to pick up the slack if the Federal Government withdraws its commitment, either in the numbers of people who are covered or in the benefits that are reimbursed.

So how do you square a commitment to continue down the path to reduce minority health disparities in this country and, not only the reduction in the bill that passed the House, but also the President's budget with such a large cut in Medicaid?

Secretary PRICE. This is incredibly important, and I cannot remember whether I mentioned it in this committee for my confirmation hearing or in the other one, in the HELP Committee. But the disparities and health outcomes are absolutely unacceptable to all, because what we see is its—and it is not just necessarily rural versus urban areas.

There are areas within urban centers—I know of one in Atlanta where there is a zip code where the health outcomes, the disparities, are absolutely astounding in terms of the mortality that exists, the addiction that exists, the chronic disease that exists. And that is not because of lack of services close by, because it is in the center of the city. But imagine, if you would, please, a system that allowed for the Medicaid program in the State of Georgia to provide increasing resources to that zip code to provide a case manager—if you will—for every single individual in that zip code who has a chronic disease within the Medicaid program. That is now not possible. You cannot do that.

That is the kind of waiver, that is the kind of partnership, that I think is so incredibly important to make it so that we actually identify those folks who need greater assistance if we are going to end the disparities that are out there, which you and I both have a commitment to ending.

Senator CARDIN. I am all for flexibility for the States. I appreciate that, but I also know the pressures on State budgets.

And I know in my State of Maryland, where our Governor and legislature have been pretty aggressive in helping the Medicaid population, they cannot pick up the slack. A waiver will not give them what they need to be able to make that type of commitment to underserved areas.

Thank you, Mr. Chairman.

The CHAIRMAN. Okay. Senator Casey?

Senator CASEY. Thank you, Mr. Chairman.

Secretary Price, good to be with you this morning.

I want to start by referencing a letter that I and, I guess, 14 other Senators sent to you recently about the House bill H.R. 1628. But in particular, I wanted to reference the Congressional Budget Office report that just came out on the 24th of May. Of course, this is a nonpartisan report by the Congressional Budget Office assisted by the Joint Committee on Taxation.

I just delivered to the table, next to you there, a copy of the CBO report so you could go to the page. I direct your attention to page 17 of the CBO report. On that page, the following statement is set forth there: “Medicaid enrollment would be lower throughout the coming decade, culminating in 14 million fewer Medicaid enrollees by 2026,” a reduction of about 17 percent from current numbers.

It then references this chart which you will see on page 19 showing the numbers going down for Medicaid over that time between 2018 and 2026, all bars going down.

I reference that in the context of what you said on CNN on May 7th. I am quoting you now, and the transcript is right in front of you. “There are no cuts to the Medicaid program.” That is what you said.

Do you still stand by that statement being made on CNN?

Secretary PRICE. The Medicaid program under the President’s budget would increase by—

Senator CASEY. Secretary Price, “yes” or “no”? You can explain after that, but “yes” or “no”? Do you stand by that statement you made on May 7th on CNN?

Secretary PRICE. What I stand by is the statement that the President’s budget—

Senator CASEY. Do you stand by that statement? That is a very—I think there are eight words.

Secretary PRICE. What is the baseline?

Senator CASEY. “There are no cuts to the Medicaid program.” Do you stand by that statement?

Secretary PRICE. What is the baseline?

Senator CASEY. I am not—

Secretary PRICE. If there are no cuts, it is relevant.

Senator CASEY. You have the statement in front of you.

Secretary PRICE. Yes, I stand by that statement.

Senator CASEY. Okay.

Secretary PRICE. It is relative to something.

Senator CASEY. Go ahead. You can—go ahead.

Secretary PRICE. If the baseline is today’s amount of money being spent on Medicaid, the President’s budget provides for an increase, a CPI medical or CPI medical plus-one increase, in Medicaid spending for the programs—

Senator CASEY. Are you saying the statement in the CBO report on page 17 is not accurate?

Secretary PRICE. I am saying that the statement that CBO made does not include the constellation of activities within the administration regarding how we would move forward on health care.

Senator CASEY. CBO says there will be 14 million fewer Medicaid enrollees. So that is one.

Secretary PRICE. Do you have the CBO report on the ACA when it was proposed in 2010, because what they said then—

Senator CASEY. I am talking about the House Republican bill that was passed. That is what we are talking about today.

Secretary PRICE. I am talking about what the CBO did, because they had a similar graph about the number of individuals who would be covered now, and in fact, they were—

Senator CASEY. Let me direct your attention to the same CBO report you have in front of you, page 13. On the top of that page, it

says the following; the introductory sentence is, "The total deficit reduction includes the following amounts shown in table 3 at the end of the document." The first bullet under that is, "A reduction of \$834 billion in Federal outlays for Medicaid." So do you still assert in light of that and in light of the previous CBO statement—do you still assert that there are no cuts to the Medicaid program? Do you stand by that statement?

Secretary PRICE. Senator, as you understand, it depends—

Senator CASEY. All I am asking you to do, Mr. Secretary, is to tell us whether you stand by that statement or not.

Secretary PRICE. I stand by that statement.

Senator CASEY. Okay.

Finally, let me go to a statement that was made in the CBO report. Now I am going to page 19 and 20, which you have in front of you. At the bottom of page 19, the following is set forth: "Under the act"—meaning under the Republican bill passed in the House—"premiums for older people could be five times larger than for those younger people in many States, but the size of the tax credits for older people would only be twice the size of credits for younger people. As a result"—and here is the first bullet point—"for older people with lower income, net premiums would be much larger than under current law on average."

Then it refers to table 5 at the end of the report. So I ask you, in the context of another statement you made—now, this is "Meet the Press" in March—March 12th. You said that "nobody will be worse off financially as a result of the bill." Do you stand by that statement?

Secretary PRICE. I do not believe that statement was in reference to the bill. It was in reference to the health-care plan that we have put forward, and I stand by that statement.

The CHAIRMAN. Senator, your time is up.

Senator CASEY. Well, I hope that you focus more on, not just the proposed reforms you talk about for Medicaid, but I hope you focus on people like the 15 million Americans who get Medicaid because they have a disability.

We are all for a discussion about making programs better. But I think you should focus more intensively on those people and be truthful when you are commenting about something as important to American lives as the Medicaid program.

And I would argue, sir, you have been deliberately misleading based upon those statements.

Secretary PRICE. Senator, with respect, that is precisely what we are focusing on. The American people understand and appreciate that the health-care system that we currently have, for many of them, is not working. For many of them in the Medicaid program, it is not working.

And what we are trying to do—and we would love to have your support. What we are trying to do is to make certain that we have a system that responds to the wishes and needs and the health-care needs of all Americans.

Senator CASEY. We all agree on that. But I think you have to start being straight with people about what will happen.

These are major cuts. The CBO said it in more ways than one. I think you should be truthful about that.

The CHAIRMAN. Senator McCaskill?

Senator MCCASKILL. Thank you, Mr. Chairman.

Let me start by saying, Mr. Chairman, that you and Senator Grassley I have a great deal of respect and admiration for.

So my first question that I would make of the chair is, will we have a hearing on the health-care proposal?

The CHAIRMAN. Will we?

Senator MCCASKILL. Yes.

The CHAIRMAN. We have already had one, but—

Senator MCCASKILL. No, I mean on the proposal that you are planning to bring to the floor of the Senate for a vote. Will there be a hearing?

The CHAIRMAN. Well, I do not know that there is going to be another hearing, but we have invited you to participate and give your ideas and—

Senator MCCASKILL. That is not true, Mr. Chairman. Let me just say, I watched carefully all of the hearings that went on on the Affordable Care Act. I was not a member of this committee at the time, although I would have liked to have been.

Senator Grassley was the ranking member. Dozens of Republican amendments were offered and accepted in that hearing process. And when you say that you are inviting us, and I heard you, Mr. Secretary, just say, “We would love your support.” For what? We do not even know. We have no idea what is being proposed.

There is a group of guys in a backroom somewhere who are making these decisions. There are no hearings in the House.

I mean listen, this is hard to take, because I know we made mistakes on the Affordable Care Act, Mr. Secretary. And one of the criticisms we got over and over again was that the vote was partisan. Well, you could not have a more partisan exercise than what you are engaged in right now.

We are not even going to have a hearing on a bill that impacts one-sixth of our economy. We are not going to have an opportunity to offer a single amendment.

It is all being done with an eye to try to get it by with 50 votes and the Vice President. I am stunned that that is what Leader McConnell would call “regular order,” which he sanctimoniously said would be the order of the day when the Republicans took the Senate over.

We are now so far from regular order that new members do not even know what it looks like. And I know that does not make you happy, Mr. Chairman or Senator Grassley, because you have been in the Senate so long. You know the value of the hearing process and the amendment process.

And even though the vote ended up being partisan, just as yours will be, the amendment process was not. Both of you had amendments that were put into that bill, as did other members of this committee. I want that opportunity. Give me that opportunity. Give me an opportunity to work with you. That is what is so discouraging about this process.

So, Mr. Secretary, I want to ask you. There is a 27 year-old young man who lives in Jefferson County, and he is finally making enough money that he can do one or two things. He can either buy

a health insurance policy or he can buy a new Harley. And which do you think he is going to buy?

Secretary PRICE. You tell me.

Senator MCCASKILL. I think he is going to buy the new Harley, because he feels young and invincible. And he has wanted a Harley his whole life.

He buys a new Harley. He lays it on the pavement on the interstate. An 18-wheeler cuts him off, and he is life-flighted to the hospital. Do you believe that hospital should treat him?

Secretary PRICE. Absolutely. We have an obligation to do so.

Senator MCCASKILL. In America, we treat you whether you are insured or not; correct?

Secretary PRICE. Yes, and there is a mandate that he buy insurance right now.

Senator MCCASKILL. Okay, but you are going to do away with that. So we are now——

Secretary PRICE. In your scenario, is it working?

Senator MCCASKILL. That is not my question. I am saying——

Secretary PRICE. It was my question.

Senator MCCASKILL. I am saying under your scenario, he does not have to buy insurance. He buys the Harley, he is life-flighted to the hospital. He has traumatic brain injuries, and we deliver \$3 million worth of care for him.

My simple question to you, Mr. Secretary, is, who pays for it?

Secretary PRICE. Well, sadly it is spread among the entire system, and frankly, nobody pays for it from the Federal Government standpoint.

Senator MCCASKILL. Correct. So people pay for it.

Secretary PRICE. Or people provide the services without any compensation whatsoever.

Senator MCCASKILL. Well, they have to make it work out at the end of the year. So what the hospital does is, they call the insurance company and they say, “We had X amount of uninsured care this year. We are going to have to raise your prices for labor and delivery, or we are going to have to raise your prices for an angioplasty.”

And then that insurance company calls the small business down the road and says, “I have bad news for you. We are going to have to raise your premiums because the hospital is charging us more, because we have to cover the uninsured care.”

Secretary PRICE. And in your State, premiums were up 145 percent between 2013 and 2017.

Senator MCCASKILL. That is not true.

Secretary PRICE. Yes, ma’am.

Senator MCCASKILL. No.

Secretary PRICE. We will be glad to show you the numbers.

Senator MCCASKILL. I will be glad to debate you on the numbers. But the point is that when we add 24 million more uninsured, who is going to pay the bills?

Secretary PRICE. Well, we will not be adding 24 million uninsured.

Senator MCCASKILL. So you disagree with the CBO score?

Secretary PRICE. Absolutely.

Senator MCCASKILL. Okay.

But if there are any more uninsured, if anybody is kicked off Medicaid, who pays those bills? I want to make sure everybody understands, we are just passing along these costs to people who have insurance policies.

Secretary PRICE. There are 20 million individuals in America right now who do not have insurance under the current system. That is a problem.

Senator MCCASKILL. I know, and we are paying their bills by higher premiums.

Secretary PRICE. Exactly. And so what we are trying—

Senator MCCASKILL. So we are going to increase that and create even more uninsured.

Secretary PRICE. On the contrary.

The CHAIRMAN. Okay. Okay. Your time is up.

Secretary PRICE. We are trying to decrease the number—

The CHAIRMAN. Senator Grassley has one question. He has been waiting here patiently, and—

Senator MCCASKILL. Well, I was only over by 35 seconds, Mr. Chairman. I think I did okay. [Laughter.]

The CHAIRMAN. You have done so much better than the rest of your colleagues. I am very proud of you.

Senator Grassley?

Senator GRASSLEY. Mr. Secretary, I only have one question, because I have to run to another meeting. So I am going to ask you this one question and then submit other questions for you to answer in writing.

The Rural Community Hospital Demonstration program was established in a bipartisan manner to protect patients' access to health care. These hospitals are collectively called "tweeners."

Another bipartisan piece of legislation, the 21st Century Cures Act, extended this program. The language was very, very clear. The program was to be extended beginning on the date immediately following the last day of the initial 5-year period.

Despite this clear language, CMS proposes to begin implementation of this extension on or after October 1, 2017. This gap in implementation is inconsistent with congressional intent, which requires a seamless extension of this critical program. Furthermore, it is inconsistent with the way the agency implemented the first 5-year extension of this program.

I have a bipartisan letter to Administrator Verma asking her to look at the alternative payment timing that was included in the proposed rule. I would like to submit the letter for the record, Mr. Chairman.

The CHAIRMAN. Without objection.

[The letter appears in the appendix on p. 45.]

Senator GRASSLEY. And by the way, you, Mr. Secretary, were cc'd on this letter.

So, Dr. Price, a very simple question. I hope you can give consideration to this request in this letter, because in several States, many States, this is an issue, particularly rural States. One of them is Alaska, as an example. I hope you can help us make sure that we have a seamless implementation of this program.

Secretary PRICE. Absolutely, Senator. And we will get back with you, because my understanding in looking into this is that the pro-

posed rule was put out in April of this year and allowed for rural hospitals to apply to this program, literally, as we speak. I think the deadline was the latter part of May.

But we have a commitment to it, and it is so incredibly important for rural areas. We will get back with you, and I look forward to working with you on it.

Senator GRASSLEY. Thank you.

I yield back my time.

The CHAIRMAN. Thank you.

Senator Brown?

Senator BROWN. Thank you, Mr. Chairman.

Mr. Secretary, thank you for joining us.

You call the opioid epidemic a key public health priority, and you highlight how this year's budget proposes a \$50-million increase in funding over previous levels, up to \$811 million. Eight hundred eleven million dollars might seem like a lot of money, and it is. But do you know what is a bigger number? Nine hundred thirty-nine million dollars—\$939 million is the amount of money one State, my home State of Ohio, spent on fighting the opioid epidemic last year alone. Nine hundred thirty-nine million dollars my State spent.

This chart came from the Ohio Department of Medicaid's website, Republican Governor Kasich's website. In 2016, Ohio invested \$939 million in fighting this opioid epidemic.

Now, do you know where 70 percent of that total \$939 million came from? Six hundred fifty million dollars came from Medicaid, \$650,200,000 came from Medicaid. Despite this investment, despite Governor Kasich investing nearly \$1 billion in prevention, education, medication, assisted therapy, and other treatment, eight people—if today is like most days—eight people in my State will die from an opioid overdose. Four thousand Ohioans died from overdoses last year. We are on track to far exceed that number. In some counties, we have already exceeded the number of the year before, and this is only June.

Forty-three people died in Cuyahoga County, the State's largest or second-largest—it is really close now—county in the State. Forty-three people since Memorial Day.

This epidemic continues to devastate communities in my State. I know you know that. I agree with what you wrote in your testimony: we are not winning this fight against this epidemic.

But I am confident we would lose far more people, far more lives, have far more families turned upside down, if we were not spending this money, if Medicaid were not spending this \$650 million. Do not take my word for it. Two weeks ago, my colleagues—both members of this committee—Senator Portman, my Ohio friend, Republican, and Senator Carper, my Delaware friend, Democrat, held an important hearing about this epidemic to discuss proposals.

I want to quote from a couple of people. The witnesses on the second panel of that hearing were a doctor and a police chief from Newtown, OH, the most conservative part of our State. He was the former head of drug control policy and coroner from Cuyahoga County. Both voiced opposition to either ending the Medicaid expansion or cutting the program.

The four experts brought by Senator Portman to his committee all said, do not cut Medicaid—do not cut it and do not end the expansion.

The Cuyahoga County coroner noted anything like Medicaid expansion being eliminated that limits people's access to health care—I cannot see any good coming from that in this crisis, especially with the high rates of mortality. The police chief from Newtown, OH, a little town near Cincinnati, he is on the front lines of this fight. He said we should not be decreasing Medicaid.

He talked about one of the programs that his teams are doing in the Hamilton County area, signing people up for Medicaid, then getting them into treatment. You sign them up for Medicaid, then you get them into treatment.

Right now, 200,000 families in Ohio are getting opioid addiction treatment who have insurance because of Medicaid. Yet your administration continues to talk down, to criticize Medicaid expansion and to suggest cuts in Medicaid.

He went on to say, taking away Medicaid would make this fight even more difficult. I do not even want to imagine the number of overdose deaths we would have had in Ohio if our Republican Governor—I am proud of what he did, and he has gotten a lot of criticism from President Trump, and a lot of criticism from your party—had not expanded Medicaid to those 700,000 families.

The budget proposal your team put together cuts Medicaid by \$600 billion. That is in addition to the House ACA repeal which cuts Medicaid by \$800 billion. Medicaid covers one-third of all substance abuse treatments in communities across Ohio. In Ohio it covers 50 percent of all medication-assisted treatment.

You sit in front of us. You have taxpayer-funded health insurance. We have taxpayer-funded health insurance. The 200-plus Republican members of the House who have taxpayer-subsidized health insurance are all willing to take it away from these 200,000 Ohioans getting opioid treatment.

You say you are interested in fighting the opioid epidemic, but your policy proposals tell a different story. You flat-fund substance abuse treatment grants. You actually reduce spending on prevention programs in the National Institute on Drug Abuse.

You cannot treat the disease with just grant funding. You have all of a sudden found that we can do all kinds of things with grants. No you cannot. Compare it to the size of this problem. It is like, maybe you do not know many—but I do not want to go there.

I think probably Senators do not meet enough people who are in these programs and who are benefitting from them. But you would never propose we fight cancer and pay cancer treatments through a \$50-million increase in a grant program.

You said in a recent op ed, and I appreciated it, in *The Charleston Gazette Mail* that increasing access to substance-use disorder treatment, including medication-assisted treatment, is part of your department's plans to address the opioid crisis. What you are not telling your West Virginia readers, Donald Trump's second-best State in the country, you are not telling them what you are really doing.

So my question is—sorry for the preface, but how do you plan to increase access to treatment when you cut the single-biggest source of funding for treatment by \$600 billion in your budget? How does that possibly add up in the Trump math, the Trump-Price math of 2017?

Secretary PRICE. Yes, Senator, you know that I visited your State, the southwest corner of your State, to visit with victims of opioid addiction, the parents of kids who died. One mom told me about her son who died in the bathroom of a Macy's from an overdose.

The scourge that we have running across this country right now is absolutely unacceptable to you. It is unacceptable to me. It is unacceptable to the President.

Our commitment is to make certain that what we put in place is a program that actually works. You have seen the graphs. The numbers continue to go in the wrong direction.

So if we are going to be married to a system that has resulted in 52,000 overdose deaths in 2015, that is not a system I want to be married to. What I commit to you, and what I look forward to working with you on is a system that actually works for the parents who are suffering today because they have lost a loved one. What I commit to working with you on is a system that actually works for those who are addicted who want to gain recovery and treatment. So that is the system that I look forward to working with you on.

Whether or not it is paid for through the Medicaid system or whether or not it is paid for through—imagine a system that actually isolates the individuals' treatment for addiction and takes it out of the current system that we have so that we can focus resources on those individuals who have the addiction.

Imagine that kind of system, what that would do for (1) the ability to treat those folks, but (2) the ability for the system to actually thrive in a better way fiscally as well.

Imagine a system that works better than the one that results in 52,000 Americans dying of overdoses.

Senator BROWN. It is a little curious to blame Medicaid, as you seem to be doing, for the system that has resulted in 50,000 deaths. It is not because of Medicaid.

I mean, how do you do this when 200,000 people right now are getting treatment in my State? They are getting treatment. They are not all successful. We know people are in and out, and it often takes three, or four, or five times, but if you cut Medicaid, as you want to bludgeon Medicaid, how are you—you can talk about a grant program and all of this good talk, and I know you mean it in terms of wanting to take care of people. You are a physician. I know all of that, but how does this possibly work if you are going to cut the biggest revenue stream that takes care of these families and puts them in these treatment programs?

The CHAIRMAN. I will allow you to answer that. You are way over your time, Senator. Answer that, and then I am going to go to Senator Cantwell.

Go ahead.

Secretary PRICE. That is what I am trying to encourage us to look at, is a system that actually works for the individuals who are

suffering from this addiction, a system that actually focuses attention and focuses treatment on it, a system that recognizes that we need greater public health surveillance, a system that recognizes that pain management in this Nation is flawed, a system that has not put the kind of resources into research so that we can turn this curve in an appropriate direction, which is down.

We continue to tolerate a system that allows for these kind of addiction and overdose deaths in this Nation. It is unacceptable to me, and I will not stand for it.

The CHAIRMAN. Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

Secretary Price, I have a couple of questions. There have been press reports that the Department is working on a rule that would deny birth control for employees. Are you aware of this?

Secretary PRICE. There is a proposed rule that is out currently on conscientious objection in the contraceptive mandate.

Senator CANTWELL. You are proposing that you will allow employers to discriminate against woman in having birth control be part of an insurance policy provided by employers?

Secretary PRICE. What is currently occurring is solicitation of input, and in that process we are—I am not able to make any further comment.

Senator CANTWELL. You cannot make a comment whether you think that birth control should be part of basic health offered in insurance plans?

Secretary PRICE. I think that for women who desire birth control, it ought to be available.

Senator CANTWELL. Are you promulgating the rule?

Secretary PRICE. There is a proposed rule that has been put forward.

Senator CANTWELL. So you think that employers should offer birth control as part of insurance programs, and not be able to just say on a conscientious basis they do not believe in providing it?

Secretary PRICE. No. I believe that women who desire to have access to birth control ought to be able to have access to birth control.

Senator CANTWELL. Through their employer?

Secretary PRICE. I believe that women who desire to have access to birth control ought to have access to birth control.

Senator CANTWELL. Okay. This is a very big problem. Women cannot be discriminated against by their employer who wants to cherry-pick various aspects of women's health. So if this is the intent of this rule, I guarantee you, there will be a big fight on this issue.

I want to ask you about proposed Medicare cuts, because I know the administration had said that they were not going to cut Medicare, but my understanding is that the budget includes a 2-year extension, a mandatory sequestration, which would impose a 2-percent cut on Medicare providers, such as hospitals and rural hospitals. The extension of the mandatory sequester would be about a \$30-billion cut from the Medicare program. So does your budget include that?

Secretary PRICE. I think that what you are referring to is the continuation of current law, and the budget accommodates or reflects current law.

Senator CANTWELL. So you are saying that the extension of the mandatory sequester is not a cut to Medicare?

Secretary PRICE. Again, it is the same kind of question that Mr. Casey had. It depends what your baseline is. If your baseline is current law, then there are no reductions.

Senator CANTWELL. Okay. And so you believe we should be making these reductions to rural health-care facilities?

Secretary PRICE. I believe that what we should do is make sure we have a health-care system that is financially viable and feasible and makes it so that the American people have access to the kind of care that they need.

Senator CANTWELL. And you are behind the cut—okay. I will just take that as a “yes,” that you are behind this particular cut. And I would just say that our rural hospitals are struggling to make sure that we are providing good care.

There are lots of efficiencies with the delivery system. I had a chance to ask you about this issue of rebalancing on the Medicaid budget. I do not know if you have had more time to look at that, to rebalance from nursing-home care to community-based care. That is something that we wrote into the Affordable Care Act that States are doing, and it is a huge savings to the budget.

Is that something that you think the administration can get further behind?

Secretary PRICE. Yes. As I mentioned in answer to a couple other questions, the dynamism of the health-care market is so important to embrace, because we ought to be allowing and accommodating in our system for individuals to receive care where it best suits them and their providers.

So you have identified an area where we ought to be able to accommodate that, and the system should allow for it.

Senator CANTWELL. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Nelson?

Senator NELSON. Thank you, Mr. Chairman.

Good morning, Mr. Secretary.

Secretary PRICE. Good morning.

Senator NELSON. Mr. Secretary, I just want to ask you, for clarification, about some things that are in the budget, in your proposed budget.

Something that we have heard a lot about are the cost-sharing reduction subsidies. Seventy-two percent of Florida’s Affordable Care Act consumers benefit from these, and that is why I am asking.

Now, it is hard to get a clear answer on this. The private market providers under the exchanges cannot take the uncertainty of knowing whether or not the subsidies are going to be there. Insurers have confirmed this to my questions, when proposing rate hikes or even pulling out of the markets because of the uncertainty.

So can you confirm that the administration will continue to reimburse insurers for these subsidies that help so many of my constituents see a doctor? I notice it is in your budget through fiscal year 2018. What should we believe?

Secretary PRICE. Senator, as you know, the answer may not prove satisfying to you, but the current court case is now *House v.*

Price, and so I am the defendant in that case. So what I can tell you is just what you said, and that is that the budget reflects the payment of the CSR payments through 2018.

Senator NELSON. So does that answer mean if the court case went in the favor of the administration that, basically, those subsidies would be cut?

Secretary PRICE. What I can tell you—and again, I would like to be able to share more, but as the defendant in the case, I am not able to do so. But I can tell you, as you noted, that the budget accommodates and reflects CSR payments through 2018.

Senator NELSON. And the unfortunate dilemma is, Mr. Chairman, that because of the uncertainty, it predicts an outcome that—the ACA, the Affordable Care Act, is in the exchanges which are bringing health insurance to millions and millions of people who otherwise could not afford it. The uncertainty of whether or not those subsidies will be there in the future, in fact, is undermining the ability of insurers to be able to project what their premiums are going to be and, therefore, to protect themselves. What they are doing is jacking up their premiums, which is undercutting the whole reason for having the subsidies in the first place.

Let me shift to the Zika virus, Mr. Secretary. As we discussed, you know there are a bunch of cases, 1,400 in Florida alone. And your administration's 2018 budget states, "Outbreaks like Zika will not be a onetime event. Capacity building at all levels as well as innovation in diagnostics are needed to prevent and control these outbreaks and understand more about these vectors."

Yet, the administration slashes the very programs designed to bolster capacity at all levels. So, Mr. Secretary, does your budget cut more than \$7.2 billion from NIH?

Secretary PRICE. As it relates to Zika, I cannot tell you how proud I am of the work that is being done at NIH to work on a vaccine. We are in the phase 2-B trials of a vaccine.

The CDC is doing phenomenal work to make certain that the surveillance and detection is out—

Senator NELSON. I understand all of that. Does the budget—

Secretary PRICE. We believe that the budget accommodates for handling any challenge that may exist from the Zika threat.

Senator NELSON. I understand. But the question is, does it cut \$7.2 billion from NIH?

Secretary PRICE. The proposed budget identifies reductions that we believe can be accomplished at NIH, and savings that can be accomplished at NIH, by increasing efficiencies and making certain that we have the core mission of NIH accomplished through the resources that are made available.

Senator NELSON. Right. Efficiencies are great. But I just want to know black or white, does it cut \$7.2 billion from NIH?

Secretary PRICE. The reductions—I think your number is accurate. It depends, again, what the baseline is, but I think your neighbor is accurate.

Senator NELSON. Okay.

The CHAIRMAN. Okay.

Senator Bennet?

Senator NELSON. Wait a minute, Mr. Chairman. I have a couple other questions, just simple "yes" or "no" questions. May I get—

The CHAIRMAN. Why don't you go ahead, but your time is up.

Senator NELSON. Well, I understand, but——

The CHAIRMAN. Go ahead. Go ahead.

Senator NELSON [continuing]. It is hard to get a "yes" or "no" answer.

The CHAIRMAN. Go ahead.

Senator NELSON. Thank you.

Does the budget cut more than \$600 billion from the Medicaid program on top of the cuts included in the House-passed health care bill?

Secretary PRICE. No.

Senator NELSON. Your budget does not. Okay.

Does it cut more than \$1.3 billion from the CDC?

Secretary PRICE. It is about a 10-percent reduction in resources available to CDC through appropriate priorities and identifying efficiencies within CDC. We believe strongly that the CDC budget is what is needed to continue to protect, not just the United States, but the world.

Senator NELSON. So is that a "yes," it cuts \$1.3 billion from CDC?

Secretary PRICE. What it is is a statement that affirms the President's desire to get folks to appreciate that you do not measure success of a program by the amount of money that is going into it. You measure it depending on whether or not the outcome and the mission are accomplished.

And if we can accomplish the mission, the appropriate mission of CDC, with less resources, then one would think that that would be something to celebrate.

Senator NELSON. Mr. Chairman, I understand all the reasoning behind it. I just want to know, does it cut \$1.3 billion from CDC?

Secretary PRICE. As I said, there is about a 10-percent reduction in resources going to CDC.

Senator NELSON. Does that equate to \$1.3 billion?

Secretary PRICE. I think your number is accurate.

Senator NELSON. Great. Does it cut \$850 million from the Food and Drug Administration?

Secretary PRICE. I do not believe so. The FDA—what we envision in the FDA is to shift the resources coming to FDA, and I think, in fact, there is about a \$500-million increase in resources coming to the FDA through a modification and an improvement in the user fee process.

The CHAIRMAN. Senator, you are way over your time. You can submit questions in writing. I am sure the Secretary will answer them.

Senator Bennet?

Senator BENNET. Thank you, Chairman Hatch. If it is okay with you, I think I will yield to Senator Roberts who has been here waiting. And then I would like to go after him, if that is okay.

The CHAIRMAN. That is very gracious of you, because he has been waiting.

So I will go to Senator Roberts, and then I will come back to you.

Senator ROBERTS. Mr. Chairman, are we under the 10-minute rule now, or 5, or 6, 7? What are we doing? I am assuming we are under the 5-minute rule.

The CHAIRMAN. Right.

Senator ROBERTS. I want to get in the weeds a little bit.

Welcome back, Doctor.

Secretary PRICE. Thank you. It is good to be back.

Senator ROBERTS. There are statements that you are responsible for people dying in Ohio, all of the current problems in the Affordable Care Act for the last 8 years, reductions in funding in rural areas—which of course, I am very much interested in—the entire budget by the President, or to be more accurate, OMB. And the chairman has been chided for not having regular order where what we have in the Senate today is called cloture and delay. That is not regular order. And then I sort of lost my place—oh, the Zika virus—hindering eradication of the Zika virus.

Are you enjoying yourself?

Secretary PRICE. The job is a great challenge, and I am enjoying the challenge, yes, sir.

Senator ROBERTS. I am going to get in the weeds here a little bit. In your prior life on this side of the witness table, I know you shared my frustration with the implementation of the competitive bidding program. I am not going to go too much further into this, except we do not have the providers that we used to have, and people are having to drive 150 miles with regards to durable medical equipment and access to it.

Last year, we passed a 21st Century Cures Act. We sought to reduce, at least temporarily, the impact of these payment changes. So to preserve the intent of the program to improve the effectiveness of payment amounts and reduce the beneficiary costs, save the Medicare program money, do you think the agency needs to provide additional regulatory changes to its implementation and—what I am trying to do is get a sense of whether legislation is needed.

Secretary PRICE. Legislation would be welcome that moved in the direction of allowing the durable medical equipment providers out there a greater opportunity to provide services to their clients, to the patients across the land. Regardless of whether legislation is forthcoming, the Department is looking very seriously at the issue of DME, because we believe strongly that the previous program that has been put in place is limiting the access to appropriate services for folks all across this land, especially in rural areas.

Senator ROBERTS. I appreciate that. I have been sitting here listening to my friends across the aisle with regard to their concerns with what is happening to our health-care system. I had a question that could be repetitive. The chairman is here somewhere, and you have talked about it, about what is happening with our premiums and our copays—here it is. Blue Cross Blue Shield of Kansas City announced they are pulling out of Obamacare exchanges next year, leaving Kansas with less options. In Kansas and nationwide, premiums have doubled; in three States they have tripled.

And yet I hear my colleagues saying “stay the course” or “full steam ahead,” full funding, if, in fact, we could do that—keep funding what is not working.

I must say that is 180 degrees from what has happened, and trying to pin it on you is rather amazing. This is like blaming Butch Cassidy and the Sundance Kid for jumping off the cliff. Or to be more accurate, we are in the Obama car, and it is a lot like being

in the same car with Thelma and Louise, and we are going into the canyon.

We have to get out of the car. I think that is what you are trying to do. And I wish you well in that. I do not think you are responsible for the entire budget that has been proposed by OMB.

I am not really in favor of some of the things with regard to agriculture. And we plan to change that. We hope to get a budget. I do not know of any time the Senate has considered seriously any budget that came from a President since Reagan.

And then this other business of regular order, with regard to the chairman. I was here during that whole episode of when we put Obamacare together, and days and nights, and days and nights. It started in the HELP Committee. That product is sitting on a shelf somewhere gathering dust.

I had one amendment. It was on rationing—you know what I am talking about, with IPAB and all the rest of them. It failed on a party-line vote.

And I came here. And again I had the same amendment on rationing. It failed on a party-line vote. And then the product went to the floor of the House and went behind closed doors in the Leader's office—sort of like Charlie Rich, singing "Behind closed doors." And out came Obamacare. And we have had 8 years of this now, and I just think blaming you for all of these deficiencies that we are trying to correct on a bipartisan basis has been over the top.

And my time, sir, has expired.

The CHAIRMAN. Well, thank you. And I endorse what you just said.

Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman. I really am grateful for you holding this hearing.

Mr. Secretary, it is great to see you again.

Secretary PRICE. Good to see you.

Senator BENNET. I want to start just by understanding the Medicaid cuts, or however you want to characterize them. But the numbers as I understand them are that there is about \$834 billion of cuts in the House bill, the House health-care bill.

And there is about \$610 billion in savings or cuts to the Medicaid program in the budget. Is it right to add those numbers together, or is there overlap among those numbers? I just want to make sure we are accurate.

Secretary PRICE. I do not believe it is correct to add those numbers together. My understanding is the budget does not assume passage of the House bill.

Senator BENNET. My understanding is that it absolutely does assume passage of the House bill.

Secretary PRICE. It assumes as it relates to Medicaid.

Senator BENNET. Yes.

Secretary PRICE. It assumes that what is put in place is a per-cap or a block-grant program that will reflect over a 10-year period of time a savings of \$610 billion.

Senator BENNET. Okay. If we could work together, I would appreciate the opportunity to work with your staff to see whether in the end we are talking about \$834 billion or \$1.4 trillion. In either

case, it is a huge cut to the Medicaid program. I mean, even if it is just \$834 billion, I think that is a 25-percent cut to Medicaid.

I would ask you—I asked the Governor’s office in Colorado to tell me who is on Medicaid in my State. And here is what they said, and I would like to ask you whether you dispute any of this.

They said that when you look at who is on Medicaid in Colorado, nearly half the program are children. Does that strike you as probably right?

Secretary PRICE. That is in the ballpark for most States.

Senator BENNET. And more than 40 percent of our Medicaid spending supports the disabled and seniors, many of whom are in long-term care facilities. So these are people in general who have spent down their life savings for the privilege of being in a nursing home funded by Medicaid. Would you agree that that is right?

Secretary PRICE. It sounds a little higher than most States, but I think it is in the ballpark.

Senator BENNET. Rough justice.

And they say of the remaining adults on Medicaid, the vast majority work but still cannot afford health insurance on their own. Does that sound familiar to you in terms of Colorado or other States?

Secretary PRICE. There are certainly individuals who have Medicaid coverage who are employed.

Senator BENNET. Well, what they would say is, there is a tiny residual percentage of people who are not disabled, are not elderly, are not children, and do not work, but are on Medicaid. There is some small percentage of such people. Is Colorado different from other States, or do you think that is—

Secretary PRICE. We can get you the numbers for your State, I am sure.

Senator BENNET. That would be great, but do you see any reason to dispute what I just said?

Secretary PRICE. I suspect that is—

Senator BENNET. So here we have the Secretary—and I appreciate your candor—saying that Medicaid is not supporting a whole bunch of people who should be working and are not working. Would you agree with that?

Secretary PRICE. I think it varies from State to State. There are certainly individuals who are able-bodied without kids on Medicaid who are not working.

Senator BENNET. But that is a very small percentage of the people. I do not want to have to walk back through the list. I mean, I think we have agreed that that is a very small percentage.

So I think it is important, because this is the Secretary of Health and Human Services, and he is not saying there are a whole bunch of Americans out there who are lazy, who are on Medicaid because they do not want to work. It does not comport with the evidence. It is not true, and it certainly is not true in my State.

So the question then becomes, if we are going to cut the program by 25 percent, if you were running Colorado’s Medicaid program—and I have a story that I will share with your staff from *The Denver Post* yesterday or the day before, a front-page story about the \$700 million a year by 2023 that the State is going to have to come up with to compensate for the withdrawal of the Federal Govern-

ment, the Medicaid reductions that are in just the House-passed bill, not your budget, but the House-passed bill.

What is your advice to us in our State about how we ought to handle those cuts, that \$700 million to our State? When 40 percent of the people on the program are poor children, when you have a whole bunch of people who are in nursing homes, when you have a whole bunch of people who are working but unfortunately cannot afford private insurance, what is my State supposed to do?

Secretary PRICE. I think, again, the constellation of programs that we would envision would provide for greater opportunity for individuals to get health coverage as opposed to less right now. I would remind folks that, again, there are 20 million Americans without health coverage. I do not know what the number, specifically, is in Colorado, but there is a significant number of individuals who do not have health coverage.

What we would envision is a system that actually responds to those folks and individuals who find that it is better for them not to be covered on the Medicaid system, but on a system that actually is more responsive to them.

Senator BENNET. My time is up. And with respect—and I do respect you a lot for your service in the House and the fact that you are a doctor—to believe what you just said, you would have to first reject the findings of the Congressional Budget Office that the House bill throws 23 million off insurance, that it creates 23 million more people who do not have insurance. You would have to believe that, and you would have to believe that, despite a 25-percent cut to Medicaid, which covers poor children, people in nursing homes, people who are already working and cannot afford insurance are somehow magically going to be able to buy health insurance under a system that no longer regulates the insurance industry.

That is what we are being asked to believe. And I can tell you this, Mr. Secretary and Mr. Chairman—because the Republicans in the Senate have not yet taken up the bill, and I hope that we will—if you set out to design a bill less responsive to the critics of Obamacare in Colorado, to Republican critics of Obamacare, you could not write a bill less responsive than the House bill.

So my hope is that—in the Senate you could not do it. My hope is that in the Senate, we will not do this in a partisan way, but we will come together as Democrats and Republicans and address the health-care system in a way that is actually believable to the people whom I represent.

What you just have said is just not believable in any respect to people at home, and I am talking about Republicans, to say nothing of Democrats or Independents.

The CHAIRMAN. Thank you, Senator.

Senator Heller?

Senator HELLER. Mr. Chairman, thank you.

Secretary Price—

Secretary PRICE. Senator, how are you?

Senator HELLER. Thanks for taking time and taking some of our questions. I want to talk a little bit about Nevada and the AHCA, obviously; that seems to be the topic of discussion here.

Our legislature just finished Monday. So as of 2 or 3 days ago, it adjourned for the next 2 years. One of the questions and comments that is being made is that if the AHCA in its current form, what came out of the House, were to pass, then it would put a \$250-million annual hole in Nevada's budget.

And these numbers and indications, I am getting out of the Governor's office also, from the State of Nevada. I would like your reflection on that. If it is \$250 million a year, that is \$500 million during a biennium, and we do not go back into session, obviously, for another couple of years. Their concern is that they will have to call a special session, obviously, in order to correct that kind of a budget offset.

Do those figures sound accurate to you?

Secretary PRICE. I do not think so, because—and again, the House bill does not, as I understand it, it does not anticipate any significant changes until 2019. So from a financing standpoint, 2020 would be the time when the majority of changes would come into play.

So we would be happy to review the genesis of those numbers and see whether or not they are accurate, and if so, how we can address that.

Senator HELLER. Have you had an opportunity to do some research on Nevada? The reason I ask you this question is because we had a member of our delegation on the House who said that—he had a conversation with you and the Director of CMS.

Between the two of you, you were able to convince him that these numbers, perhaps, are not as accurate or as dreadful as they come out of the Governor's office.

Secretary PRICE. That is correct.

Senator HELLER. What kind of reflection did you have? Do you recall what kind of conversation you had?

Secretary PRICE. Yes, in fact, I think that there was specific language that accommodated that concern. Which is why I say I do not believe that any changes would occur over the ensuing 2 years. But again, we would be happy to talk with you and work with you and the Governor and your State to see where they believe those numbers are coming from and determine their accuracy.

Senator HELLER. What do you anticipate being the growth rate of health-care costs over the next 10 years? What have you calculated?

Secretary PRICE. It depends what population you are talking about. The Medicaid population annual growth rate has been in the range of 2.6, 2.8 as I recall, annually.

Senator HELLER. That is historic. What do you guys anticipate over the next 10 years?

Secretary PRICE. I can get back to you on the specific amount. I think it is increasing a little bit, but I can get you the exact number. I do not have it on—

Senator HELLER. Are you working with leadership on our side as we go through the changes? I am going to guess that leadership on our side has had discussions with you, CMS, on some of the particular changes we are looking at.

In other words, it is including growth rates. I do not know what the growth rate is going to be, if it is going to be CPI medical plus

one, as they did in the AHCA, whether it is just CPI medical, or inflation for that matter.

Have you had any discussions? I am trying to find an answer to this question, and I cannot get it out of our meetings. I was just wondering if you had any insight as to what the rate may be that we are proposing over the next couple of weeks to send to CBO?

Secretary PRICE. Well, as it relates to Medicaid, the proposal within the budget is the CPI medical plus one for those aged and disabled, CPI medical for the others.

Senator HELLER. Do you still endorse that?

Secretary PRICE. That is what is accommodated in the budget.

Senator HELLER. If it was anything below that, would you support it? In other words, if they went to inflation rate, would you support that?

Secretary PRICE. I think it depends what the entire program looks like. If we are accommodating anybody who would have challenges with that in a supplemental manner, if you will, then I would have to look at that. But what I support, and what I think is important, is to make certain that every single American has access to the coverage that they need.

Senator HELLER. CPI plus one you said is for the disabled?

Secretary PRICE. CPI medical plus one.

Senator HELLER. For disability, and what was the other—

Secretary PRICE. Aged.

Senator HELLER. Now if that were to change, just to CPI medical or just inflation, would you oppose that?

Secretary PRICE. As I said, it depends what the entire program looks like. In isolation, I think that might be a challenge.

But that does not address what the entire constellation of whatever the program is, because there are other ways to accommodate individuals who need financial assistance. And we are committed to making certain that that happens.

Senator HELLER. Over the next 10 years, what is the rate increase overall then? What is the rate increase overall, over the next 10 years?

Secretary PRICE. We will get that to you. I do not have it on the tip of my tongue.

Senator HELLER. If it is below that, would you have a problem with it? In other words, we figure it out, you tell me what it is, and if we have a proposal that is less than that, would you oppose it?

Secretary PRICE. I think what is important in this conversation is to make certain that we accomplish the goals that we have set out, and that is to make certain that every single American has access to the coverage that they want. And when you have that as your goal, then it requires that you provide resources in an array of different ways to make certain that that is accomplished.

Senator HELLER. I just want to make sure with medical inflation, as it increases over the next 10 years, that the funding mechanism we have is not below that, because if it is, then we do not meet your goals.

Secretary PRICE. In isolation, I would agree.

Senator HELLER. Okay. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Your time is up.
Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

Secretary Price, thanks for being here today. I appreciate the budget's attention to the need to repeal and replace the collapsing Affordable Care Act, the need for medical liability reform, as well as the budget program's integrity provisions. We have a number of important issues to tackle in the health-care space. So again, I thank you for your work.

Secretary PRICE. Thank you.

Senator THUNE. I want to—I discussed this with you at your confirmation hearing, but I have serious concerns, I think as you know, about the Indian Health Service. We continue to see significant problems even after two IHS facilities in South Dakota entered the systems improvement agreement with the Center for Medicare and Medicaid Services.

CMS continues to find serious deficiencies at both facilities, with the Pine Ridge emergency department in immediate jeopardy status after a recent unannounced site visit from CMS. These systemic problems over the years are what prompted Senators Barasso, Hoeven, and I to introduce the Restoring Accountability in the IHS Act.

The bill will give IHS the flexibility to terminate poorly performing employees, streamline the hiring process so IHS can recruit talented medical professionals more quickly, and create incentives so those folks will stay on the job longer.

My question is, will the Department commit to working with us on this legislation and other reforms to improve the quality of care at IHS?

Secretary PRICE. Absolutely, Senator. I have been impressed with the commitment of individuals in IHS and the resources that we are trying to identify for new facilities, one of them—as you know, in South Dakota—to make sure that we are living up to our responsibility and the commitment that we have as a Nation in the IHS arena.

Senator THUNE. We would love to give you more tools to create the kind of accountability we need, and I think our legislation accomplishes that, so we would look forward to working with you on that.

Last year you and I both worked on legislation to address the application of Medicare competitive bidding rates and noncompetitively bid areas. Ultimately, the 21st Century Cures Act provided a temporary delay in this reimbursement change and required the Department to study and report to the committees of jurisdiction on how payment adjustments affect beneficiary access. And that was supposed to have been done by January 12th of this year.

I am just wondering if you could provide an update on the status of that report for the committee?

Secretary PRICE. Yes. I think it remains in process, and we have a significant commitment to make certain that the DME program is functional and works for folks all across this land, especially in the rural areas.

Senator THUNE. And I guess I would say additionally, as you discuss regulatory relief—which I know is the priority for the adminis-

tration, something that we very much agree with—what might the Department’s approach be for addressing these beneficiary access challenges that are posed by the current reimbursement structure? Is there something you could do in the interim that would help bring some relief?

Secretary PRICE. Absolutely. You cannot have a system that awards—as you well know—contracts to entities that have never provided services in a geographic area. And that is the system that we currently have, one that awards contracts to servicers or providers that have never demonstrated the capability to provide that service. And sadly, that is the system that we have in place right now.

So what we are looking at is the entire array of the DME system. And again, the goal is to make certain that all Americans, regardless of where they live, have access to the kind of services, whether it is hospital beds, whether it is wheelchairs, whether it is home oxygen, whatever it may be in the DME space—these are quality of life issues for so many, many people. From my perspective, we have failed to date in making certain that we ensure the kind of accessibility that folks need.

Senator THUNE. Yes; thank you.

And finally, during your confirmation hearing, we discussed CMS’s 2009 rule requiring that all outpatient therapeutic services be provided under direct supervision, which has been delayed annually since then for small and rural hospitals. You expressed an interest in working with me on a permanent extension of the non-enforcement of this policy.

I am wondering if you have an update on where things stand from the Department’s perspective? I think the permanent non-enforcement is part of a bill that we have out there, and we have been trying—we can sort of kick the stone down the road each year, but I am hoping that we can get a permanent solution somewhere. Could you tell us where you see things from your department’s standpoint?

Secretary PRICE. Senator, it is an area of significant interest, and I can tell you that it is a work in progress.

Senator THUNE. All right. Well, we hope that we can get some permanent relief there, and we look forward to working with you and your team on that going forward.

Thank you, Mr. Chairman.

Secretary PRICE. Yes, sir. Thank you, Senator.

The CHAIRMAN. Thank you, Senator Thune.

Senator Stabenow has a question or two, and we will wrap this up.

Senator STABENOW. Well, thank you, Mr. Chairman. First I want to thank you for your courtesies this morning in allowing us to have thorough opportunities to ask questions.

And Secretary Price, again, thank you for being here. There are so many issues that I continue to have great concerns about, and certainly when we look at this budget that in practicality cuts Medicaid, nursing home services, children’s health care, rural health care, research on lifesaving drugs—I could go on and on.

But one type of cut that I know we need is not in this budget, and that is a cut in the costs of prescription drugs. President

Trump repeatedly stated he wanted to drastically bring down prescription drug prices through Medicare negotiation, saying pharmaceutical companies were getting away with murder.

I support Medicare negotiation. I have for a long time, and 90 percent of Americans support that. But this budget does not include any major proposals to bring down the cost of prescription drugs, whether it is Medicare negotiating, safe importation of prescription drugs, transparency, or any other policy for that matter, even though the prices of the most popular drugs have increased by 208 percent—208 percent in the last 10 years.

However, the House Republican health care plan, and I assume the Senate one, that is proposed does give drug companies a huge \$25-billion tax cut paid for by the people who are seeing their prescription drug prices go up: middle-class families and seniors.

Given that this budget is the major policy document from the administration, is it fair to say that lowering prescription drug prices is no longer a priority?

Secretary PRICE. No, absolutely not, Senator. In fact, we have, at the Department—the President has made this an absolute priority and has charged us with making recommendations to his office on reducing drug prices.

And over the past 6 weeks, 8 weeks, we have had a half-dozen to eight stakeholder meetings with all sorts of individuals. We have charged HRSA and FDA and CMS with coming up with specific proposals to make certain that we can provide the President with the most effective way to be able to reduce the increase in drug prices.

So, no. It is an absolute priority, and we look forward to working with anybody who is interested in holding down or bringing down drug prices for the American people.

Senator STABENOW. Should a family have to pay \$700 for EpiPens for their child?

Secretary PRICE. Well, regarding EpiPen, what has occurred in the past is that the ability for competition to hold down those prices, or to bring down those prices, was prevented by a previous decision through the previous administration. So we are looking, through the FDA, at exactly those kinds of things, because our goal is to make certain that the American people have access to the kind of medication that they need at a price that they can afford.

Senator STABENOW. Which I wish was in this budget, because it is not in the budget at this point. But should someone who learns they have Hepatitis C have to pay \$80,000 to get the drug they need to be cured?

Secretary PRICE. Well, you are identifying a drug that is saving lives.

Senator STABENOW. Eighty thousand dollars in order for someone to have the opportunity to save their life?

Secretary PRICE. The question is, what is the right price for that drug?

Senator STABENOW. Is that the right price?

Secretary PRICE. There is a way to determine that price. And the question is, what is the right price for that, and how do we make certain that we incentivize innovation, and make it so that, in fact,

companies are able to identify these remarkable cures that are out there?

I do not know what the right price is, but I know how you figure out what the right price is.

Senator STABENOW. Okay. Well, I will be anxious to know what you think the right price is.

If you have cystic fibrosis and need the latest drug to improve lung function, should you have to pay \$300,000?

Secretary PRICE. No. What I think we ought to be doing is celebrating the incredible invention and work that individuals are doing to save lives in the area of cystic fibrosis.

Senator STABENOW. I celebrate that. It is difficult if someone cannot afford what is put forward on the market. So we certainly celebrate innovation. That innovation needs to be affordable so that people actually have access to treatment that can save their life.

Secretary PRICE. I would agree.

Senator STABENOW. Is it appropriate to give pharmaceutical companies a \$25-billion tax cut in the health-care reform bill when there is nothing to bring down the cost of prescription drugs in that bill?

Secretary PRICE. Well, regarding what is in that bill as it relates to drug pricing, I am not sure that—

Senator STABENOW. I am talking about the tax cut. Do you think it is appropriate to give a \$25-billion tax cut to the pharmaceutical industry in a bill that is actually taking away health care from people and does nothing about lowering the cost of prescription drugs?

Secretary PRICE. I do not know that that is what it does. What I am—what I do believe—

Senator STABENOW. I do know that is what it does.

Secretary PRICE. Well, then you do. What I do believe is that it is imperative that we have a system in place that incentivizes innovation so that we can realize the remarkable, remarkable productivity and entrepreneurship and innovative spirit of the American scientists at NIH and elsewhere who are discovering these wonderful kinds of drugs to save lives.

Senator STABENOW. Well, I totally agree with that. Do you think that the industry should be spending more on R&D today than they spend on advertising drugs to us?

Secretary PRICE. I think that, again, the system needs to be such that it incentivizes innovation so that we can realize the benefit of wonderful inventions.

Senator STABENOW. Okay.

Well, just for the record, all those ads are written off, and we pay for them as taxpayers. I would love to be helping them write off much more on R&D.

Mr. Chairman, as I close, let me just say for the record—we do not have to debate it today—but, Mr. Secretary, you have talked about a study, over and over again, about prices. And I just want for the record to say, this is a highly disputed study that you have been talking about that compares two different kinds of systems, does not include the tax credits that have substantially brought down out-of-pocket costs for real people.

And so another day I look forward to debating with you what I believe and what I know, in Michigan, are very flawed numbers.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Let me just say that I have been in this health-care business for 41 years. And every year we demand more and more money, more and more spending, more and more Federal Government, more and more interference, more and more intrusion, and we wonder why it costs us so much.

Now all I can say is, we have never had a better Secretary than you.

Secretary PRICE. Thank you.

The CHAIRMAN. Nor have we had anybody more patient in answering all of these questions. Now I want to thank you for participating the way you have. I especially want to thank you, Secretary Price, for attending today. I think we can all agree this is certainly not the most enjoyable activity that you could have participated in today. But it is nevertheless extremely important, and my colleagues have extremely important questions that they have asked.

As I have said many times before, I would like to work with anyone, Republican or Democrat, who would like to resolve these important and pressing issues. Health care is no joke to any American, and to those with diminishing access, it means the world.

So I look forward to hearing from each of you in the coming weeks, and I hope we can find ways to work together.

Now for any of my colleagues who have written questions for the record, I ask that they submit them by June 15th—

Senator STABENOW. I am sorry. I do not mean to interrupt, but Senator Carper—

The CHAIRMAN. Oh, no, I am not going to—this is going to have to be it. I do not have any more time.

Do you have to ask questions, Senator?

Senator CARPER. I have only been waiting for 2 hours, Mr. Chairman. That is okay.

The CHAIRMAN. Well, you used 10 minutes before—

Senator CARPER. Well, 9.

The CHAIRMAN. Excuse me?

Senator CARPER. Nine. [Laughter.]

The CHAIRMAN. Well, you can—

Senator CARPER. He came in large part so he could answer one of my questions—it is not really a question. I just want to say one thing if I could. It will be very, very brief.

The CHAIRMAN. Sure.

Senator CARPER. Mr. Chairman, I mentioned earlier that my colleagues get tired, Dr. Price, of hearing me describe myself as a recovering Governor, but I am. And I have enjoyed as a Governor sitting right where you are sitting, past Governor, and trying to provide a Governor's perspective on issues just like this one—just like this one.

And one of the things we asked for—John Engler and I asked for for welfare reform—we said, give us the opportunity to have waivers. You guys pass the law, but give us the opportunity to apply for a waiver on what we are going to do on welfare reform. And that was granted.

We asked for, when we did the Race to the Top, the education reform stuff in the last administration, we said, well, let us make

sure the States can apply for waivers to the Federal law. And we do.

And as it turns out with Medicaid, if I am not mistaken, States can apply for waivers. I think almost every State, maybe every State, has at least one or more waivers with Medicaid.

There are some cases in the law where you cannot get a waiver, States cannot get a waiver. I think we ought to have a good discussion with Governors about whether that makes sense or whether there should be some further broadening with respect to waivers.

As Governor, I always liked to have some flexibility, find out what works best in my State and maybe well in others, maybe not. But I think that could be a helpful thing to do.

The other thing I want to ask for—just a UC request, Mr. Chairman—I have something here from Blue Cross Blue Shield of North Carolina, “Premiums to rise in 2018 for Affordable Care Act.” They say it in quotes. I will say just one sentence. “The single biggest reason”—this is Blue Cross Blue Shield, North Carolina—“the single biggest reason for the sharp increase in rates is lack”—again in the exchanges—“of Federal funding for cost-sharing reductions beginning in 2018.”

This is the program we have been talking about earlier. In the administration’s budget, to their credit, they fund cost sharing. The President keeps talking it back in his tweets and other things. He is opposed to it, does not want to do this, raising questions. It is the questions, it is the lack of certainty, predictability for the insurance companies that drives up the prices, and so let us just keep that in mind.

The CHAIRMAN. Well, thank you, Senator. You always add a great deal of understanding to these issues, and I appreciate you doing that.

Senator CARPER. In that case, could I have a couple more minutes, Mr. Chair? [Laughter.]

The CHAIRMAN. No. I am going to kill you if you keep this up. [Laughter.]

Senator CARPER. I would die happy.

The CHAIRMAN. No; I think you are doing a great job.

Mr. Secretary, you have been very patient, and I personally really admire you. I know you know this field very, very well. I know you know the problems. I know you know how difficult it is to solve these problems, and I know you know that there are no quick answers to some of these questions that have been asked.

You have handled these very well today, and I just want to personally thank you.

With that, we will adjourn this meeting.

Secretary PRICE. Thank you, Mr. Chairman.

Senator STABENOW. Thank you, Mr. Chairman.

[Whereupon, at 12:06 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

LETTER SUBMITTED BY HON. CHUCK GRASSLEY,
A U.S. SENATOR FROM IOWA

Congress of the United States

Washington, DC 20515

May 19, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

RE: Rural Community Hospital, IPPS Proposed Rule (CMS-1677-P)

Dear Administrator Verma:

The Centers for Medicare and Medicaid Services (CMS) is conducting the Rural Community Hospital Demonstration Program (RCH), which was initiated by the Medicare Modernization Act of 2003 (MMA). The RCH was extended under the Affordable Care Act (ACA) and most recently under section 15003 of the 21st Century Cures Act. Congress directed CMS to create this program in response to the financial concerns of small rural hospitals.

As you know, the goal of the program is to evaluate cost based reimbursement for small rural hospitals with fewer than 51 beds. Each year since 2004, CMS has reported on the progress of this program. Eligibility is based on States with the lowest population densities and currently includes: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming.

Section 15003 of the 21st Century Cures Act extended the duration of this program by changing the language in the ACA from “5 years” to “10 years,” beginning on the date *immediately following* the last day of the initial 5-year period. Despite this language, CMS proposes to begin implementation of this extension on a hospital’s first cost reporting period beginning on or after October 1, 2017, following the announcement of the selection of additional hospitals to the RCH. This will result in a gap in the reasonable cost payment methodology paid to hospitals that previously participated in the program of up to 3 years.

In the proposed rule, CMS recognized the problem this gap creates for previously participating hospitals and an alternative approach was proposed. In that proposal, previously participating hospitals would begin the second 5 years of the 10-year extension period and the cost-based payment methodology on the date immediately after the date the period of performance under the first 5-year extension period ended. For example, a hospital whose 5-year period of performance authorized by ACA ended June 30, 2016, the extension of the period under section 15003 of Pub. L. 114-255 would be effective July 1, 2016. In the proposed rule, CMS states “we believe that this alternative approach would be consistent with the language of section 410A of Pub. L. 108-173 (as amended) . . .” and we concur. We strongly encourage you to consider congressional intent as you finalize the rule.

The RCH program has been a lifeline for certain rural hospitals at risk of closure. Since 2010, more than 60 rural hospitals have closed nationwide. According to a report by iVantage Health, 673 more rural hospitals are at risk of closure.

For one rural hospital in Iowa, the delay in implementation of the extension will result in a loss of \$1.1 million dollars. A second rural hospital will lose nearly \$5 million. These rural hospitals operate on minimal margins and will not be able to keep the doors open if those losses continue. This will greatly impact the ability of Iowans to receive medical care in a timely manner.

One of the regional hospitals in Juneau, Alaska faces nearly \$5 million in projected losses due to delay. The hospital is located in a geographically isolated area and has limited ability to take advantage of economies of scale due to a small population base, making programs like RCH critical to the hospital's success. The citizens that benefit from this hospital come from communities throughout Southeast Alaska by boat or plane and would be forced to travel even farther from home to receive care otherwise.

This gap in implementation is inconsistent with congressional intent, which requires a seamless extension of this critical program. It is also inconsistent with the way the agency implemented the first 5-year extension of this program. Most importantly, however, this proposal would cause financial hardship for many of the hospitals that have been participating in the RCH. As a result, we are concerned these hospitals will be forced to reduce or eliminate the services they offer to their communities, thereby further threatening access to health-care services for individuals living in these rural communities.

As the sponsors of the Rural Community Hospital Demonstration Extension Act of 2015—the basis for section 15003 of the 21st Century Cures Act—we encourage you to address this issue expeditiously and provide certainty to the previously participating hospitals as well as the new enrollees.

Sincerely,

Charles E. Grassley
United States Senator

Lisa Murkowski
United States Senator

Michael Bennet
United States Senator

David Young
Member of Congress

Rod Blum
Member of Congress

Joni Ernst
United States Senator

Dan Sullivan
United States Senator

Don Young
Member of Congress

Dave Loebsack
Member of Congress

Steve King
Member of Congress

cc: Secretary Tom Price, Department of Health and Human Services

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing examining the Trump administration's fiscal year (FY) 2018 budget request for the Department of Health and Human Services (HHS):

Welcome to this morning's hearing on the President's proposed budget for fiscal year 2018, with specific attention to the Department of Health and Human Services.

I want to thank Secretary Price for being here. These hearings are an annual event for the Finance Committee. And, Secretary Price, since this is your first time around, I'll just warn you that these hearings can be a little grueling.

Of course, you already know that.

I am grateful that the President and HHS are eager to work with Congress to fix our health-care system in order to ensure Americans are able to access affordable health coverage. And, as we know, time is of essence in regard to this effort.

Earlier this week, we received word that Anthem is pulling out of Ohio's Obamacare marketplace, potentially leaving more than 10,000 patients and consumers in 20 counties without any insurance options on Ohio's exchange for 2018.

This news is particularly frightening as we expect to hear similar notices from Anthem as they reevaluate their participation in Obamacare exchanges throughout the United States.

This recent story is just the latest in a long line failures, all of them demonstrating the need to move forward with repealing Obamacare and replacing it with a more workable approach, one that will take seriously the ballooning health-care costs impacting every American family.

Let me talk for a few minutes about the specifics of the President's budget.

The budget assumes \$250 billion in total savings from the repeal and replacement of Obamacare.

Despite some insinuations to the contrary, the budget does not incorporate the specific legislative proposal—the American Health Care Act—that is before Congress right now.

Therefore, it is not accurate to associate the specific Medicaid savings the CBO has estimated from enactment of the AHCA with the President's budget. To do so would assume a level of specificity that, for obvious reasons, is just not there.

Moreover, the President's budget does not cut \$1.5 trillion from Medicaid. Nor does it assume that the specific Medicaid-reform proposals from the AHCA will be enacted into law.

I'm quite certain we'll hear a lot about that today. But any attempt to make that connection is simply unfounded. And any Senator who harps on the AHCA Medicaid numbers here today either does not understand the explicit language and estimates provided in the President's budget, or they are simply attempting to muddy the waters in order to scare Americans who rely on Medicaid for health-care coverage.

Ultimately, the President's Budget appears to accept the reality that the Senate will need to come up with its own health-care reform proposal that includes a fundamental fix to Medicaid, which is, quite frankly, long overdue.

In addition to the savings assumed from the repeal of Obamacare, the budget also explicitly assumes \$610 billion in savings from putting Medicaid on a sustainable fiscal path by capping funding in FY 2020 through per capita caps or block grants at the States' option.

All told, most of the budget's overall Medicaid savings would be achieved by returning the focus of Medicaid to serving those with the greatest needs—the elderly, the disabled, and needy mothers and children—and by giving States more flexibility to run their own Medicaid programs.

Any Senator who would like to argue that the Federal Government should spend more Medicaid dollars to provide coverage for non-disabled, childless adults at the expense of disabled patients who remain on waiting lists should explain why.

Furthermore, any Senator who would like to argue that the States are ill-equipped to handle their Medicaid programs should explain why that is the case given that the overwhelming consensus we've heard from governors nationwide over the last several years is that States want more independence and flexibility to tailor the Medicaid program.

Washington needs to stop measuring the success of a Federal program by how much money it spends, or how many other programs are a part of it. Instead, Washington needs to focus on how well a Federal program helps those it is intended to serve and how efficient the program is at fulfilling its mandate.

Long story short, we need to stop focusing on spending and pay more attention to outcomes.

I think the President's budget, while it is by no means flawless, largely recognizes this reality, and the President and the administration deserve credit for that.

I look forward to having an open and frank discussion with Secretary Price about his thoughts on these and other matters.

PREPARED STATEMENT OF HON. THOMAS E. PRICE, M.D., SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for inviting me to discuss the President's budget for the Department of Health and Human Services (HHS) in fiscal year (FY) 2018. It is an honor to be here.

Whenever a budget is released, the most common question asked in Washington is "how much?" How much money does the budget spend on this program, how much does it cut from that other program?

As a former legislator, I understand the importance of this question. But too often, it's treated as the *only* question worth asking about a budget—as if how much a program spends is more important than, or somehow indicative of, whether the program actually works.

MEASURING SUCCESS, NOT SPENDING

President Trump's budget request does not confuse government spending with government success. The President understands that setting a budget is about more than establishing topline spending levels. Done properly, the budgeting process is an exercise in reforming our Federal programs to make sure they actually work—so they do their job and use tax dollars wisely.

The problem with many of our Federal programs is not that they are too expensive or too underfunded. The real problem is that they do not work—they fail the very people they are meant to help. In Aid to Families with Dependent Children, we had a program that undermined self-sufficiency and work. Congress did well when it realized the devastating long-term harm this program had on children, in particular, and took action by creating Temporary Assistance for Needy Families (TANF)—a program that promoted the empowerment of parents through work. By helping more Americans climb out of poverty, TANF caseloads have declined by 75 percent through FY 2016. Under the TANF program, the employment of single mothers increased by 12 percent from 1996 through 2000, and even after the 2008 recession, employment for this demographic is still higher than before welfare reform. In the wake of the recession, the emphasis on work in TANF has increased the job entry rate, retention rate, and earnings gain rate for program participants.

Our budget reduces TANF spending in part because we understand that the amount spent in the program has not been the key to its success. Our goal is to continue and even expand on the progress made since enactment of Welfare Reform. Toward that end, we would welcome an opportunity to work with Congress to further strengthen TANF so that States, Territories, and Tribes can empower more low-income families to achieve financial independence.

Fixing a broken government program requires a commitment to reform—re-designing its basic structure and refocusing taxpayer resources on innovative means to serve the people that the program is supposed to serve. And sometimes it requires recognition that the program is unnecessary because the need no longer exists or there are other programs that can better meet the needs of the people that the program was originally designed to serve. That's exactly what President Trump's budget will do, at HHS and across the Federal Government.

Consider Medicaid, a critical safety net program that is the primary source of medical coverage for millions of low-income American families and seniors facing some of the most challenging health circumstances.

If how much money the government spends on a program were truly a measure of success, Medicaid would be hailed as one of the most successful in history. Twenty years ago, annual government spending on Medicaid was less than \$200 billion; within the next decade, that figure is estimated to top \$1 trillion.

Despite these significant investments, one-third of doctors in America do not accept new Medicaid patients. Some research has shown that enrolling in Medicaid does not necessarily lead to healthier outcomes for the newly eligible Medicaid population. The Oregon Health Insurance Study replicated a randomized clinical trial by enrolling some uninsured people in Medicaid through a lottery. Comparing this population to those who remained without coverage, the data showed an increase in emergency room use for primary care, the probability of a diagnosis of diabetes, and the use of diabetes medication, but no significant effects on measures of physical health such as blood pressure, cholesterol, or average glycosylated hemoglobin levels (a

diagnostic criterion for diabetes). However, the same Oregon data showed a significant reduction in rates of depression among those enrolled in Medicaid.

This mixed impact of Medicaid coverage on health outcomes suggests we need structural reforms that equip States with the resources and flexibility they need to serve their unique Medicaid populations in a way that is as compassionate and as cost-effective as possible.

SAVING AND STRENGTHENING MEDICAID THROUGH STATE INNOVATION

That's exactly what the President proposes in his budget. Under current law, outdated, one-size-fits-all Federal rules prevent States from prioritizing Federal resources to their most vulnerable populations. States are also limited in testing new ideas that will improve access to care and health outcomes. The President's budget will unleash State-level policymakers to advance reforms that are tailor-made to meet the unique needs of their citizens.

Over the next decade, these reforms will save American taxpayers an estimated \$610 billion. They will achieve these savings by harnessing the innovative capacity of America's Governors and State legislators who, informed directly by the people and those providing the services, have a proven record of developing creative, effective ways to meet the health-care needs of friends and neighbors in need, while empowering them to manage their own health.

Furthermore, the budget includes provisions to extend funding for the Children's Health Insurance Program. The budget proposes to rebalance the Federal-State partnership through a series of reforms, including ending the Obamacare requirement for States to move certain children from CHIP into Medicaid and capping eligibility at 250 percent of the Federal Poverty Level to return the focus of CHIP to the most vulnerable and low-income children.

These reforms will go a long way toward improving access to health care in America. But there is more work to be done. That's why the President's budget commits to working with Congress to transition from the failures of Obamacare to a patient-centered system that empowers individuals, families, and doctors to make health-care decisions.

HHS ADVANCES THE HEALTH SECURITY OF THE AMERICAN PEOPLE WITH A FOCUS ON PREPAREDNESS AND RESPONSE FOR MEDICAL AND PUBLIC HEALTH EMERGENCIES

As everyone here knows, HHS's mission of protecting and promoting the health of the American people involves far more than overseeing the Nation's health-care and insurance systems.

For generations, HHS has been the world's leader in responding to and protecting against public health emergencies—from outbreaks of infectious disease to chemical, biological, radiological, and nuclear threats—and assisting the health-care sector to be prepared for cyber-threats. I recently had the privilege of seeing the importance of this work during an international trip to Africa and Europe.

Visiting with Ebola survivors in Liberia and representing the United States at the G20 Health Ministerial Meeting in Berlin and then the World Health Assembly in Geneva reinforced just how vital a role HHS plays in preparing for, and responding to, domestic and global public health emergencies. To support HHS's unique Federal role in public health emergency preparedness and response, the President's budget provides \$4.3 billion for disaster services coordination and response planning, bio-defense and emerging infectious diseases research, and development and stockpiling of critical medical countermeasures. These investments help ensure that State and local governments have the support and resources they need to save lives, protect property, and restore essential services and infrastructure for affected communities.

KEY PUBLIC HEALTH PRIORITIES: SERIOUS MENTAL ILLNESS, SUBSTANCE ABUSE, AND CHILDHOOD OBESITY

In addition, today America faces a new set of public health crises that—if we're honest with ourselves—we have been far less successful in resolving. Those crises are: (1) serious mental illness; (2) substance abuse, particularly the opioid abuse epidemic; and (3) childhood obesity.

As Secretary, I am committed to leading HHS to address each of these three challenges. The President's budget calls for the investments and policy reforms that will enable us to do just that.

The budget invests in high-priority mental health initiatives to deliver hope and healing to the 43.1 million adults with mental illness,¹ including nearly 10 million Americans suffering from a serious mental illness,² as well as the 19.6 million adults with both mental and substance use disorders,³ the 3.0 million adolescents who have experienced a major depressive episode,⁴ and 350,000 adolescents with both a major depressive episode and substance use disorders.⁵ These initiatives will target resources for psychiatric care, suicide prevention, homelessness prevention, and children’s mental health. For example, the budget proposes \$5 million in new funding authorized by the 21st Century Cures Act for Assertive Community Treatment for Individuals with Serious Mental Illness. The budget also includes a demonstration within the Children’s Mental Health Services program to test the applicability of new research from the National Institute of Mental Health on preventing or delaying the first episode of psychosis.

According to the Centers for Disease Control and Prevention (CDC), during 2015 drug overdoses accounted for 52,404 U.S. deaths, including 33,091 (63.1 percent) that involved an opioid. To combat the opioid epidemic sweeping across our land, the budget calls for \$811 million—an increase of \$50 million above the FY 2017 continuing resolution—in support for the five-part strategy that has guided our Department’s efforts to fight this scourge:

- (1) Improving access to treatment, including Medication-Assisted Treatment, and recovery services;
- (2) Targeting availability and distribution of overdose-reversing drugs;
- (3) Strengthening our understanding of the epidemic through better public health data and reporting;
- (4) Providing support for cutting edge research on pain and addiction; and
- (5) Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total, the budget continues to fully fund the \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

Finally, the President’s budget invests in the health of the next generation by supporting services that promote healthy eating and physical activity, especially among the nearly 20 percent of school-aged children in America who are obese. The budget establishes the new \$500-million America’s Health Block Grant, which will provide flexibility for States and Tribes to implement specific interventions that address leading causes of death and disability facing their specific populations. This could include interventions to spur improvements in physical activity and the nutrition of children and adolescents, and to treat leading causes of death such as heart disease.

¹Center for Behavioral Health Statistics and Quality (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16–4984, NSDUH Series H–51). Pg. 27, retrieved from <http://www.samhsa.gov/data/>.

²Center for Behavioral Health Statistics and Quality (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16–4984, NSDUH Series H–51). Pg 27, retrieved from <http://www.samhsa.gov/data/>.

³Center for Behavioral Health Statistics and Quality (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16–4984, NSDUH Series H–51). Retrieved from <http://www.samhsa.gov/data/>.

⁴Center for Behavioral Health Statistics and Quality (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16–4984, NSDUH Series H–51). Pg 38, retrieved from <http://www.samhsa.gov/data/>.

⁵Center for Behavioral Health Statistics and Quality (2016). *Key substance use and mental health indicators in the United States: Results from the 2015 National Survey on Drug Use and Health* (HHS Publication No. SMA 16–4984, NSDUH Series H–51). Page 40, retrieved from <http://www.samhsa.gov/data/>.

OTHER BUDGET HIGHLIGHTS

The President's budget prioritizes women's health programs through investing in research to improve health outcomes, maintaining support for women's health services, empowering women and families, and emphasizing prevention. For instance, funding for the Maternal and Child Health Block Grant and Healthy Start is increased to improve the health of mothers, children, and adolescents, particularly those in low-income families. In addition, funding is maintained for a variety of vital programs serving women across HHS, including, community health centers, domestic violence programs, women's cancer screenings and support, mother and infant programs, and the Office on Women's Health.

CONCLUSION

Members of the committee, thank you for the opportunity to testify today and for your continued support of the Department. It is an incredible privilege to serve the American people as the Secretary of Health and Human Services and support its mission to protect the health and well-being of all Americans.

QUESTIONS SUBMITTED FOR THE RECORD TO HON. THOMAS E. PRICE, M.D.

QUESTIONS SUBMITTED BY HON. CHUCK GRASSLEY

VACCINES

Question. In 2006, Iowa was the center of one of the largest mumps outbreak in the United States.

This past December, another increase in the number of cases of mumps was reported in Iowa.

Mumps is a highly contagious disease that is easily passed from one person to another. It can have serious consequences. The good news is that it is preventable with vaccination.

Dr. Price, State and local authorities often depend on Federal dollars to ensure protection against preventable diseases.

Will you work to prioritize funding for these programs?

Answer. Vaccines are one of the greatest success stories in public health and are among the most cost-effective ways to prevent disease. For example, for each dollar invested in the U.S. childhood immunization program, there are over \$10 of societal savings and \$3 in direct medical savings. Moreover, childhood immunizations over the past 20 years have prevented 322 million illnesses, 732,000 deaths, and nearly \$1.4 trillion in societal costs.¹

The discretionary Immunization Program plays a fundamental role in achieving national immunization goals and sustaining high vaccination coverage rates to prevent death and disability from vaccine-preventable diseases. It is the backbone of our Nation's public health immunization system that supports the science that informs our national immunization policy and programs; provides a safety net of vaccines for uninsured, poor adults and use in outbreak response; monitors the safety and effectiveness of vaccines; educates providers and the public about the benefits of vaccines and the diseases they prevent; and conducts surveillance, laboratory testing, and epidemiology to respond to disease outbreaks.

The CDC Immunization Program provides funding to all 50 States, the District of Columbia, 5 major cities and 8 territories. Currently, 90 percent of immunization programs are entirely funded by Federal funds. At the funding level proposed in the FY 2018 President's budget request, CDC will continue to provide vaccines and funding for immunization infrastructure to the 64 awardees, but at a reduced level. CDC will continue providing technical assistance and laboratory support to States and local communities responding to vaccine-preventable disease investigations, including outbreaks, but at a reduced level.

¹"Benefits from Immunization During the Vaccines for Children Program Era—United States, 1994–2013," Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, April 25, 2014/63(16):352–355.

HEARING AIDS

Question. Dr. Price, as a physician you know that hearing loss is serious issue for the Medicare population. But hearing aids cost over \$4,600 a pair on average and 80 percent of the people that need them, don't get them—mostly because of the expense. There is a market-based, regulation-reducing solution. Both the National Academies of Science and the President's Council of Advisors on Science and Technology have recommended that FDA should allow hearing aids to be sold OTC for mild and moderate hearing loss, *and FDA agrees.*

Senators Warren and I, along with Senators Isakson, Collins, and Hassan, have a bill that would direct FDA to do exactly that, S. 670.

This legislation has the support of the Academy of Doctors of Audiology—experts in the recognition and treatment of hearing loss. The bill also has the support of AARP and the Hearing Loss Association of America.

Bills don't get much better than this!

This is a common-sense solution to provide high-quality hearing aids to the 80 percent of people who need one and don't get one under the current system.

So I want to commend the FDA and ask that you support their efforts.

I have letters of support from the audiologists, AARP, and the Hearing Loss Association.

Answer. Thank you for your leadership in considering the creation of a class of over-the-counter hearing aids. The under-treatment of hearing loss in the United States is a significant public health issue. The President recently signed the Food and Drug Reauthorization Act of 2017 which, thanks to your involvement, includes a section relating to the establishment of a category of over-the-counter hearing aids. The administration looks forward to the implementation of this section which has the potential to provide consumers with additional options in treating their hearing loss.

QUESTION SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Through legislation like the 21st Century Cures Act and recent appropriations bills, Congress has worked to strengthen our Nation's investment in medical research at the National Institutes of Health (NIH). These investments have shown incredible results in the related fields of scientific study and in my own Commonwealth, where brilliant researchers like Dr. Carl June at the University of Pennsylvania have used that funding to spur breakthroughs in using immunotherapies to fight against cancer. Increased investments in the NIH also will play a key role in unlocking the secrets of Alzheimer's disease, which already affects 5.5 million Americans and has no cure, effective treatment, and is 100-percent fatal.

Will you work with me to reduce spending in other areas, so that we can preserve and hopefully increase our country's commitment to medical research?

Answer. The Department is committed to medical research, including Alzheimer's disease research. The Department will assess and allocate funding to ensure that HHS invests in activities that are core to its mission and not duplicative of other efforts across the Federal Government.

QUESTION SUBMITTED BY HON. JOHN THUNE

Question. Recently, Veterans Affairs Secretary David Shulkin announced that the VA plans to adopt a new Electronic Health Record (EHR) system and move away from using its current Veterans Health Information System and Technology Architecture (VistA) program. While I applaud the VA's efforts to improve its EHR system, I want to ensure work that has been done to improve IHS and VA coordination, particularly the sharing of medical records, is not undone during this transition. What steps can your Department take to ensure that changes to the VA EHR system doesn't degrade IHS-VA coordination? Will IHS also migrate to the new VA EHR system?

Answer. The move by the Department of Veterans Affairs (VA) will impact the Indian Health Service (IHS) as the IHS Electronic Health Record (EHR) system is dependent on the VA's VistA system through shared software development. IHS

adopted software developed by the VA and adapted it for use in its EHR without having to expend funds on the development.

IHS will continue to have technical support for Resource and Patient Management System (RPMS) as long as the VA continues to produce new software patches. However, the VA will begin shifting from development that adds functionality to software development that focuses narrowly on patches that address patient safety and readies the system for archive.

Prior to the announcement by the VA, IHS formed a workgroup to examine our current EHR platform. The workgroup is comprised of a broad range of stakeholders who offer various viewpoints based upon their role and interaction with our systems. The workgroup is expected to make recommendations by fall 2017 regarding the future of our EHR system. As the transition continues to evolve, IHS and VA will maintain open lines of communication to maintain our strong collaborative relationship.

QUESTION SUBMITTED BY HON. PAT ROBERTS

Question. The Protecting Access to Medicare Act of 2014 included a provision to reform the Medicare Clinical Laboratory Fee Schedule (CLFS) so that it becomes a “market-based” fee schedule. While a market-based fee schedule should ultimately provide certainty for clinical laboratories and patients, my office has received reports that some labs found CMS guidance confusing and that most large hospital outreach laboratories were excluded from reporting, meaning that this segment of the laboratory community wouldn’t be included in setting the payment rates. Can your office provide this committee with a summary of how many laboratories reported private market rates under PAMA and, of those labs, how many were hospital labs versus physician office labs or independent laboratories? Further, can your office detail efforts to protect against data errors that may lead to flawed rates?

Answer. CMS is committed to the successful implementation of the new private payer rate-based clinical laboratory fee schedule (CLFS) and looks forward to working with the laboratory industry to ensure accurate payment rates. On March 30, 2017, CMS announced that it would exercise enforcement discretion until May 30, 2017, with respect to the data reporting period for reporting applicable information under the CLFS and the application of the Secretary’s potential assessment of civil monetary penalties for failure to report applicable information. Since the enforcement discretion deadline of May 30th has now passed, CMS is currently performing a comprehensive analysis of the CLFS data. The administration will continue to review the operations of the program and look forward to feedback on how to improve the program.

QUESTIONS SUBMITTED BY HON. DEAN HELLER

Question. Earlier this year when you came before this committee for your confirmation, I asked if I had your commitment to working with Congress and members of this committee to protect access to care for patients in Nevada, particularly the more than 600,000 Nevadans that are currently on Medicaid. Is this budget—which includes over \$600 billion in cuts to Medicaid—a reflection of that commitment?

Answer. The administration remains committed to the mission of the Department to protect the health and well-being of the American people—the elderly, children, pregnant women, and individuals with disabilities—and working with States to ensure they are able to make the most use of available resources to serve their citizens. As you know, Medicaid is the primary source of medical coverage for millions of low-income American families and seniors facing health challenges. However, its costs have been growing drastically without improvement in outcomes. The problem isn’t lack of funding; the problem is lack of flexibility. The FY 2018 budget puts Medicaid on a path to fiscal stability by restructuring Medicaid financing and reforming medical liability laws.

Rigid and outdated Federal rules and requirements prevent States from pioneering delivery system reforms and from prioritizing Federal resources to their most vulnerable populations, which hurts access and health outcomes. The President’s budget will give States as much freedom as possible to design reforms that meet the spectrum of diverse needs of their Medicaid populations.

Question. To review, this budget proposes cutting Medicaid spending by \$610 billion over 10 years—which is on top of the more than \$800 billion in cuts called for under the House-passed American Health Care Act. These are staggering numbers, and for me, it's a reminder of the more than 600,000 Nevadans, including the 200,000 newly eligible under Medicaid expansion, who rely on this program to meet their health-care needs. Under this budget proposal, can Nevadans be assured that their access to care will be protected?

Answer. The President's FY18 budget does not incorporate specific legislation that was before Congress at the time of the hearing. Therefore, it is not accurate to apply the specific Medicaid savings the CBO has estimated for legislation before Congress to the President's budget. To do so would assume a level of specificity that does not exist in the budget. The budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. In fact, under the budget, Medicaid spending will continue to grow over the next decade.

Question. In my home State of Nevada, there are 1.3 million people with employer-sponsored health care who will be impacted by Obamacare's 40-percent excise tax on employee health benefits, also known as the Cadillac tax. In the January 24th Finance hearing to consider your nomination, you committed to working with me to fully repeal the Cadillac tax, which I consider to be an unduly onerous tax. Is this still your commitment?

Answer. Our budget calls for Congress to repeal and replace Obamacare, including the Cadillac tax. The administration looks forward to working with you to reform our health-care system.

Question. As the Senate works to craft our own health-care legislation, there has been a lot of discussion on how to ensure Americans with pre-existing conditions will continue to have affordable coverage. As someone who hears from constituents on a daily basis on this issue, I am committed to ensuring Nevadans with pre-existing conditions have the coverage they need. Since the House passage of the AHCA, this is a topic that you have addressed at length. Do you agree that individuals with pre-existing conditions should have access to affordable, high-quality insurance? Do you believe the House-passed AHCA achieves this goal?

Answer. The President's first principle of health reform is to ensure that no one will be denied insurance coverage for being sick. The House-passed AHCA explicitly prohibited insurers from denying coverage to individuals with pre-existing conditions.

Question. The Children's Health Insurance Program (CHIP) is up for reauthorization this year. This is a vital program that provides medical coverage and care to more than 23,000 children in my home State. I'm encouraged that the administration favors a renewal of CHIP and proposes to extend CHIP funding for 2 years. I'm hopeful that Congress will act to reauthorize this critical program. Will you commit to working with Congress to ensure that children who rely on CHIP will have access to high-quality, affordable health coverage?

Answer. As you noted, CHIP funding will expire at the end of FY 2017, and without an extension of funding, children could lose health-care coverage. This proposal would extend CHIP funding for 2 years through FY 2019. The administration remains committed to working with Congress to provide budgetary stability and additional flexibility to States while focusing the program on lower-income families.

QUESTIONS SUBMITTED BY HON. RON WYDEN

WOMEN'S HEALTH

Question. Under the Affordable Care Act (ACA), a record-number of women have gained access to health-care coverage and preventive care at no cost; maternity care was established as an essential health benefit (EHB); women were no longer discriminated against by health insurers for having a pre-existing condition, such as a previous Cesarean section or history of breast cancer; and health plans were not allowed to charge a woman more because of her gender.

With the massive budget cuts proposed in the President's budget, how will you lead HHS to continue the progress the ACA achieved for women's health?

Answer. (See answer provided below.)

Question. Medicaid funds nearly half of all births in the country. With the proposed cuts in the hundreds of billions to Medicaid, how will you assure the country's most vulnerable women will have access to maternity care?

Answer. The budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. In fact, under the budget, Medicaid spending will continue to grow over the next decade.

In addition, the budget increases funding for the Maternal and Child Health Block Grant by \$30 million above the FY 2017 Continuing Resolution. The Maternal and Child Health Block Grant supports services to more than half of the pregnant women and nearly one-third of all infants and children in the country. The additional funding will support greater State investment to improve the health of all mothers, children, and adolescents, particularly those in low-income families. The FY 2018 budget also provides a \$10 million increase above the FY 2017 Continuing Resolution for the Healthy Start Program, which connects individuals with services that can reduce infant mortality and improve perinatal outcomes, while allowing grantees to tailor services according to community need.

Question. According to a leaked draft of an HHS rule which you confirmed was proposed during the hearing, employers and insurers who have a religious or moral objection to providing birth control and related services would not be required to offer contraception to their employees or enrollees. This turns back the provision in the ACA that offers preventative benefits, including contraception, at no cost. What is the status of this leaked rule? Will you abide by procedures under the Administrative Procedure Act (APA) to solicit public comment before finalizing the rule? How will you consider the religious liberty of women who are seeking contraception when drafting this rule?

Answer. The administration is not at liberty to discuss the details of pending regulations.

Question. If enacted into law, the House-passed AHCA would defund Planned Parenthood health clinics of all Federal funding sources. The law injects funding into Community Health Centers (CHCs) as a substitute for Planned Parenthood health clinics. However, experts have repeatedly reported that CHCs do not have the capacity to absorb 2.4 million Planned Parenthood patients. Additionally, the President's budget includes a rider to prohibit Planned Parenthood from participating in Federal programs. If Planned Parenthood is defunded, how will you assure access to health care for the women in the 21 percent of America's counties that rely on a Planned Parenthood health center as a safety-net family planning provider? If CHCs are unable to absorb patients from Planned Parenthood health centers, what steps will you take to assure the 6 in 10 women who rely on these centers as their main source of health care that they will have access to primary care?

Answer. The mission of the U.S. Department of Health and Human Services (HHS) is to protect the health and well-being of all Americans. The administration takes our mission seriously, and will work to support access to quality, affordable health care for all Americans. Health Centers have delivered affordable, accessible, quality primary health care to patients regardless of their ability to pay for more than 50 years. In 2015, Health Centers served 16.8 million female patients ages 15-65, of 24.3 million that they served.

SHORT-TERM PLANS

Question. Recently, 14 Republican Senators sent you a letter asking the Trump administration to reverse a regulation (Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 FR 75316) on the term of coverage for short-term, limited-duration health insurance plans. This regulation was initially promulgated to protect consumers from misconceptions about how limited short-term coverage can be and to align the duration of short-term policies with individual responsibility payment requirements, helping consumers make informed choices about their health coverage. The regulation effectively limits short-term coverage to 3 months and requires insurers to warn consumers that short-term coverage does not satisfy the individual responsibility to have adequate health coverage. You have previously stated that you do not want people with a pre-existing illness or injury not to be covered, but short-term plans don't abide by the same consumer protections as Qualified Health Plans under the Affordable Care Act.

How do you plan to respond to the Republican Senators' letter on short-term plans? Do you support expanding the use of short-term plans or making any changes to the regulation?

If you plan to expand the use of short-term plans, do you retract your comments about protecting those with pre-existing conditions when allowing for the expansion of this type of coverage that doesn't offer essential consumer protections to those with pre-existing conditions?

How will you protect consumers from purchasing short-term coverage without knowing the risks?

Answer. The administration remains committed to relieve Americans from Obamacare's burdensome regulations and mandates. The administration is evaluating policy options to restore choice and competition to the individual and small group markets, while increasing availability of health insurance options so that all Americans can purchase coverage that meets their needs while continuing to protect individuals with pre-existing conditions.

MEDICARE SEQUESTER

Question. During the campaign, President Trump promised: "I'm not going to cut Social Security like every other Republican and I'm not going to cut Medicare or Medicaid." He also tweeted: "I was the first and only potential GOP candidate to State there will be no cuts to Social Security, Medicare, and Medicaid. Huckabee copied me."

On page 50, the HHS FY18 budget in Brief states that "[t]he budget does not include any direct Medicare cuts." However, in fact, the President's FY18 budget proposes to extend the sequester on mandatory spending—including Medicare—for an additional 2 years through 2027.

At the hearing, Senator Cantwell asked you whether the President's budget includes "a 2-year extension of mandatory sequestration, which would impose a 2 percent cut on Medicare providers." In response to her question, you stated that the President's budget reflects only the "continuation of current law."

Isn't it true that—under current law—the sequester on mandatory spending ends in 2025?

Isn't it also true that the President's FY18 budget proposes extending the sequester on mandatory spending for an additional 2 years (through 2027)?

How do you reconcile those facts with your response to Senator Cantwell that the President's budget reflects only the "continuation of current law"—when, in fact, the President's budget includes a 2-year extension that does not exist under current law?

In total, how much would payments to Medicare providers, suppliers, and plans be cut as a result of the President's proposal?

Answer. The President's budget reflects current law. In addition, the budget proposes to continue current law by extending sequestration by 2 years. This is not a cut to what Medicare currently pays to providers and does not change benefits or prices charged to beneficiaries generally.

VALUE OF MEDICAID

Question. You have previously stated that Medicaid costs are growing without improvements in health outcomes. However, studies indicate that Medicaid has increased access to health services, including preventative care among formerly uninsured adults, a critical step to achieving improved health outcomes in the long run.

For example, in a literature review, the Kaiser Family Foundation reported in April 2016 that Medicaid helps to improve access to health services, boost utilization of preventive health services, and reduce cost-sharing among beneficiaries. Several studies confirmed that Medicaid enrollees were able to access health services comparable to those offered under employer-based insurance, and that these services were accessed at a significantly lower per-person cost. For example, a 2013 study published by Teresa Coughlin et al., at the Urban Institute reported that Medicaid beneficiaries' health-care costs would be over 25 percent higher if they used employer-sponsor insurance. This was true even while Medicaid beneficiaries had similar access to and use of services like inpatient care, prescription drugs, and primary care doctors when compared with employer-insured individuals. Coughlin et al., also noted that out-of-pocket spending would increase threefold for Medicaid beneficiaries if they switched to private insurance, rising from \$257 to \$784 on average per year. This may in part be due to the fact that per capita spending for Medicaid enrollees has remained stable over time, as reported by John Inglehard and Ben-

jamin Sommers in a 2015 *New England Journal of Medicine* study. The authors noted that Medicaid spending growth was driven primarily by increased enrollment in the program, and that per capita Medicaid spending stayed flat between 1998 and 2014 when adjusted for inflation.

Do you agree that increasing access to primary care and preventative services has the capacity to save costs to the health-care system and improve health outcomes for beneficiaries over time? If so, would you agree that Medicaid has the capacity to protect and improve the health outcomes of covered individuals?

Proposed cuts to Medicaid under the AHCA would compromise individuals' access to preventative and primary care services, especially for the 14 million low-income Medicaid beneficiaries who will be left uninsured and without access to affordable, comprehensive coverage. How will you use your capacity as the Secretary of Health and Human Services to provide these individuals with affordable coverage to access these services should the Medicaid expansion be repealed?

If individuals are unable to access primary and preventative care, we could see an increase in the utilization of emergency departments to address medical conditions. How do you plan to allocate resources to compensate for the potential rise in costs associated with these emergency services?

Answer. The FY 2018 budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. The administration's goal is to ensure that all Americans have access to affordable coverage that best meets the needs of themselves and their families so that they can receive preventive care from the doctor of their choice in a primary care setting. The Department looks forward to collaborating with States to explore ways to support further adoption of Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician-patient relationships through enrolling Medicaid patients in DPC practices. Existing DPC practices enhance physicians' focus on patient care by simplifying healthcare payments for patients and doctors. DPC arrangements also often include benefits such as extended visits and electronic communication, which allow for improved patient access to primary care services.

IMPLICATIONS OF DIRECT PRIMARY CARE INITIATIVE

Question. In its FY 2018 budget, the administration proposed a Medicaid Direct Primary Care Initiative to encourage State Medicaid programs to use Direct Primary Care practices. Under this model, a set price is paid to providers in exchange for improved access to primary care services. Some State Medicaid programs are currently experimenting with this model of primary care payment.

Over 75 percent of Medicaid beneficiaries are enrolled in private plans that manage their care. Since so many Medicaid beneficiaries are enrolled in managed care, how would consumers enrolled in Medicaid managed care plans participate in the Direct Primary Care Initiative? Would there be a pathway to participation for Medicaid managed care plans?

The Centers for Medicare and Medicaid Services (CMS) recently approved several Medicaid waivers testing new delivery system reforms that rely on provider-led organizations, such as in Alabama and New Hampshire. How would these new delivery models and organizations be affected by the Direct Primary Care Initiative?

Would Medicaid beneficiaries have cost sharing obligations under the Initiative? If so, how would they be implemented?

How does CMS plan to support States in these initiatives? It does not appear any new Federal support is made available under the proposal in the President's budget for such initiatives. Lack of Federal support coupled with hundreds of billions of dollars in cuts to Medicaid under the President's budget would hugely hamper States' ability to implement new innovative models of care delivery.

Answer. The Department looks forward to collaborating with States to explore ways to support further adoption of Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician-patient relationships through enrolling Medicaid patients in DPC practices. Such practices enhance physicians' focus on patient care by simplifying healthcare payments for patients and physicians. DPC arrangements also often include benefits such as extended visits and electronic communication, which allows for improved patient access to primary care services. Working with States and primary care physicians, HHS will support the development of DPC practices, identify barriers to their entry into Medicaid, and outline flexibilities under existing authorities to facilitate these innovative approaches to

strengthening the relationships between patients and physicians. As the Department partners with States to advance this initiative, we look forward to gathering feedback about how this initiative will interact with the existing Medicaid program and State-based waivers and programs.

CMS PRIORITIES

Question. In addition to the President's proposals to cut Medicaid and the Children's Health Insurance Program (CHIP) by over \$600 billion, the President's FY 2018 budget includes a 10-percent cut to the budget of the agency running those programs and Medicare.

How will proposed cuts to discretionary administration spending be distributed across CMS? How was this distribution determined?

What staff positions will be eliminated as a result of these proposed cuts to discretionary administration spending? How would the loss of these positions impact the programs they support?

How would the proposed cuts impact CMS programs' ability to meet their statutory objectives?

How would CMS ensure its programs would be able to continue to meet the needs of their current beneficiaries?

How would the administration measure the impact of the proposed cuts on vulnerable populations, including older Americans and people with disabilities?

Answer. The FY 2018 discretionary budget request for CMS Program Management is about \$3.6 billion, a decrease of \$379 million below the FY 2017 Annualized Continuing Resolution level. This request will enable CMS to continue to effectively administer Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The FY 2018 budget reflects CMS's key priorities to: reduce costs through contract efficiencies; prioritize customer service; invest in program integrity; and strengthen the Federal workforce. Additionally, for FY 2018, the budget requests \$723 million for CMS Federal administrative costs, \$10 million below the FY 2017 Annualized Continuing Resolution level. Of this total, \$651 million will support a direct full-time equivalent level of 4,370, a decrease of 155 full-time equivalents below the FY 2017 Annualized Continuing Resolution level. With this level of staff, CMS will be able to effectively and efficiently support operations, successfully carry out the Secretary's priorities, and focus on improving CMS's traditional programs. The reduction in workforce will occur through natural attrition across CMS.

TESTIMONY CONCERNING PREMIUM HIKES

Question. During the June 8, 2017 hearing on the President's Fiscal Year 2018 budget, you cited statistics to demonstrate evidence of increasing health insurance premiums. For example, in one instance during an exchange with Senator McCaskill, you stated that premiums in Missouri had increased by 145 percent between 2013 and 2017.

These statistics appear to have been drawn from a May 23, 2017 report released by the Assistant Secretary for Planning and Evaluation (ASPE), which sought to measure the Affordable Care Act's (ACA's) impact by comparing Medical Loss Ratio data from 2013 and CMS Multidimensional Information and Data Analytics System data from *HealthCare.gov* in 2017. However, since its release, this report has been criticized by health-care experts for its methodology and misleading conclusions.

Fundamentally, the comparison of premiums between 2013 and 2017 is inappropriate, as the ACA's reforms and affordability programs did not go into effect until 2014. This means that individual plans in 2013 are simply not comparable to those in 2017. In 2013, many plans failed to cover critical health services now included as Essential Health Benefits, including maternity care and mental health services. Moreover, before the ACA's consumer protections were in place, plans were permitted to exclude individuals with preexisting conditions. Finally, ASPE failed to take into account the use of subsidies in the ACA Health Insurance Marketplaces, which significantly lowers the actual cost of plans for individuals purchasing coverage through the Marketplaces. In fact, an earlier ASPE report released on October 24, 2016 stated that 8 in 10 Marketplace enrollees can obtain insurance for \$100 a month or less after subsidies are applied.

Do you agree that by failing to take into account subsidies offered to individuals on the marketplace, the May 23, 2017 ASPE report does not accurately describe the average amount paid by consumers to acquire insurance on the individual market?

Do you agree that plans in 2013 are not comparable to those offered to individuals in 2017 for individuals due to substantial protections for consumers and more comprehensive coverage?

Do you agree that the American people have a right to sufficient and unbiased information to help them make apples-to-apples comparisons? If so, do you believe that the administration has a duty to provide it?

Answer. Obamacare is a disaster, delivering high costs, few options, and broken promises. Americans across the country have seen their health insurance choices disappear and premiums spiral out of control, increasing by double and triple digits. This administration is committed to empowering consumers with providing more choices and access to the health care they want and deserve.

CSRS AND RISING PREMIUMS

Question. Since April, insurers in California, Colorado, Connecticut, Iowa, Maryland, New Hampshire, New Mexico, North Carolina, Pennsylvania, and Washington have expressed serious concerns about uncertainty in the private insurance market caused by the administration's actions and rhetoric.

The specific actions from the administration include:

- A January 20th executive order to delay or halt the implementation of the ACA, which could undermine enforcement of the individual mandate;
- The administration's decision in January to stop advertising for open enrollment and to slash the budget for marketing and outreach by 20 percent for FY 2018;
- Threats directly from the President to let the marketplaces "explode";
- And repeated warnings from the administration to buck the cost-sharing reduction payments (CSRs) owed to insurers who cover low- and moderate-income Americans enrolled in marketplace plans.

This last point is particularly urgent. Under the CSR program, insurers subsidize plans for individuals earning up to 250 percent of the Federal Poverty Level (FPL) to reduce their deductibles and out-of-pocket expenses. Insurers report to HHS on how many enrollees they have provided CSRs, and then the Treasury Department reimburses insurers for these payments. More than 6.4 million individuals were enrolled in a CSR-eligible plan last year. Though the Trump administration has continued to reimburse insurers each month since taking office, the administration now refuses to state whether it will honor its financial commitment to insurers.

Without this clarity, insurers have been unsure how to price premiums for the future, causing instability in the health-care market and driving up premiums across the country. Uncertainty surrounding CSR funding has also threatened the continued participation of insurers in the marketplace. In early June, Anthem withdrew from 20 counties in Ohio, citing these uncertain CSR payments as a key reason for its departure.

In your testimony before the Senate Finance Committee on June 8, 2017, you repeatedly made reference to rising premiums under the ACA. Do you agree, however, that the administration's refusal to honor these CSR payments has contributed to uncertainty in the marketplace and contributed to insurers' decisions to raise their premiums for 2018? Has HHS done any internal analysis to estimate the cost of this uncertainty to the taxpayers?

The Kaiser Family Foundation has reported that a refusal to pay these subsidies could end up costing the Federal Government \$2.3 billion in added premium tax credits. Is refusing to reimburse insurers for the CSR program fiscally responsible for the Federal Government?

Have rising premiums and insurers exiting the marketplace due to the administration's decision to withhold CSR payments already jeopardized the ability of Americans to continue accessing affordable coverage?

The President's budget assumed \$6.3 billion to continue funding CSRs. Do you agree with the President's budget that the Federal Government should honor its financial commitment to reimburse CSRs made by insurers? Will you commit to ensuring CSRs are paid in full by the Federal Government to insurers?

Answer. The administration has emphasized the importance of reforming our health-care system to one that works better for patients and their providers, and The administration's budget calls for Congress to repeal and replace the Affordable Care Act. In the interim, we are evaluating policy options to relieve Americans from

Obamacare's burdensome mandates and to restore choice and competition to the individual and small group markets, increasing availability of health insurance options so that all Americans can purchase coverage that meets their needs.

Question. Rising premiums and the exit of insurers could have particularly dire consequences for patients residing in bare counties where no insurers are offering Marketplace plans. Do you agree that facilitating the ability of insurers to offer Marketplace plans in these counties would help patients better afford their medical care? Do you agree that facilitating the ability of insurers to offer these plans is a responsibility of HHS?

Do you commit to encouraging insurers to offer plans to patients residing in bare counties? How do you plan to fulfill this commitment?

Answer. Obamacare is a disaster, delivering high costs, few options, and broken promises. Americans across the country have seen their health insurance choices disappear. The administration is committed to empowering consumers with providing more choices and access to the healthcare they want and deserve.

The administration recognizes that States are the primary regulators of health insurance, and it remains imperative for the executive branch to empower States with more flexibility and control. Among other regulatory actions and guidance documents, the Department also finalized a Market Stability Rule in April, which tightened special enrollment periods, made it more difficult for enrollees to skip premium payments, adjusted the open enrollment period to align with other healthcare markets, lifted one-size-fits-all requirements regarding network access, and widened the actuarial value bands within which insurers can offer plans to patients.

MYLAN TAXPAYER RECOVERY (EPIPENS)

Question. The FY 2018 request increases funding for program integrity initiatives. Ensuring providers properly report relevant information and pay rebates to Medicaid under the Medicaid drug rebate program has been the topic of renewed focus following revelations that Mylan overcharged the American public by \$1.27 billion by classifying EpiPen as a generic drug instead of a name-brand product. According to the Centers for Medicare and Medicaid Services (CMS), CMS informed Mylan they were misclassifying EpiPen several times, but Mylan failed to correct the classification of the product. In October, Mylan reported that it had reached an agreement in principle with the United States to pay \$465 million. To date, the settlement has not been finalized.

What are the specific activities that the U.S. Department of Health and Human Services (HHS) will employ to recover the remaining lost taxpayer money that the HHS Office of Inspector General (OIG) identified? Will HHS push for any further action against Mylan?

Why was Mylan able to continue misclassifying the status of the EpiPen for purposes of the Medicaid drug rebate program and continue to pay a lower rebate based on that misclassification after they were made aware of the error?

What additional provisions are being put in place to help prevent similar future errors?

Mylan has also recently drawn public attention for price gouging its EpiPen product, raising the price six fold since 2007. What efforts will the administration make to protect Americans from similar price gouging on life-saving medications and help contain the costs of drug coverage?

Answer. The U.S. Department of Health and Human Services (HHS) is actively reviewing the findings of the Office of the Inspector General and have also been in discussion with Members of Congress regarding their concerns over the EpiPen price. As you are aware, the public disclosure of any discussions on potential recoupment of funds or future decisions on classification could impact our ongoing efforts to evaluate the program. Please contact the Office of the Assistant Secretary for Legislation so that they can schedule a briefing to candidly inform you of our ongoing activities.

MEDICAID AND COVERAGE FOR INDIVIDUALS WITH DISABILITIES

Question. For millions of Americans with disabilities, Medicaid is a critical program that allows them to access the services and care they need. Nationally, people with disabilities make up roughly 15 percent of all Medicaid enrollees but account for approximately 40 percent of all Medicaid spending.

On June 6, 2017, NPR gave a face to these individuals with a profile on Mr. Evan Nodvin, a Medicaid beneficiary living in Georgia with Down syndrome. Mr. Nodvin, who works at a local fitness community center, credits his independence to the State's Medicaid program.

For Mr. Nodvin and many families across the Nation like his, the proposed cuts to Medicaid spending contemplated in the FY 2018 budget—\$627-billion-plus in additional cuts to Medicaid—have caused serious concern as to what their future care will look like. Moreover, the proposed restructuring of Medicaid in the American Health Care Act would lead to \$834 billion in cuts to Medicaid and an effective cap on care for individuals with disabilities.

Will you commit to ensuring that individuals with disabilities are able to access the services and care they need to maintain the highest level of independence possible? How do you intend to fulfill this commitment in light of these proposed reductions to Medicaid spending?

Do you anticipate the creation of additional Federal programs or requirements to protect these individuals' access to health services?

If additional flexibility is granted to States in administering their Medicaid programs, how do you plan to maintain requirements to ensure adequate access to needed programs or services for people with disabilities?

Answer. The administration remains committed to the mission of the department, to protect the health and well-being of the American people—this includes individuals with disabilities. The budget recognizes that States understand the unique needs of their citizens far better than Washington, and we intend to provide States with maximum flexibility to ensure that Medicaid prioritizes the most vulnerable Americans.

PRESCRIPTION DRUG PRICES

Question. As the Secretary of the U.S. Department of Health and Human Services (HHS), you have broad power, independent of Congress, to impact the cost of prescription drugs. The agency is able, for example, to initiate rulemaking regarding payment for physician-administered drugs, while the Centers for Medicare and Medicaid Services has broad authority to test new payment models for prescription drugs.

On January 18, 2017, in a hearing before our colleagues at the Senate Committee on Health, Education, Labor and Pensions, you committed to working with Congress to “make sure drug pricing is reasonable.” However, the President's FY 2018 budget proposed no policies to stop the rise of prescription drug prices.

If the President is committed to lowering drug prices, why are there no proposals (even proposals he claimed to support on the campaign trail) included in the President's budget aimed at lowering drug prices?

In responding to a question by Senator Stabenow, you stated the Department of HHS has held approximately 6–8 stakeholder meetings to discuss the issue of drug pricing. Could you please provide the individuals and organizations who attended those meetings?

Also during that exchange with Senator Stabenow, the price of the Hepatitis C drug Sovaldi was discussed. In discussing whether or not Gilead's price is acceptable, you stated, “I don't know what the right price is but I do know how to figure out what the right price is.” Can you please provide the committee with how you would “figure out the right price” of Sovaldi and other high-cost prescription drugs coming on to market in the near future?

Answer. High drug prices and costs are an issue of major concern for HHS and for the American people. This includes the millions of seniors who rely on Medicare for their drug coverage, and the taxpayers who have to foot the bill for government spending on this program. As you know, the President has made prescription drug prices an absolute priority and has charged the U.S. Department of Health and Human Services (HHS) with making recommendations to his office on reducing drug prices. HHS has been meeting with stakeholder groups from across the health-care spectrum over the past several months in order to understand where there are areas of consensus.

It is important that we move forward quickly, but also carefully, so that our policies do not have unintended consequences. We need to balance the goal of ensuring

affordability and access with the mandate to continue supporting development of lifesaving innovations.

CHIP FUNDING EXTENSION

Question. In FY 2016, the Children's Health Insurance Program (CHIP) covered nearly 9 million children in families who earn too much to qualify for Medicaid but still lack access to affordable private coverage. While this successful, bipartisan program is permanently authorized, funding is set to expire later this year. Secretary Price, during your nomination hearing you called for an 8-year extension of Federal funding for the Children's Health Insurance Program (CHIP). This multi-year extension is in line with other calls to renew the program for multiple years by the National Governor's Association, the Bipartisan Policy Center, and the independent Medicaid and CHIP Payment and Access Commission (MACPAC) in order to provide much deserved certainty to States and families. However, President Trump's budget proposes to extend Federal CHIP funding by only two additional years with additional cuts to the program including a cap on coverage for currently enrolled children in working families.

Do you still support an 8-year extension of CHIP funding?

Did you advise the President on his CHIP policy proposals? If so, what factors led the administration to decide that a 2-year extension was sufficient.

The President's budget also includes a 20 percent cut in Federal support to States for CHIP. How does the administration plan for States to continue being able to provide valuable coverage to families in need despite these cuts?

Children make up nearly half of those enrolled Medicaid. With billions of dollars in proposed cuts to the Medicaid program and a 20 percent cut to Federal CHIP funding, how will you assure America's children continue to have access to affordable, comprehensive health care that meets their child-specific needs?

Answer. The CHIP program needs to be looked at and extended. The budget proposes to extend funding for CHIP for two additional years through FY 2019. Extending CHIP funding for 2 years provides stability to States and families while the future of the program is addressed alongside other health reforms. This funding guarantees that the most vulnerable children will continue to have coverage.

The budget also proposes a series of improvements that rebalance the State-Federal partnership and increase State flexibility. This proposal ends the 23-percentage point increase in the enhanced Federal match rate and the current law maintenance of effort requirement after FY 2017. The budget also proposes ending the Obamacare requirement for States to move certain children from CHIP into Medicaid and capping the level at which States could receive the CHIP enhanced Federal matching rate at 250 percent of the Federal Poverty Level. These provisions would return the focus of CHIP to the most vulnerable and low-income children.

ALASKA REINSURANCE WAIVER

Question. As you note in your March letter to Governors, Alaska significantly decreased projected premium increases for 2017 through a 2-year reinsurance program. This program reduced both premium costs for consumers and tax credit expenditures by the Federal Government. In December 2016, Alaska released its application for a State Innovation Waiver under section 1332 of the Affordable Care Act (ACA) to sustainably implement the Alaska Reinsurance Program. The ACA's 1332 waivers require States to maintain high standards for access to quality, affordable coverage while giving them the flexibility to improve market stability and lower costs for consumers.

Given the benefits of reinsurance that you highlighted using Alaska's program, why has the pending Alaska reinsurance waiver not yet been approved?

Does the March letter guidance still reflect the current position of the administration?

Answer. The Centers for Medicare and Medicaid Services and the Department of Treasury announced approval of Alaska's section 1332 waiver application on July 11, 2017.

The administration stands ready to work with States to implement solutions that work for their local markets.

ACA MARKETING AND OUTREACH

Question. On January 26, 2017, the White House ordered the U.S. Department of Health and Human Services (HHS) to prematurely stop advertising for open enrollment for the Affordable Care Act's (ACA) health insurance marketplaces. This decision was made without clear explanation from the administration, other than a statement from HHS that the agency was looking for efficiencies. However, former officials under President Obama's administration confirmed news reports that these advertisements had already been paid for.

Please provide an explanation for stopping the administration's marketing for open enrollment before its scheduled end date.

What impact was anticipated by HHS prior to freezing marketing and outreach efforts? Please provide HHS's analysis used to make this decision, including money spent on advertisements that were not run.

Do you agree closing advertising for open enrollment prematurely could have caused fewer individuals to sign-up for ACA coverage, especially younger individuals who historically sign up closer to the deadline?

Do you agree that enrolling more individuals in the ACA marketplace helps distribute risk within the health insurance marketplaces? If so, would you agree that deciding to prematurely halt advertising for 2018 enrollment could have been one of the sources of uncertainty that causes insurers to raise their premiums?

In 2016, how much did HHS spend on marketing for enrollment for 2017? How much is HHS projected to have spent this year for 2018 enrollment?

Were the marketing plans and contracts withdrawn in January previously paid for by President Obama's administration? If so, was HHS able to recapture the funds paid towards these outreach efforts? If not, was the loss of these funds considered in making the decision to prematurely halt advertising for enrollment? If these funds were recouped, where has the agency redistributed these funds, or where does the agency plan to allocate these funds in the future?

The President's budget for Fiscal Year 2018 proposed a \$310-million cut to the budget for the Federally-Facilitated Marketplace, which may hinder outreach efforts for future enrollment periods. In light of these cuts, how will you ensure that reduced funding will not lead to depressed enrollment for the future?

Will you commit to engaging in full and uninterrupted outreach and marketing efforts to encourage individuals to enroll in ACA Marketplace plans during future open enrollment periods?

Answer. Until Congress can act to repeal and replace Obamacare, the administration is carrying out its responsibilities under current law, including funding and maintenance of the exchange call center, even within a lean and efficient budget request. However, this budget reflects the goal of moving control of the health insurance market back to States and issuers. This includes recognition of the traditional role of States to perform outreach to their citizens, and the value of experienced agents and brokers to enroll individuals into health insurance. The Federal Government should not be duplicating these efforts.

OREGON EXPERIMENT

Question. During the June 8, 2017 hearing on the President's FY 2018 budget before the U.S. Senate Committee on Finance, you testified that Medicaid coverage does not lead to healthier outcomes for the newly eligible Medicaid population by reference to the Oregon experiment.

However, I think it is important to talk about what the Oregon health experiment actually found. The study found that those who gained Medicaid coverage were more likely to get primary and preventive care, including screening and treatment for depression and diabetes. In addition, new Medicaid beneficiaries were 40 percent less likely to have suffered a decline in their health in the previous 6 months and 40 percent less likely to go into medical debt or leave other bills unpaid to cover medical expenses, nearly eliminating all catastrophic out-of-pocket medical expenditures. Finally, although the researchers also found that some patients' cholesterol levels fell, the small sample size and short duration of the study made it difficult to draw concrete conclusions about health outcomes.

It's also important to note that since this study was conducted nearly a decade ago, Oregon has seen a transformation of its health-care system to one of coordi-

nated care and expanded Medicaid coverage to hundreds of thousands of low-income Oregonians—all while continuing to improve care. This has meant fewer emergency room visits, a 75-percent increase in enrollment in patient-centered primary care homes, substantial increases in substance use disorder treatment, and reductions in preventable hospital admissions.

Instead of focusing on what works and improving care, the House-passed AHCA bill and the President's budget would rip health care away from millions of Medicaid beneficiaries, including as many as 465,000 Oregonians. Millions more Americans could see caps and cuts to their coverage, including 65,000 Oregonians who rely on Oregon's Community First Choice option to receive community-based long-term care services and supports.

While you cited the Oregon health experiment as providing evidence that Medicaid expansion leads to increased use of emergency departments for primary care, results from the Quarterly Legislative Report of Oregon's Health System Transformation demonstrate that Oregon's Medicaid program is increasing preventative care and reducing emergency department utilization among Oregon's Medicaid beneficiaries. Given this evidence and your reliance on Oregon's Medicaid program to draw your conclusions, do you plan to change your position on the effects of Medicaid for millions of Americans?

According to the independent Congressional Budget Office, 14 million Americans will lose Medicaid under the repeal of the Medicaid expansion included in the House-passed AHCA bill and end up uninsured, including hundreds of thousands of Oregonians. How do you think the health outcomes for these individuals would change when they no longer have access to affordable, comprehensive health care? Do you expect that these 14 million low-income Americans without insurance or access to affordable coverage would need to rely on emergency rooms even more than they do today? How do you think increasing the number of uninsured individuals in the United States by 23 million would impact rates of emergency room use across the country?

Answer. As you know, Medicaid is the primary source of medical coverage for millions of low-income American families and seniors facing health challenges. However, its costs have been growing drastically without corresponding improvement in outcomes. The problem isn't lack of funding; the problem is lack of flexibility. The FY 2018 budget puts Medicaid on a path to fiscal stability by restructuring Medicaid financing and reforming medical liability laws.

Rigid and outdated Federal rules and requirements prevent States from pioneering delivery system reforms and from prioritizing Federal resources to their most vulnerable populations, which hurts access and health outcomes. The President's budget will give States as much freedom as possible to design reforms that meet the spectrum of diverse needs of their Medicaid populations.

The administration is committed to making sure that States have the flexibility to design their Medicaid programs to meet the needs of the most vulnerable in their State. By strengthening the Federal and State Medicaid partnership, we will empower States to develop innovative solutions that meet their unique demographic, budgetary, and policy needs, rather than telling States how they should run their programs.

EPM RULE

Question. On January 3, 2017, the Department of Health and Human Services (HHS) published a final rule implementing three new Episode Payment Models (EPMs) for Medicare Parts A and B and a Cardiac Rehabilitation (CR) incentive payment model through the Center for Medicare and Medicaid Innovation. Under the three new EPMs, acute care hospitals in certain selected geographic areas will participate in retrospective EPMs targeting care for Medicare fee-for-service beneficiaries receiving services during acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and surgical hip/femur fracture treatment (SHFFT) episodes.

On May 19, 2017, HHS published a final rule delaying the start date for the EPMs and CR from July 1, 2017, to January 1, 2018. The May 19, 2017, final rule also reiterated HHS's position that "these models will further [its] goals of improving the efficiency and quality of care for Medicare beneficiaries receiving care for these common clinical conditions and procedures."

Given HHS's statement that these models will further the goals of improving the efficiency and quality of care for Medicare beneficiaries, will you commit to imple-

menting these EPMs and CR—without any substantive changes—and adhering to the new January 1, 2018 start date without any further delays?

Answer. On March 21, 2017, the U.S. Department of Health and Human Services (HHS) published an interim final rule with comment period that delayed the effective date of the final rule titled “Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and changes to the Comprehensive Care for Joint Replacement Model (CJR)” to May 20, 2017, the applicability date of certain EPM regulations to October 1, 2017, and the effective date of certain CJR regulations to October 1, 2017. We received public comments suggesting changes to the overall design of the EPMs, CR incentive payment model and CJR model that were unfortunately outside of the scope of the March 21, 2017 IFC regulation. These comments touched on participation requirements, data, pricing, quality measures, episode length, CR and SNF waivers, beneficiary exclusions and notification requirements, repayment, coding, and model overlap issues. We consider these public comments to be outside of the scope of the March 21, 2017 IFC; and therefore, we did not address them in the May 19, 2017 final rule, which finalized the effective date of the rule as May 20, 2017 and the applicability date of certain EPM regulations and certain CJR regulations as January 1, 2018. We may consider these public comments in future rulemaking.

MEDICAID ADDITIVE EFFECTS

Question. The President’s FY 2018 budget proposes \$627 billion in spending cuts to Medicaid. However, the President’s budget also includes language that these \$600-plus-billion in Medicaid reductions are on top of “additional savings to Medicaid as a result of the administration’s plan to repeal and replace Obamacare.” According to the independent Congressional Budget Office, the American Health Care Act (AHCA) would reduce Medicaid by \$834 billion, the result of which would be the removal of 14 million beneficiaries from the program and cuts to care for millions more.

Secretary Price, for the record, what is the total amount of Medicaid cuts under the President’s budget? Please note, I am not asking about government-wide savings target or total savings from “repeal and replace.” I am simply asking the administration to clarify the *total* amount of assumed reductions to Medicaid under the President’s budget. Without an exact number of the Medicaid-specific cuts assumed by the President in his budget, one can only assume that the “additional savings to Medicaid as a result of the administration’s plan to repeal and replace Obamacare” is the over \$800 billion in cuts included in the House-passed AHCA bill. If that is not accurate, please provide the total amount of Medicaid cuts in the budget combined with the AHCA.

Answer. The President’s FY 2018 budget does not incorporate specific legislation that is before Congress. Therefore, it is not accurate to apply the specific Medicaid savings the CBO has estimated for legislation before Congress to the President’s budget. To do so would assume a level of specificity that does not exist in the budget. The budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. The budget specifies savings of \$610 billion by providing additional flexibility to States by reforming the fiscal structure of Medicaid, allowing a choice between per capita cap or a block grant, beginning in FY 2020. In fact, under the budget, Medicaid spending will continue to grow over the next decade.

SECTION 1115 AND 1332 WAIVERS

Question. Section 1115 of the Social Security Act provides the U.S. Department of Health and Human Services (HHS) Secretary with the authority to approve demonstration projects that promote the objectives of Medicaid and the Children’s Health Insurance Program (CHIP).

Section 1332 of the Patient Protection and Affordable Care Act (ACA) provides the Secretary with broad authority to approve waivers to certain ACA marketplace provisions. Applications must meet four criteria: individuals must get insurance coverage at least as comprehensive as provided under the ACA; insurance coverage offered to individuals must be at least as affordable as it would be under the ACA; as many people must be covered as would be under the ACA; and the proposal must not increase the Federal deficit.

You have indicated your intention to streamline waiver rules and procedures. What changes, if any, does the administration intend to implement in its consideration of 1332 and 1115 waivers relative to standing guidance?

What are HHS's internal controls for ensuring compliance with transparency as well as notice and comment requirements for 1332 and 1115 waivers?

What is your goal for the length of time it takes HHS to approve a waiver while upholding the letter of the law?

Answer. In March, U.S. Department of Health and Human Services (HHS) sent letters to America's 50 Governors regarding 1332 waivers announcing the Department's commitment to letting States develop innovative strategies to adapt many of the Affordable Care Act's requirements to suit the State's specific needs. HHS and CMS Administrator Seema Verma then sent a separate letter to the Governors announcing our commitment to ushering in a new era for Federal and State Medicaid partnership where States have more flexibility to design programs that meet their unique needs.

To receive approval for a 1332 State Innovation Waiver, a State must demonstrate that a proposed waiver will provide access to quality health care that is at least as comprehensive as would be provided without the waiver, will provide coverage and cost sharing protections against excessive out-of-pocket spending at least as affordable as would be provided without the waiver, will provide coverage to at least a comparable number of residents of the State as would be provided coverage without a waiver, and will not increase the Federal deficit. Further, before submitting its section 1332 waiver application the State must also provide a public notice and comment period, including public hearings, sufficient to ensure a meaningful level of public input, and have in place a law providing for its implementation of the waiver.

HHS and the Department of Treasury jointly oversee and set standards for the application, review, and reporting process. Upon receipt of a State Innovation Waiver application, the Departments will work with the State on the review and approval process. A preliminary review by the Departments will occur within 45 days of submission to determine if the application is complete and a final decision will be issued no later than 180 days after the determination that an application is complete.

CMS established a new "fast-track" process for reviewing proposals from States to extend established Medicaid and CHIP 1115 demonstrations that reauthorize longstanding policies with proven program outcomes. States that want to be considered for the fast-track process must use the streamlined extension application for the 1115 extension pathway under which it is requesting to be extended. The July 24, 2015 CMCS Informational Bulletin contains additional guidance and information on the "fast-track" Federal review process.

MEDICAID AND SUBSTANCE USE DISORDER TREATMENT

Question. Medicaid is the single largest payer of substance use disorder services in the Nation and pays for a third of all medication-assisted treatment (MAT) in the United States. Many States with the highest opioid overdose death rates have used Medicaid to expand access to MAT including Kentucky, Maine, Pennsylvania, Ohio, and West Virginia as well as many other States being devastated by the opioid epidemic like my home State of Oregon. Under the ACA's Medicaid expansion, one out of three people covered through the Medicaid expansion have a mental illness, substance use disorder, or both. In fact, independent researchers estimate that repealing the Medicaid expansion would cut \$4.5 billion from mental health and substance use services for low-income Americans. In fact, according to SAMHSA, the Affordable Care Act, including the expansion of Medicaid, is expected to increase total spending on behavioral health by more than \$7 billion per year by 2020. Unfortunately, the House-passed AHCA bill would undermine this investment and progress in addressing the opioid epidemic by causing 23 million more individuals, including 14 million on Medicaid, to become uninsured.

As Secretary of HHS, how do you intend to protect the gains in access to SUD treatment achieved through Medicaid expansion if Medicaid is cut by over \$800 billion and the Medicaid expansion is repealed?

One of the critical ways in which we see the importance of access to SUD treatment is by looking to the spread of the opioid epidemic, particularly in rural regions of the country. How do you plan to combat this epidemic if millions of Americans lose coverage for mental health and SUD treatment? Given the fact that this epidemic is particularly devastating for rural communities, do you have plans to combat opioid abuse that will target individuals in these regions?

The House-passed AHCA bill repeals the requirement that States provide certain Medicaid beneficiaries with access to the essential health benefits including substance user disorder coverage. This coupled with the increased financial pressure placed on States through the repeal of the Medicaid expansion and conversion of Medicaid into a capped program may lead States with no option but to drop coverage for this critical benefit. How do you plan to work with States to ensure that they do not limit or drop coverage for substance use disorders?

Answer. The U.S. Department of Health and Human Services (HHS) is keenly aware of the devastating impact that opioid addiction is having on our families and communities. The administration is committed to doing all that we can to end the scourge of opioids that is sweeping across this Nation.

The administration is committed to bringing everything the Federal Government has to bear to address the health crisis opioids pose. The budget calls for \$811 million in support of the five-pronged strategy guiding our Department's efforts to fight this scourge:

1. Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
2. Targeting availability and distribution of overdose-reversing drugs;
3. Strengthening our understanding of the crisis through better public health surveillance;
4. Providing support for cutting edge research on pain and addiction; and
5. Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Community Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total is \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants will help to address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

One of the key pillars of our approach is improving access to treatment and recovery services, including medication-assisted treatment (MAT) with naltrexone, buprenorphine, or methadone. As mentioned above, through the State Targeted Response to the Opioid Crisis grants authorized in the 21st Century Cures Act, HHS is expanding access to opioid addiction treatment through evidence-based interventions, including MAT. We are targeting the primary barriers to seeking and successfully completing treatment and achieving and sustaining recovery. This funding is critical to reversing the opioid epidemic.

IMPACTS OF THE AHCA ON RURAL AND OLDER AMERICANS

Question. In a May 24th report, the nonpartisan Congressional Budget Office (CBO) provided an estimate of the coverage and budgetary effects of the House-passed American Health Care Act (AHCA). According to the CBO analysis, the AHCA would lead to 23 million more uninsured Americans, 14 million of which would lose insurance after only 1 year.

Under the AHCA, insurers would be allowed to charge older Americans five times more than younger Americans for the same insurance plan. The AHCA would also replace the Affordable Care Act (ACA) ACA's tax credits with credits that raise premium costs for older and rural Americans. This is confirmed by CBO's analysis, which concluded that younger and healthier consumers would be able to obtain skimpier policies with lower premiums, while older and sicker enrollees would face higher costs. In addition, because the AHCA's tax credits do not account for local variation in health-care costs, rural Americans are more likely to face higher premium costs than non-rural Americans.

A recent State-by-State analysis by the National Academy for State Health Policy (NASHP) confirmed the predicted negative effect of the AHCA on rural and older Americans. For example, with tax credits, a 60-year-old in the Portland-metro area could see an increase in their premium from \$2,480 under the ACA to \$8,590 under the AHCA, a nearly 400-percent increase, while a 27-year-old could only face premiums as low as \$1,340. Meanwhile, in rural Umatilla County, a 60-year-old would see an increase in their premium from \$2,480 under the ACA to \$15,770 under the AHCA, an over 600 percent increase, while a 27-year-old would pay premiums of \$3,240.

President Trump promised, “We’re going to have insurance for everybody. . . . There was a philosophy in some circles that if you can’t pay for it, you don’t get it. That’s not going to happen with us.” Secretary Price, the AHCA clearly would not keep President Trump’s promise, especially for rural and older Americans. Does the administration support the AHCA even though it violates the President’s promises?

The MacArthur amendment would allow States to apply for waivers that would permit insurers to charge older Americans even more than the five times what they charge younger Americans for the same plan. These waivers would harm older adults and likely price them out of their coverage, again violating the President’s promises. Does the administration support the MacArthur amendment to the AHCA even though it violates the President’s promise?

How do you defend the President’s statement that no one would lose health insurance under his administration when CBO makes clear that 23 million Americans will lose coverage?

In a meeting with Republican senators, the President reportedly told them that the AHCA is “mean.” Do you agree with the President that the AHCA is mean? If not, please explain why causing 23 million Americans to lose their health coverage, causing older Americans to pay five times as much for coverage as younger Americans and cutting more than \$800 billion from the Medicaid safety net—all to pay for tax cuts for the affluent—is not “mean.”

Answer. Americans across the country have seen their health insurance choices disappear and premiums spiral out of control, increasing by double and triple digits. Last year alone, 73 insurers left the exchanges. In one-third of counties, Americans have only one choice for a health-care provider on the exchanges. Without action, Americans are stuck with Obamacare’s higher costs and fewer choices.

The administration is committed to working with Congress to repeal and replace Obamacare. The budget proposal represents the President’s commitment to rescue Americans from the failures of the Obamacare. The President supports a repeal and replace approach that provides individuals and families tools to choose the coverage that best meets their needs.

ACTUARIAL SOUNDNESS IN MEDICAID MANAGED CARE

Question. In April 2016, the Centers for Medicare and Medicaid Services (CMS) posted the final rule for Medicaid and CHIP Managed Care. This rule finally updated Medicaid managed care regulations, the first formal update in over a decade. One of the key principles of the final rule was to update the standards for actuarial soundness in Medicaid managed care plans. In short, actuarial soundness requirements assure health plan rates are sufficient to reimburse provider networks for services they provide to Medicaid beneficiaries. Ensuring rates are actuarially sound is essential to ensuring beneficiaries can access the care they need under the Medicaid program, an issue you have highlighted as an area of focus in your past statements.

Will you commit to ensure that Medicaid managed care plans achieve the Federal standard of actuarial soundness established in the Medicaid and CHIP Managed Care Final Rule?

Will you uphold Federal oversight of rate-setting to assure health plans achieve Federal actuarial soundness requirements in all States and that beneficiaries have access to the care they need as required under the Medicaid statute?

Answer. The U.S. Department of Health and Human Services (HHS) is conducting a full review of managed care regulations in order to prioritize beneficiary outcomes and State priorities.

BENEFITS OF AND FUNDING FOR TANF AND SSBG

Question. You describe TANF as a program that promotes empowerment of families through work. However, only 8 percent of States’ TANF funds are directed toward work.² Rigorous studies also show that the employment gains from work requirements were short-lived: within 5 years, recipients who were not subject to the work requirements were just as or more likely to work as those who were subject to them.³ Very few States collect data on the employment of families when they

² http://www.cbpp.org/sites/default/files/atoms/files/4-8-15tanf_0.pdf.

³ <http://www.cbpp.org/sites/default/files/atoms/files/6-6-16pov3.pdf>.

leave the welfare rolls, but the few that do show that the vast majority of former recipients are stuck in low-wage jobs or not working at all. Overall, few States have made steady progress toward increased earnings and more stable employment.

Do you still believe that TANF, in its current state, is a program that promotes empowerment of families through work?

Answer. TANF's fundamental focus on requiring work and establishing time limits on assistance has been transformative in changing the welfare policy landscape. These two pillars of the TANF program continue to be integral to TANF's framework. While there are areas of TANF that could be strengthened, this core framework continues to promote the empowerment of families through work. The administration looks forward to working with Congress to strengthen the work requirement to increase participant engagement in activities that will better help adult participants find jobs, remain employed, and advance in the workforce.

Question. You tout the fact that so few families receive TANF as a sign of success: for every 100 families in poverty, only 23 receive cash assistance from TANF, down from 68 in 1996 when TANF was created.⁴ But, one of the consequences of welfare reform is a significant increase in the number of families who are deeply poor, including many who have no access to any stable income from either work or cash assistance, which we know has lifelong negative consequences for children.

Do you believe that caseload decline, even if it puts children in harm's way, is an adequate measure of success?

Answer. Caseload decline is only one piece of the TANF story and is not an adequate measure of success on its own. The goal is to move families off of TANF through work. Under the TANF program, the employment of single mothers increased by 12 percent from 1996 through 2000, and even after the 2008 recession, employment for this demographic is still higher than before welfare reform.

TANF's primary measure is the work participation rate, which measures the degree to which families with a work-eligible individual receiving cash assistance are engaged in specified work activities. States must engage families to meet their target rate or face a financial penalty. The goal is to help families prepare for and go to work in a way that increases their capacity to support their families financially and reduce their dependency on public benefit programs.

Question. How do you reconcile your view that the TANF caseload decline is a measure of success with the scientific evidence that exposing children to high levels of stress negatively impacts their growth and development and has long-term negative consequences?

Answer. The administration wants to support States in their efforts to move families from welfare to work. The administration believes the achievement of gainful employment and economic independence is critically important for the well-being of parents and their children. More than just a means of income, work creates opportunities for individual growth; instills personal dignity; promotes health and well-being; and provides low-income families with a clear pathway to financial self-sufficiency.

Question. In your January 2017 responses to questions for the record related to TANF, you stated, "I think the best way to measure the success of the law is to see where the Nation was prior to its passage and where we are now." The Center on Budget and Policy Priorities (CBPP) has reported that extreme poverty has more than doubled since the passage of TANF in 1996.⁵ HHS has also previously referred to TANF as an "anti-poverty program."

How do you reconcile your view that the TANF caseload decline is a measure of success with evidence that extreme poverty has more than doubled since the passage of TANF?

Answer. As stated above, caseload decline is only one measure, and is not an adequate measure on its own. The administration believes the emphasis should be on moving families from welfare to work. On that score, TANF has been a clear success. The employment rate for never-married mothers rose from 49 percent in 1995 to 66 percent in 2000 and has never returned to pre-welfare reform lows.

As a result, the official poverty rate for single mothers and their children fell from 44 percent in 1994 to 33 percent in 2000 and, despite a still-recovering economy,

⁴ <http://www.cbpp.org/sites/default/files/atoms/files/6-16-15tanf.pdf>.

⁵ *Ibid.*

the poverty rate for this group in 2015 (36.5 percent) was still below the rates seen prior to welfare reform.

Nevertheless, poverty—and in particular deep poverty—remains too high in our country, and we must implement policies that will build on the progress TANF made in helping many families experience financial stability and security through employment. The administration looks forward to working with you to find better ways to help low-income Americans rise out of poverty.

Question. If you still believe that TANF is successful, then why, under your budget, would it face \$22 billion in cuts over the next decade?

Answer. TANF's success is not the result of the amount of dollars spent; rather its success comes from its restructuring of a welfare system to create a program that provides time-limited assistance, promotes empowerment through work, and fosters innovation.

As you know, TANF is a State-run program that offers flexibility in the use of funds to achieve the program's purposes. While this flexibility has been essential to allowing States to create innovative and effective strategies for helping families gain self-sufficiency, States have also been able to use their funds for benefits that fail to serve the core intent of the program. For example, States have used their TANF funds on services that are not targeted to a low-income population, and have even replaced existing State spending with TANF dollars in an effort to fill State budget gaps. Over time, States have reduced the portions of their block grants spent on work programs. Under the budget proposal, States will be able to maintain and strengthen services that promote employment, family stability, and self-sufficiency—and thereby reduce the need for TANF cash assistance benefits—by renewing attention to the core purposes of the program.

Question. Clearly if States could no longer transfer TANF funds to SSBG, they would spend their flexible TANF dollars within the purposes of TANF. It seems clear that the justification for cutting TANF as to “align” with the proposed elimination of SSBG is nothing more than window dressing for reducing funding. How would you respond to governors across the Nation who are concerned by the proposed \$22 billion in cuts to funding that their States, citizens and service providers have come to rely upon?

Answer. Many States are not sufficiently investing their current dollars in TANF's key welfare-to-work activities. In Fiscal Year 2015, States spent only about 28 percent of their total TANF and State maintenance-of-effort funds on the combination of work, work supports such as child care and transportation services, and case management services. States do not need more money in the TANF program; they need to use taxpayers' money more effectively to help move families dependent on public resources into stable work that can lead to self-sufficiency, to the benefit of both parents and children.

Question. In January 2017, you stated, “As a 2011 GAO report pointed out, SSBG is a program of fragmentation, overlap, and duplication.” You additionally stated that “there is not a one-size fits all approach to how States might react should there be an elimination of any Federal program.”

Could you specifically describe which 2011 GAO reported that SSBG is identified as a program of “fragmentation, overlap, and duplication and provide page numbers to support this claim?”

Answer. On March 1, 2011, the GAO released its report, “Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue” (GAO-11-318SP). Its supplement report, “List of Selected Federal Programs That Have Similar or Overlapping Objectives, Provide Similar Services, or Are Fragmented Across Government Missions,” was released on March 18, 2011. On page 14 of the supplement report, SSBG is cited as one of 80 Federal programs providing transportation services for transportation-disadvantaged persons.

TPP BIOLOGICS/STOCK TRADING

Question. During your confirmation process before the Finance Committee, you were asked about meetings you may have had related to your holdings and purchases in an Australian pharmaceutical company—Innate Immunotherapeutics (“Innate”). On June 1st, *ProPublica* reported in an article (“Tom Price Bought Drug Stocks. Then He Pushed Pharma's Agenda in Australia,”) that you discussed the pharmaceutical industry's trade agenda in meetings with Australian officials. Such

discussions could have impacted the business of Innate and other pharmaceutical companies you held at the time of the meetings.

Please describe any communications between you (or your staff) and the Office of the United States Trade Representative, representatives of the Government of Australia, or Members of Congress or their staff, with knowledge of the negotiations and implementation discussions regarding the TPP biologics commitments and their implementation by foreign governments between December 2015 and August 31, 2016. For each communication, please indicate the approximate date of the communication and the information provided.

Please provide the itinerary for the April 2016 congressional delegation to Australia and the Philippines described in the *ProPublica* article noted above.

Did you discuss biologics commitments and their implementation under the Trans-Pacific Partnership when you met with Australian government officials in April 2016? If so, please identify the meetings in the itinerary in which biologics commitments were raised, and describe the nature of any such discussion.

Did you or your staff discuss biologics commitments and their implementation under the Trans-Pacific Partnership with any U.S. Government officials between December 2015 and August 31, 2016? If so, please identify the meetings in the itinerary in which biologics commitments were raised, and describe the nature of any such discussion.

Answer. The administration is aware of the following communications/meetings that were undertaken between December 2015 and August 31, 2016 with individuals in the Office of the U.S. Trade Representative (USTR), representatives of the Australian Government, and Members of Congress (and staff) who may have had knowledge of the negotiations and implementation discussions regarding the Trans-Pacific Partnership (TPP) biologics commitments and their implementation.

Office of the United States Trade Representative

- The House Committee on Ways and Means hosted a members-only briefing with USTR Michael Froman on December 2, 2015.
- The Secretary and Warren Negri (Policy Advisor) met with USTR Michael Froman on April 29, 2016.

House Committee on Ways and Means

- The House Committee on Ways and Means hosted a members-only briefing on TPP on December 1, 2015.
- The House Committee on Ways and Means hosted a members-only briefing with USTR Michael Froman on December 2, 2015.
- Angela Ellard and Stephen Claeys, from the House Committee on Ways and Means, met with the Secretary and Kyle Zebley (Legislative Director) on March 23, 2016, to conduct a briefing on TPP prior to the Congressional Delegation (CODEL) trip to Australia in the spring of 2016.
- Kyle Zebley (Legislative Director) conducted a phone call with Stephen Claeys on April 26, 2016, prior to the meeting with USTR Michael Froman on April 29, 2016.

The Government of Australia

The Secretary's only interaction with the Government of Australia between December 2015 and August 31, 2016 took place during a CODEL from March 29, 2016 through April 7, 2016. The purpose of the CODEL was to meet with U.S., Australian, and Filipino defense officials and service members to evaluate U.S., ally, and partner installations, operations, and training in the Pacific region, with a particular focus on new U.S. programs, deployments, and installations in support of the Pacific rebalance. A complete manifest of the CODEL has been included.

Congressional staff had no interaction with the Government of Australia between December 2015 and August, 31, 2016.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

MENTAL HEALTH AND SUBSTANCE ABUSE

Question. Research from Harvard Medical School and New York University shows that eliminating Medicaid expansion increases the addiction treatment gap by 50

percent and takes away \$5.5 billion per year from treatment for substance use disorders and mental health.

Do you agree that the cut to Medicaid in the HHS budget will reduce access to substance use disorder and mental health services?

Do you support the waivers in the American Health Care Act that would allow insurance companies to end the requirement that plans cover addiction services and mental health treatment?

Answer. Addressing serious mental illness across our Nation and combating the opioid epidemic are two of the Department's top priorities. The U.S. Department of Health and Human Services (HHS) is keenly aware of the devastating impact that opioid addiction is having on our families and communities. The administration is committed to doing all that we can to end the scourge of opioids that is sweeping across this Nation.

The administration is committed to bringing everything the Federal Government has to bear to address the health crisis opioids pose. The budget calls for \$811 million in support of the five-pronged strategy guiding our Department's efforts to fight this scourge:

1. Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
2. Targeting availability and distribution of overdose-reversing drugs;
3. Strengthening our understanding of the crisis through better public health surveillance data and reporting;
4. Providing support for cutting edge research on pain and addiction; and
5. Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Community Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total is \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants will help to address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

One of the key pillars of our approach is improving access to treatment and recovery services, including medication-assisted treatment (MAT) with naltrexone, buprenorphine, or methadone. As mentioned above, through the State Targeted Response to the Opioid Crisis grants authorized in the 21st Century Cures Act, HHS is expanding access to opioid addiction treatment through evidence-based interventions, including MAT. We are targeting the primary barriers to seeking and successfully completing treatment and achieving and sustaining recovery. This funding is critical to reversing the opioid epidemic.

HEALTHY MICHIGAN PLAN

Question. Last week in Lansing, business leaders, the Michigan Department of Health and Human Services, the State budget office, hospitals, health-care providers, and others held a meeting on Medicaid. There was widespread agreement that Medicaid is working in Michigan.

The State's Budget Director said about our Healthy Michigan Plan: "This is not only the right thing to do, it's the smart and fiscally responsible thing to do. Reductions in delayed and uncompensated care and increase in healthier lifestyles provide benefits to us all in so many ways."

The HHS budget would cut Medicaid funding in half 10 years from now, and the American Health Care Act ends Medicaid expansion entirely.

Do you think Michigan's Budget Director incorrectly assessed Michigan's Medicaid expansion?

Do you disagree with research that shows Medicaid expansion in Michigan has led to job creation, cost savings, and insurance coverage?

Answer. (See response below.)

Question. The State's Budget Director said that the Medicaid cuts would create an \$800-million per-year hole in the budget it could not afford.

Do you agree that Michigan couldn't continue to fund health care, and that cuts would have to be made?

Answer. The administration remains committed to ensuring that Medicaid is available for eligible beneficiaries, and working with States to ensure they are able to make the most use of available resources to serve their citizens. As you know, Medicaid is the primary source of medical coverage for millions of low-income American families and seniors facing health challenges. However, its costs have been growing drastically without improvement in outcomes.

The problem isn't lack of funding; the problem is lack of flexibility. Rigid and outdated Federal rules and requirements prevent States from pioneering delivery system reforms and from prioritizing Federal resources to their most vulnerable populations, which hurts access and health outcomes. The administration is committed to giving States as much freedom as possible to design reforms that meet the spectrum of diverse needs of their Medicaid populations.

Question. The budget doesn't include any information on the impact of Medicaid cuts.

Has HHS evaluated what these cuts would mean for Michigan?

Answer. The FY 2018 budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. In fact, under the budget, Medicaid spending will continue to grow over the next decade.

QUESTIONS SUBMITTED BY HON. MARIA CANTWELL

AFFORDABLE CARE ACT CONTRACEPTIVE BENEFIT

Question. On May 31, 2017, the media released a draft interim final rule by your department that in my understanding would allow any employer in the country to easily deny birth control to their employees. Multiple studies show that access to birth control without cost-sharing leads to better health, economic security, and lower rates of unintended pregnancies.

Are you aware of the reports about this interim final rule?

Are you familiar with the document that was released by the media?

Is your department planning an interim final rule on this matter?

Answer. The administration is not at liberty to discuss the details of pending rules and regulations.

MANDATORY SEQUESTER AND EFFECT ON MEDICARE REIMBURSEMENT

Question. President Trump has repeatedly promised the American people that he won't cut Medicare.

Does the President's FY18 budget propose to extend the mandatory sequester beyond OMB's current law baseline?

Does the mandatory sequester reduce the aggregate amount of Medicare reimbursement that providers would receive, compared to an assumption of current law?

Do you consider the mandatory sequester a cut to Medicare reimbursement?

Answer. The President's budget reflects current law. In addition, the budget proposes to continue current law by extending sequestration by 2 years. This is not a cut to what Medicare currently pays to providers and does not change benefits or prices charged to beneficiaries generally.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. President Trump repeatedly promised that he would protect the Medicare and Medicaid programs from cuts during his campaign. Proposals to cut billions of dollars from the Medicare program, increase the Medicare eligibility age, turn Medicare into a voucher program, or increase out-of-pocket costs for seniors on Medicare would affect the over 4 million Floridians who depend on the program for financial security.

The administration's budget extends the across-the-board cuts in Medicare provider payments by 2 years, effectively cutting \$30 billion from the Medicare program. Do you agree that this is a cut to the Medicare program?

Answer. The President's budget reflects current law. In addition, the budget proposes to continue current law by extending sequestration by 2 years. This is not a cut to what Medicare currently pays to providers and does not change benefits or prices charged to beneficiaries generally.

Question. Last month, OMB Director Mulvaney made comments indicating that he would advise the President to not keep his promises to protect the Medicare program from cuts.

As the President's top advisor on Medicare, do you agree with Director Mulvaney that next year's budget should cut Medicare?

Answer. For 51 years, Medicare has played a crucial role in providing health care for America's senior citizens. Unfortunately, Medicare trustees have consistently told us that the Medicare program is in financial trouble. In light of that fact, my primary concern has always been to protect the program for seniors today and the generations to come. At HHS, we take seriously our responsibility to protect Medicare for this generation and those to come, and we are pursuing all available avenues to improve Medicare's sustainability in ways that put patients first.

The Congressional Budget Office's (CBO) estimate for H.R. 1628, the American Health Care Act, shows just how much of a disaster this bill would be for American families. According to CBO:

- 14 million Americans will lose their health insurance next year.
- \$834 billion would be cut from the Medicaid program.
- Older Americans will pay more for less. In fact, the bill will result in "substantially raising premiums for older people."
- The uninsured rate "would be disproportionately larger among older people with low incomes."
- For example, in 2026, a 64-year old who earns just over \$26,000 in a non-waiver State would pay \$16,100 in premiums rather than \$1,750 under the Affordable Care Act.

Question. You stated that "nobody will be worse off financially" under the health plan. How is the bill better for Floridians? It ends the Medicaid program as we know it, charges older Americans more for less coverage, and ends the guarantee of coverage for people with preexisting conditions.

Answer. Americans across the country have seen their health insurance choices disappear and premiums spiral out of control, increasing by double and triple digits. Last year alone, 73 insurers left the exchanges. In one-third of counties, Americans have only one choice for a health-care provider on the exchanges. Without action, Americans are stuck with Obamacare's higher costs and fewer choices.

The administration is committed to working with Congress to repeal and replace Obamacare. The budget proposal represents the President's commitment to rescue Americans from the failures of Obamacare. The President supports a repeal and replace approach that provides individuals and families tools to choose the coverage that best meets their needs.

Question. The administration's budget states, "Outbreaks like Zika will not be a one-time event." Yet, the administration's budget cuts the very programs designed to respond to and prevent public health emergencies like the Zika virus. Please answer the following questions on the Zika virus with a yes or no answer, unless otherwise specified.

Does your budget cut more than \$7.2 billion from the National Institutes of Health (NIH)?

Answer. The budget includes a total of \$25.9 billion to support the highest priority biomedical research within the National Institutes of Health (NIH). NIH is the largest public funder of biomedical research in the world. NIH expands the biomedical knowledge base by funding cutting-edge research, improves health by seeking new treatment and prevention options, supports the training of the current and future biomedical workforce, and drives economic growth and productivity.

The FY 2018 budget presents an opportunity for HHS and NIH to reexamine how to optimize Federal investment in a way that best serves the American people. The budget was developed to enhance the stewardship of taxpayer dollars by focusing

our resources on innovative scientific research. The Department assessed opportunities within the NIH to determine where greater efficiencies may be possible.

Additionally, the administration will propose a package of reforms to streamline Federal compliance requirements and reduce burden on NIH grantees. These targeted policies will reduce the time and expenses that grantees must currently spend to comply with overly burdensome Federal grant requirements, thus lowering grantees' administrative costs and mitigating the impact of lower reimbursements. The approach will also seek to develop a uniform indirect cost rate to all grants that mitigates the risk for fraud and abuse by simplifying and uniformly applying the rate for grantees.

Question. Does it cut more than \$600 billion from the Medicaid program, on top of many of the cuts included in the House-passed health-care bill?

Answer. No. The President's FY 2018 budget does not incorporate specific legislation. Therefore, it is not accurate to apply the specific Medicaid savings the CBO has estimated for legislation before Congress to the President's budget. To do so would assume a level of specificity that does not exist in the budget. The budget calls for refocusing Medicaid on the elderly, children, pregnant women, and individuals with disabilities. The budget specifies savings of \$610 billion by providing additional flexibility to States by reforming the fiscal structure of Medicaid, allowing a choice between per capita cap or a block grant, beginning in FY 2020.

Question. Does it cut more than \$1.3 billion from the Centers for Disease Control and Prevention (CDC), including \$35 million from the National Center of Birth Defects and Developmental Disabilities; \$65 million from the Center for Emerging and Zoonotic Infectious Disease; and \$135 million from the Office of Public Health Preparedness and Response?

Answer. The FY 2018 budget for CDC and the Agency for Toxic Substances and Disease Registry (ATSDR) is \$11.1 billion. This total includes \$5.1 billion in budget authority, \$841 million from the Prevention and Public Health Fund, and \$143 million in Public Health Service (PHS) Evaluation Funds.

At this funding level, CDC will continue to protect the Nation and the world by: detecting, responding to, and stopping new and emerging health threats; preventing injuries, illness, and premature deaths; and discovering new ways to protect and improve the public's health through science and advanced technology. The budget prioritizes funding for key areas where CDC can have the greatest impact, including: continuing the fight against opioid abuse, misuse, and overdose; supporting efforts to combat childhood obesity; protecting the Nation's national security through medical countermeasure stockpiling; and investing in CDC's infrastructure to ensure the safety, security, and productivity of CDC staff.

The budget provides CDC with increased flexibility to allocate resources and implement policies that best support mission-critical activities based on current science and public health expertise. This programmatic flexibility will enable the CDC to focus on programs that have been proven effective, while reducing costs and improving the efficient use of resources. The budget establishes the new America's Health Block Grant, reforming the model of existing State-based chronic disease programs to increase flexibility, allowing States to focus on leading public health challenges specific to their State.

Question. Does it cut \$850 million from the Food and Drug Administration and propose to replace this loss of budget authority with user fees? Under current law, user fees cannot currently be used to support public health work. Does this change under the administration's budget?

The FY 2018 budget requests a total program level of \$5.1 billion to support FDA's core mission to protect the Nation's public health by enhancing the safety of food and ensuring the safety and effectiveness of medical products. FDA's jurisdiction of products and activities is vast, ranging from analyzing the latest in medical technology to ensuring the safety of the Nation's food supply. The challenge of ensuring the safety and effectiveness of these products increases in complexity within a growing global market.

In a constrained budget environment, the budget acknowledges medical product industries have sufficiently matured to assume a greater share of costs associated with FDA's administrative actions. User fees have been instrumental in allowing FDA to build capacity and improve the timeliness of the medical product review process without compromising the agency's high standards. The FY 2018 President's budget recalibrates FDA medical product user fees to over \$2.5 billion in 2018, an

increase of \$1.2 billion over the annualized CR level. The budget supports, through 100-percent user fee funding, medical product review and approval activities associated with the prescription and generic drugs, biosimilar, medical device, and animal drugs programs, including operational and support costs associated with White Oak campus operations, rent payments to the General Services Administration, other commercial rent and rent-related charges, as well as anticipated FY 2018 inflation for rent costs. Legislative revisions will be needed for all of these programs to ensure continuity of review and approval activities. To support speeding patient access to safe and effective medical products, the budget also includes a portfolio of administrative actions to achieve regulatory efficiencies through program and process improvements.

The FY 2018 budget request also includes reductions totaling \$127.2 million in budget authority, targeted to certain areas where better tools and policies will allow FDA to do more with less, while preserving core mission activities. These reductions will be coupled with policy efforts to improve the efficiency of the programs that see reductions, to improve effectiveness and take a risk-based approach to FDA's consumer protection mission.

Question. Florida is relying on Medicaid to help prevent the spread of the Zika virus and treat those affected. With the broad Medicaid cuts outlined in both the administration's budget and the House-passed health-care bill, the State of Florida will have to choose between prevention and treating those affected by an epidemic, continuing to serve seniors in nursing homes, and caring for Florida's medically complex children.

How would you recommend that States handle a public health threat like Zika, if their Medicaid funds are capped?

Answer. Rigid and outdated Federal rules and requirements prevent States from pioneering delivery system reforms and from prioritizing Federal resources to their most vulnerable populations, which hurts access and health outcomes. The President's budget will give States as much freedom as possible to design reforms that meet the spectrum of diverse needs of their Medicaid populations.

The administration is committed to making sure that States have the flexibility to design their Medicaid programs to meet the needs of the most vulnerable in their State. By strengthening the Federal and State Medicaid partnership, we will empower States to develop innovative solutions to challenges like Zika, rather than telling States how they should run their programs.

Question. The opioid crisis is devastating Florida and the rest of the Nation. Over 2,500 Floridians died from opioids in the first half of 2016 alone. Yet the administration's budget cuts over \$600 billion from Medicaid, in addition to many of the cuts included in the House-passed health-care bill; cuts 9 percent from the Substance Abuse and Mental Health Services Administration; cuts \$355 million from the National Institute of Mental Health; and cuts \$235 million from the National Institute on Drug Abuse.

During his campaign, President Trump promised to give people addicted to opioids access to the help they need. Given the cuts outlined above, how does the administration's budget prioritize giving people with opioid addiction the help they need?

Answer. (See answer provided below)

Question. As the single largest payer for substance use services and treatments, Medicaid plays a critical role in the fight against the opioid epidemic. Changing the Medicaid program through block grants or caps, as the administration's budget proposes, will shift costs to States, eliminate critical Federal protections, and hurt the more than 4 million Floridians who rely on the program, including those with opioid addiction.

If these cuts are made, how do you propose States like Florida provide the necessary services to help individuals with substance use disorders?

Answer. Addressing serious mental illness across our Nation and combating the opioid epidemic are two of the Department's top priorities. The U.S. Department of Health and Human Services (HHS) is keenly aware of the devastating impact that opioid addiction is having on our families and communities. The administration is committed to doing all that we can to end the scourge of opioids that is sweeping across this Nation.

The administration is committed to bringing everything the Federal Government has to bear to address the health crisis opioids pose. The budget calls for \$811 million in support of the five-pronged strategy guiding our Department's efforts to fight this scourge:

1. Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
2. Targeting availability and distribution of overdose-reversing drugs;
3. Strengthening our understanding of the crisis through better public health surveillance data and reporting;
4. Providing support for cutting edge research on pain and addiction; and
5. Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Community Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total is \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants will help to address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

One of the key pillars of our approach is improving access to treatment and recovery services, including medication-assisted treatment (MAT) with naltrexone, buprenorphine, or methadone. As mentioned above, through the State Targeted Response to the Opioid Crisis grants authorized in the 21st Century Cures Act, HHS is expanding access to opioid addiction treatment through evidence-based interventions, including MAT. We are targeting the primary barriers to seeking and successfully completing treatment and achieving and sustaining recovery. This funding is critical to reversing the opioid epidemic.

The administration's objective is ensuring all Americans have access to the best and highest quality coverage and care. Having coverage is not meaningful if one cannot access the care they need or the quality of care leaves them worse off—we must work toward both coverage and care.

Question. I recently heard from a constituent whose son has Down Syndrome. After years of being on the Medicaid waiver list, he finally began receiving benefits. At this point, his life drastically changed for the better. He began to participate in an adult supervised day program. He receives transportation so that he can socialize with his peers. Overall, his quality of life has improved.

Have you considered what a Medicaid cap or block grant would look like for this constituent and his family? Limiting State Medicaid funding will force States to limit eligibility and/or benefits, and create lengthy waiting lists for Floridians who are sick and/or disabled. What do I tell his parents when programs that improve their child's quality of life are cut? What about all of the other Floridians who rely on Medicaid?

Answer. The administration remains committed to ensuring that Medicaid is available for eligible beneficiaries, and working with States to ensure they are able to make the most use of available resources to serve their citizens. As you know Medicaid is the primary source of medical coverage for millions of low-income American families and persons with disabilities. However, its costs have been growing drastically without improvement in outcomes.

The problem is not lack of funding; the problem is lack of flexibility. Rigid and outdated Federal rules and requirements prevent States from pioneering delivery system reforms and from prioritizing Federal resources to their most vulnerable populations, which hurts access and health outcomes. The administration is committed to giving States as much freedom as possible to design reforms that meet the spectrum of diverse needs of their Medicaid populations.

Question. For 20 years, the Children's Health Insurance Program (CHIP) has provided low-cost health coverage to children in families that earn too much money to qualify for Medicaid.

The Medicaid and CHIP Payment and Access Commission (MACPAC) recommends a 5-year extension of CHIP funding through fiscal year 2022. MACPAC also recommends extending the enhanced 23-percentage-point Federal match and Maintenance of Effort requirement through fiscal year 2022.

At your confirmation hearing, you recommended an 8-year extension, as did CMS Administrator Verma. Despite its critical need, CHIP is extended for just 2 years in the administration's budget. The budget proposes to end the enhanced 23-percent Federal match for States, as well as the Maintenance of Effort requirement.

What is the rationale for attempting to disrupt a stable source of health coverage for 8.4 million children, including 375,000 in Florida?

Answer. The budget proposes to extend funding for CHIP for 2 additional years through FY 2019. Extending CHIP funding for 2 years provides stability to States and families while the future of the program is addressed alongside other health reforms. This funding guarantees that the most vulnerable children will continue to have coverage.

The budget also proposes a series of improvements that rebalance the State-Federal partnership and increase State flexibility. This proposal ends the 23-percentage point increase in the enhanced Federal match rate and the current law maintenance of effort requirement after FY 2017. The budget also proposes ending the Obamacare requirement for States to move certain children from CHIP into Medicaid and capping the level at which States could receive the CHIP enhanced Federal matching rate at 250 percent of the Federal Poverty Level. These provisions would return the focus of CHIP to the most vulnerable and low-income children.

Question. ALS is a progressive neuromuscular disease that typically leads to death within 2 to 5 years of symptom onset. Studies by the National Institutes of Health (NIH) and Department of Defense (DOD) have documented that military veterans are about twice as likely to die from ALS. We know this because the National ALS Registry, housed at the CDC, analyzes information from the DOD, the Department of Veterans Affairs, NIH, and CMS, as well as from individuals living with ALS.

The National ALS Registry is a critical resource for (1) providing data to researchers focused on developing treatments and prevention strategies; and (2) matching patients to potential clinical trials. Unfortunately, the administration's budget called for the elimination of the National ALS Registry.

I'm concerned that if funding for the National ALS Registry were eliminated, people living with ALS would lose their opportunity to be contacted directly for a wide range of clinical trials and other important research. Moreover, public and private researchers would lose their access to the unique data and patients needed to drive understanding of the disease and development of therapies.

Do you think we should keep this unique and valuable resource that researchers and patients rely on?

Answer. In a constrained budget environment, difficult funding decisions must be made to ensure that HHS invests in activities that are core to its mission and not duplicative of other efforts across the Federal Government. NIH-funded research on ALS will continue, and external researchers may still use biospecimens previously obtained from the ALS biorepository.

Question. The Pandemic and All Hazards Preparedness Act (PAHPA) created the office of the Assistant Secretary for Preparedness and Response—a leader in preventing and responding to public health emergencies like the Zika virus. Unfortunately, the administration's budget cuts \$25 million from this critical office and many other programs that are critical to our Nation's public health emergency preparedness.

How do you intend to use lessons learned from past public health emergencies, like Hurricane Matthew, Ebola, and now the Zika virus, to improve coordination and communication among Federal agencies involved in emergency preparedness?

Answer. Incorporating lessons learned into policies, plans, and procedures is a vital component of emergency preparedness. It ensures that issues identified in past events do not reoccur during future responses. ASPR is continually evaluating its responses to public health and medical events, developing lessons learned, and implementing actions to improve coordination and communication. Such lessons are also provided to emergency response planners and are incorporated into future exercises and responses. Lessons learned from past natural hazard incidents and disease outbreaks such as Hurricane Matthew, Zika, and Ebola, guide strategies for improvement throughout the Department, including information sharing; intra/inter-agency coordination; State, local, tribal, and territorial coordination; and the management of public health and medical assets.

Following the Ebola response, HHS initiated and participated in a number of actions to improve interagency coordination. For instance, we recognized a need to codify how infectious disease emergencies are managed under the National Response Framework (NRF). This was accomplished through significant updates and alignment of the Biological Incident Annex (BIA) to the NRF. The BIA now provides the overarching framework under which the interagency (the Federal executive departments and agencies) organizes and coordinates. This includes identifying the thresholds for triggering such coordination, particularly for a high-consequence event/threat. The final draft BIA was approved by the interagency Domestic Resilience Group (DRG), which was convened by the White House in January 2017.

In addition, HHS has collaborated with the Department of Defense (DoD) to leverage their Interagency Transportation Support Framework (ITSF) Concept of Operations (CONOPS), which is an agreement between HHS and DoD (NORTHCOM) to facilitate the rapid airlift of personnel and equipment during a domestic response. This new ITSF CONOPS (post-Haiti response) allows HHS to request DoD airlift much faster than previous responses because HHS personnel and equipment are now planned and integrated into DoD transportation (airlift) systems prior to a response.

Building on lessons learned during the Ebola response, early in the Zika outbreak, ASPR convened partners in HHS and across the U.S. Government with a goal of sharing information about the supply chain and planned procurements of Zika insecticide, traps, and repellents. In each of those working groups, members determined how to coordinate to make the desired products more readily available to the private sector and non-Federal government partners. ASPR is now developing a formalized mechanism for coordination of purchases with the Critical Infrastructure Partnership Advisory Council.

Another example of using lessons learned from Ebola is the approach taken for planning during the initial stages of the Zika outbreak. HHS, led by ASPR and CDC, has developed a draft Federal operational plan that builds on the HHS Zika Virus Disease Preparedness and Response Goals and Objectives. The Zika planning construct displays the connections and relationships between the HHS-led Zika plans and other planning efforts. The U.S. Government Zika Virus Disease Contingency Response Plan describes the Unified Coordination Group's operational coordination and synchronization, as well as the steps necessary among Federal agency partners and State representatives to assist HHS in response activities. In the event of a large scale Federal response where the impact of a particular incident overwhelms State and local resources or the lead Federal agency, HHS would determine whether interagency support is or will be required.

Finally, the Department has utilized the lessons learned from the 2009/2010 pandemic experience and other public health responses to ensure that the Department is better prepared for the next pandemic influenza incident. The Department recently published its 2017 update to its Pandemic Influenza Plan. Originally adopted in 2005 and last updated in January 2009, the 2017 Pandemic Influenza Plan Update applies the public health lessons learned since January 2009.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

AUTISM CARES ACT PROGRAMS

Question. The Autism CARES Act of 2014, which I authored and which was passed unanimously by Congress, reauthorized Federal autism programs through fiscal year 2019. These programs include training programs, research, and State systems grants. The proposed budget eliminates all funding for these programs, despite the well-recognized and growing need for the services they facilitate.

The Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program supports the interdisciplinary training of graduate-level professionals in improving the quality of care to fit the unique needs of young people with disabilities. This program currently funds 52 projects in 44 States across the country, including at Rutgers University in my home State of New Jersey. Collectively, these projects share information with each other as part of a national network. Does the department believe that supporting the training of professionals to provide care for people with autism and other disabilities is no longer a Federal responsibility?

Answer. The President's budget prioritizes programs that support direct health-care services and give States and communities the flexibility to meet local needs.

Some of these activities could be continued by States using their Maternal and Child Health Block Grant awards.

Question. The Interdisciplinary Technical Assistance Center (ITAC), authorized by the Autism CARES Act, provides technical assistance to LEND programs and Developmental-Behavioral Pediatrics (DBP) programs and helps to coordinate activities at programs that receive funding as a result of the Autism CARES Act. Do you believe that funding the coordination and sharing of information between LEND and DBP programs is no longer a Federal priority?

Answer. The President's budget prioritizes programs that support direct health-care services and give States and communities the flexibility to meet local needs. Some of these activities could be continued by States using their Maternal and Child Health Block Grant awards.

Question. The fiscal year 2018 HHS budget justification for Autism CARES Act programs States, "The budget prioritizes programs that support direct health-care services and give States and communities the flexibility to meet local needs." Do you believe that the challenges that a person with autism faces are any less a priority based on if they live in a specific State or community?

Answer. The President's budget continues support for programs, such as the Maternal and Child Health Block Grant, which enable States and communities to determine how to best support training of professionals to provide care for people with autism and other disabilities in their State.

SUPPORTING DIVERSITY IN THE HEALTH PROFESSIONS

Question. The FY18 proposed budget eliminates funding for programs such as the Health Careers Opportunity Program, Centers of Excellence, and Scholarships for Disadvantaged Students. These programs have collectively assisted in the education and training of tens of thousands of health-care professionals from under-represented minority populations.

Federal programs that provide funding to facilitate the education and training of under-represented minorities in the health professions have historically been shown to have increased the number of health-care professionals willing to practice in medically underserved areas. The fiscal year 2018 HHS budget justification for these programs states that the budget is prioritizing funding for clinicians who serve "in areas of the United States where there is a shortage of health professionals." Aren't medically underserved areas by definition suffering from a shortage of health professionals?

Answer. The budget prioritizes funding for training and education programs that include a service obligation which ensures that clinicians are serving these medically underserved communities. The budget's investment in scholarships and loan repayment programs ensures a direct impact on the provision of services in areas experiencing shortages of providers.

In addition, the budget also proposes funding for the Teaching Health Center Graduate Medical Education (THCGME) program in which approximately 77 percent of residents received training in medically underserved communities and approximately 23 percent of residents reported coming from a financially or educationally disadvantaged background, characteristics which are both correlated with likelihood of practicing in underserved areas. In fact, 50 percent of THCGME residents report that they intend to practice in a medically underserved and/or rural area.

Question. The Association of American Medical Colleges released a survey in 2016 on diversity in medical education. In 2015, over 51 percent of matriculating students at medical colleges who were black or African-American reported that they were planning on practicing primarily in a medically underserved area. Over 39 percent of Hispanic or Latino students, 37 percent of American Indian or Alaska Native students, and over 34 percent of Native Hawaiian or other Pacific Islander students reported the same. This compares to 22 percent of white and Asian students, who together comprise 71 percent of all matriculating students at U.S. medical colleges. In the absence of Federal programs whose primary goal is to assist under-represented minority populations achieve careers in the health professions, how does the Department intend on addressing the needs of medically underserved areas, some of which have to do with cultural competency?

Answer. HRSA's key loan repayment and scholarship programs, the National Health Service Corps (NHSC) and NURSE Corps, improve the health of the Nation's underserved by recruiting and retaining health-care providers to serve in health

professional shortage areas. These programs tend to attract higher percentages of health professions students and clinicians who are underrepresented minorities and from rural and disadvantaged backgrounds relative to the broader health workforce.

Diversity Among Physicians, Dentists, and Nurse Practitioners Within the NHSC as Compared to the National Workforce

	African American	Hispanic/Latino(a)	American Indian/Alaskan Native
Total NHSC Field	13.5%	12.2%	2.6%
MD/DO			
<i>NHSC</i>	17.2%	18.1%	1.3%
<i>National</i>	4.1%	4.4%	0.4%
DDS			
<i>NHSC</i>	15.2%	14.0%	1.7%
<i>National</i>	2.9%	8.1%	---
NP			
<i>NHSC</i>	17.6%	7.4%	2.9%
<i>National</i>	8.2%	2.5%	---

NHSC providers have higher retention in poorer and less educated communities, where participants select into Health Professional Shortage Areas based on their preferences for serving underserved populations.⁶ Former NHSC participants also are more likely than non-participants to serve low-income patients—they tend to have high levels of Medicaid participation, practice in community health centers, and locate in areas with a health professional shortage (and counties with high percentages of minorities and people living in poverty).^{7, 8, 9}

Diversity Among Registered Nurses, Nurse Faculty, and Nurse Practitioners Within the NURSE Corps (NC) as Compared to the National Workforce

	African American	Hispanic/Latino(a)	Asian	American Indian/N. Hawaiian
Total NC Field	16%	6%	5%	2.7%
Registered Nurse				
<i>NC</i>	17.6%	7%	5.5%	3.5%
<i>National</i>	12.2%	6.6%	8.7%	N/A
Nurse Faculty				
<i>NC</i>	15.3%	3.4%	2%	.9%
<i>National</i>	7%	3%	2%	.6%
Nurse Practitioner				
<i>NC</i>	14.6%	6.1%	5.5%	2.7%
<i>National</i>	6.0%	3.0%	1.0%	N/A

⁶Sebastian Negrusa, Projesh Ghosh, and John T. Warner. "Provider Retention in High Need Areas." Prepared for Assistant Secretary for Planning and Evaluation. Submitted by The Lewin Group, Inc. December 22, 2014. <https://aspe.hhs.gov/report/provider-retention-high-need-areas>.

⁷Bhatavadekar, N.B., R.G. Rozier, et al. (2011). "Holding up the oral health safety net: the role of National Health Service Corps alumni dentists in North Carolina." *Int. Dent. J.* 61(3): 136–43. <https://www.ncbi.nlm.nih.gov/pubmed/21692784>.

⁸Porterfield, D.S., T.R. Konrad, et al. (2003). "Caring for the underserved: current practice of alumni of the National Health Service Corps." *J. Health Care Poor Underserved* 14(2): 256–71. <https://www.ncbi.nlm.nih.gov/pubmed/12739304>.

⁹Probst, J.C., M.E. Samuels, et al. (2003). "The National Health Service Corps and Medicaid inpatient care: experience in a southern State." *South. Med. J.* 96(8): 775–83. <https://www.ncbi.nlm.nih.gov/pubmed/14515918>.

Question. The budget justification for the Scholarships for Disadvantaged Students Program argues that students from disadvantaged backgrounds could simply seek assistance from “private and non-profit scholarships and other Federal loan programs that support student education.” Such a justification seems to simply disregard the significant institutional barriers that people of color and people from disadvantaged backgrounds face as they seek to achieve success. According to HHS’s own data, 65 percent of students with SDS scholarships during fiscal year 2015 were members of under-represented minority groups. What proportion of the students currently served by SDS do you believe would receive assistance by other means?

Answer. Grants and loans are the major forms of Federal financial aid for degree/certificate-seeking undergraduate students, including students from disadvantaged backgrounds. The largest Federal grant program available to undergraduate students is the Pell Grant program. In order to qualify for a Pell Grant, a student must demonstrate financial need. Federal loans, on the other hand, are available to all students. In addition to Federal financial aid, grants from State and local governments, institutions, and private sources are available, as are private loans. There are also Parent Loans for Undergraduate Students (PLUS) and other loans made directly to parents. The Department of Education offers assistance in finding and applying to private and Federal scholarship and loan opportunities here: <https://studentaid.ed.gov/sa/types>.

While the administration defers to Department of Education about the specifics for under-represented minorities, 86 percent of first-time, full-time degree/certificate-seeking undergraduate students were awarded financial aid in academic year 2014–2015 at 4-year degree-granting postsecondary institutions.¹⁰

CHILDREN’S HEALTH INSURANCE PROGRAM

Question. The FY18 proposed budget makes several changes to the Children’s Health Insurance Program that stand to increase costs to States and put health-care coverage for some of our most vulnerable citizens—our children—at risk. These proposals include ending the 23 percentage point increase in the enhanced Federal match rate for CHIP funding, ending the maintenance of effort provision that requires States to maintain their eligibility levels and prevents States from imposing more restrictive standards for eligibility or enrollment, and for the first time imposing a cap on the enhanced Federal match rate at 250 percent of the Federal poverty level.

New Jersey currently allows for enrollment in CHIP for children in families whose income does not exceed 355 percent of the Federal poverty level. Analysis by New Jersey Policy Perspective suggests that a cap on the enhanced Federal match rate would threaten the health-care coverage of 35,000 children in New Jersey. The Department’s proposal would weaken the flexibility that high-cost States like New Jersey have used to increase eligibility levels to fit their State’s needs. How does the Department expect high-cost States like New Jersey to continue to provide care to those that it has decided should be eligible for it?

Should the maintenance of effort provision, which does not expire until the end of fiscal year 2019, be ended early by congressional action, which States do you expect will enact policies that will restrict eligibility levels for CHIP or create new burdens to enrollment in CHIP?

Answer. The 2-year extension included in the budget provides budgetary stability and additional flexibility to States while focusing the program on lower-income families. The budget would allow States the flexibility to set eligibility levels and features of their CHIP programs that reflect individual State needs and populations. This 2-year extension would provide stability during the period of health system reforms, including the implementation of the Medicaid reforms and new flexibilities for States.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Question. The FY18 proposed budget makes deep cuts to a variety of programs at the CDC, at a time when our Nation continues to face significant public health challenges. This includes the elimination of several vital programs that have made a positive contribution to public health.

¹⁰ See: <https://nces.ed.gov/fastfacts/display.asp?id=31>.

The FY18 budget request reduces funding for Public Health Preparedness and Response by \$136.3 million. The budget justification States that resources will be directed to the States with the “greatest need.” In FY16, New Jersey received more than \$20 million in funding through the Public Health Emergency Preparedness, Public Health Preparedness and Response, and Hospital Preparedness Programs, including funding for the public health response to the Zika virus. In FY15, New Jersey received more than \$25 million through these programs to assist in the response to the Ebola virus. How do you define “greatest need?” How would the Department determine what States are prioritized at the expense of others?

Answer. The FY 2018 President’s budget restructures HHS preparedness grants to direct resources to States with the greatest need and to provide more innovative approaches. As outlined in the proposed FY 2018 budget, the Public Health Emergency Preparedness (PHEP) cooperative agreement will gain efficiencies, address gaps, and incentivize innovation by incorporating a competitive and risk-based component.

The PHEP program works to protect the health and safety of the population during a public health event or emergency. Therefore, the historical risk component is a population-based formula and is intended to direct more resources to those jurisdictions with higher populations. The proposed new funding formula is not yet final; however, all current 62 PHEP award recipients will continue to receive funding to ensure some level of sustainability and maintenance of public health preparedness and response capacity and capability.

MATERNAL, INFANT, AND EARLY CHILDHOOD HOME VISITING PROGRAM

Question. The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program has been incredibly successful since I successfully incorporated it as part of the Affordable Care Act in 2010. Through this program, nurses, social workers, or other professionals visit at-risk families in their homes to evaluate their living situation and provide information on resources available to improve the health, educational, and economic opportunities for at-risk children. These resources include services such as health care, early education, parenting skills, child abuse prevention, and nutrition education or assistance. Nearly 1 million home visits were made to over 160,000 program participants as a result of this program in FY16.

I am pleased that the Department supports the continuation of this program, which is set to expire at the end of the current fiscal year. However, I am concerned that the Department’s budget request asks only for funding to continue through fiscal year 2019. Is it the stated policy of the Department to allow the MIECHV program to expire at the end of fiscal year 2019?

Answer. The Maternal, Infant, and Early Childhood Home Visiting program is one of five HRSA programs that is funded through FY 2017 under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The FY 2018 President’s budget requests 2-year funding for Fiscal Years 2018 and 2019 for Home Visiting and the other four MACRA-funded programs—Health Centers, the National Health Service Corps, Teaching Health Center Graduate Medical Education, and Family-to-Family Health Information Centers. Funding decisions for resources beyond FY 2019 will be decided in future year budgets.

QUESTIONS SUBMITTED BY HON. THOMAS R. CARPER

Question. I understand that reducing childhood obesity and opioid addiction are two of your top priorities as the Secretary of the Health and Human Services Department. Is that right? Can you discuss your efforts to address these two critical challenges facing our country? What is your strategy for reducing obesity among our youngest children when the budget eliminated \$4 million for the early child care obesity program, which has reduced childhood obesity rates in 10 States?

Answer. Reducing childhood obesity and opioid addiction are critical priorities for HHS, along with addressing serious mental illness.

The FY 2018 President’s budget calls for \$811 million in support of the five-pronged strategy guiding the Department’s efforts to reduce opioid misuse and abuse:

- Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatment;

- Promoting targeted availability and distribution of overdose-reversing drugs;
- Strengthening our understanding of the epidemic through better public health surveillance;
- Providing support for cutting edge research on pain and addiction; and
- Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Community Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total is \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants will help to address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

CDC's activities are focused on equipping States with resources and scientific expertise to address opioid overdose. Some examples of State activities include maximizing the use of prescription drug monitoring programs (PDMPs), linking across sectors including public health, public safety, and treatment, and the analysis of State-level policies to evaluate efficacy and inform strategies that can be scaled up across States. CDC is also working to improve opioid overdose data, by making it more timely and higher quality. The better we understand the opioids problem, the better we can respond to it—on the national, State, and local levels.

With respect to childhood obesity, approximately 12 million children in the United States are obese, putting them at increased risk for serious and costly health and social consequences. A two-pronged approach is needed to: (1) prevent obesity for children by achieving and maintaining a healthy weight, and (2) treat the millions of children struggling with obesity.

Preventing obesity requires addressing a number of specific risk factors including poor nutrition, low levels of physical activity, inadequate sleep, and sedentary behaviors. The National Academies recommend that nutrition and physical activity interventions occur in the places where children spend their time. HHS grantees, therefore, address these risk factors through supporting providers and families in key community settings where children learn, live, and play through data, resources, and training including: community settings, schools, and early care and education settings.

Question. I believe we both share the goal of ensuring that Medicare is an efficient and effective payer and that it derives the greatest value that it can for both patients and taxpayers. I have heard from various parties that outcomes-based contracts can help drive our system from fee-for-service to value-based. However, I understand that there are several regulatory barriers in place, including Medicaid Best Price, that are serving as deterrents to our fully being able to realize the potential of these types of value-based arrangements. Can I count on you and others in the administration to seek to address these regulatory barriers?

Answer. (See response below.)

Question. Today, we stand on the cusp of very exciting developments in biomedical science, including but not limited to cell and gene therapies. However, as we have seen great advances in science, Medicare and Medicaid have lagged in appropriately reimbursing these technologies. What changes to our public payer systems would you suggest to ensure that this innovation continue and that these technologies are both recognized and appropriately reimbursed?

Answer. HHS is committed to achieving the President's goal of eliminating barriers to innovation, whether through regulatory relief or other actions to spur innovation on behalf of patients. The administration has included as part of this budget a set of actions to provide regulatory relief to the industry and speed the development of safe and effective medical products.

Question. I have heard from insurers that the continuous coverage requirement in the American Health Care Act will not be an adequate replacement for the individual mandate. Some of my Republican colleagues have pointed to the auto-enrollment individuals into health insurance plans as another way to ensure that insurers have adequate risk pools to spread risk and restrain premiums. From your perspective, what are the pros and cons of continuous coverage and auto-enrollment?

Answer. The individual mandate has not worked and millions of Americans are not buying into the notion of Washington-controlled health care. In January 2017, the IRS reported that around 6.5 million Americans paid \$3 billion in penalties to the IRS rather than buy unaffordable Obamacare plans in 2015. Americans should have the freedom to make the decisions that are right for them and their families, and should have more choices and access to the health care they want and deserve.

Obamacare is failing the American people, delivering high costs, few options, and broken promises. The administration has supported legislation including the House-passed AHCA that replaced the failing individual mandate with policies that encouraged continuous coverage. The devastating effects of Obamacare go beyond the flawed individual mandate. If we do not act, many more Americans could lose access to care.

The administration is taking steps to increase patient choice and provide greater flexibility for issuers to help attract healthy consumers, with the aim of improving the risk pool and bringing stability to the individual and small group markets. On April 13, 2017, CMS finalized the Market Stabilization rule, which includes policies to ease issuer burden and provide States with greater flexibility.

Question. Last year, 60,000 Americans died from a drug overdose. Drug addictions are now the leading cause of death among Americans under 50. As you have held listening sessions on the opioid epidemic around the country, what are the most important recommendations that Congress and the Federal Government should heed? Last month, Senator Portman and I held a hearing on the opioid and drug addiction crisis ravaging our country. Our second panel included a police chief and a medical examiner from Ohio, a physician from Delaware, and Michael Botticelli, the drug czar in the Obama administration. Every one of them expressed concerns that the AHCA's \$800 billion dollar cut to Medicaid would decimate their efforts to stem the opioid addiction epidemic. How many of the experts and patients that you have heard from have encouraged you to reduce Medicaid coverage or to eliminate private health insurance protections that guarantee coverage for drug addiction treatment? If you have received those types of recommendations, please share those suggestions with me and the other members of this committee in writing.

Answer. The U.S. Department of Health and Human Services (HHS) is keenly aware of the devastating impact that opioid addiction is having on our families and communities. The administration is committed to doing all that we can to end the scourge of opioids that is sweeping across this Nation.

The administration is committed to bringing everything the Federal Government has to bear to address the health crisis opioids pose. The budget calls for \$811 million in support of the five-pronged strategy guiding our Department's efforts to fight this scourge:

1. Improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
2. Targeting availability and distribution of overdose-reversing drugs;
3. Strengthening our understanding of the crisis through better public health surveillance data and reporting;
4. Providing support for cutting edge research on pain and addiction; and
5. Advancing better practices for pain management.

This funding increase will expand grants to Health Resources Services Administration (HRSA) Community Health Centers targeting substance abuse treatment services from \$94 million to \$144 million. Also within this total is \$500 million for State Targeted Response to the Opioid Crisis Grants that were authorized in the 21st Century Cures Act, which expand access to treatment for opioid addiction. Using evidence-based interventions, these grants will help to address the primary barriers preventing individuals from seeking and successfully completing treatment and achieving and sustaining recovery.

One of the key pillars of our approach is improving access to treatment and recovery services, including medication-assisted treatment (MAT) with naltrexone, buprenorphine, or methadone. As mentioned above, through the State Targeted Response to the Opioid Crisis grants authorized in the 21st Century Cures Act, HHS is expanding access to opioid addiction treatment through evidence-based interventions, including MAT. We are targeting the primary barriers to seeking and successfully completing treatment and achieving and sustaining recovery. This funding is critical to reversing the opioid epidemic.

We will continue to explore additional opportunities for States to provide a full continuum of care for people struggling with addiction and develop a more streamlined approach for section 1115 substance abuse treatment demonstrations. We look forward to building upon initial efforts, including previous collaborations, amongst the States.

Question. Our Republican colleagues are working behind closed doors with no public hearings, discussion, or transparency to pass a health-care bill that, according to the Congressional Budget Office, cuts funding to Medicaid by more than \$800 billion over 10 years and requires seniors to endure an 800 percent increase in their health insurance premiums. CBO found that the House Republicans' health-care bill would create unstable health insurance markets in a sixth of the country where sicker Americans would be priced out of insurance coverage. Maternity care and substance abuse treatment would become unaffordable for many lower-income Americans. President Trump has said that his health-care plan will result in "insurance for everybody" with "much better health care . . . at much less money." Can you explain how unaffordable maternity care and substance abuse treatment meets the standard of "much better health care" for "less money"?

Answer. President Trump is committed to signing a bill into law that will provide all Americans access to quality, affordable health-care coverage, and will provide individuals and families tools to choose the coverage that best meets their needs.

Question. You rightly noted when we first met that the cost-sharing reduction payments are the most important issue for health insurers deciding whether to remain on the health insurance marketplaces. Do you think that cost-sharing reduction payments will remain in place through 2018? What have you recommended to President Trump regarding the cost-sharing reduction payments?

Answer. (See response below.)

Question. Does the President understand that his threats to discontinue the cost-sharing reduction payments has forced insurers to exit some insurance marketplaces or increased premiums by as much as 20 percent? What was the President's response to your recommendations?

Answer. The administration has emphasized the importance of reforming our health-care system to one that works better for patients and their providers. Our budget calls for Congress to repeal and replace the Affordable Care Act. In the interim, we are evaluating policy options to relieve American's from Obamacare's burdensome mandates and to restore choice and competition to the individual and small group markets, increasing availability of health insurance options so that all Americans can purchase coverage that meets their needs.

Question. The President has said repeatedly he wants to force Democrats to the table on health-care reform. That's a ridiculous statement. I, and every Democrat I know, have been at the table since before the ACA was passed, getting stood up for the last 8 years. To your knowledge, has the President ever called or spoken to a Democratic member of Congress, on the House or the Senate, about a bipartisan path forward to improve our health-care system? Since your confirmation, how many substantive conversations have you had with a Democrat in Congress about improving the individual health insurance market and Medicaid?

Answer. Obamacare is failing the American people, and it's devastating effects are more apparent every day. The administration is eager to work with Congress—Republicans and Democrats—to rescue Americans from the failures of the Obamacare.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

NATIONAL INSTITUTES OF HEALTH (NIH) TOTAL BUDGET

Question. In your recent testimony before the House Energy and Commerce Committee, you praised the "incredibly important" work of the NIH. As a physician, you can appreciate the value of basic biomedical research leading to the development of novel medications and discovery of new medical procedures, both with the support of NIH funding, which lead to advances in patient outcomes and survival.

On June 6th, President Trump publically announced that he planned to keep Dr. Francis Collins as the director of the NIH. Just last year, Dr. Collins asked for \$33.136 billion for FY17, and in fact, the Presidential budget request for NIH has

not been below the President Trumps FY18 ask of \$26.92 billion since FY 2002. That is almost two decades.

Based on your supportive stance on the NIH and the history of the NIH budget request, can you please explain why you think a 22 percent cut in the NIH budget from FY17 to FY18 is even feasible?

Answer. The FY 2018 budget presents an opportunity for HHS and NIH to reexamine how to optimize Federal investment in a way that best serves the American people. This policy will enhance the stewardship of taxpayer dollars by focusing our resources on innovative scientific research. The Department assessed opportunities within the NIH to determine where greater efficiencies may be possible.

Additionally, the administration will propose a package of reforms to streamline Federal compliance requirements and reduce burden on NIH grantees. These targeted policies will reduce the time and expenses that grantees must currently spend to comply with overly burdensome Federal grant requirements, thus lowering grantees' administrative costs and mitigating the impact of lower reimbursements. The approach will also seek to develop a uniform indirect cost rate to all grants that mitigates the risk for fraud and abuse by simplifying and uniformly applying the rate for grantees.

Question. A cut of this magnitude will greatly impact the United States' seniority and leadership in biomedical and clinical research. I have heard repeatedly from constituents who remind me that research projects are not conducted in just a few months; clinical trials are not completed within one calendar year. The extreme fluctuations in funding levels suggested by this budget will drive American research progress to a halt. But the impact of such a cut goes beyond the research. NIH funding supports nearly 17,000 jobs in Ohio. At a recent House Energy and Commerce hearing, Representative Nita Lowey cited that the proposed NIH cuts would result in up to 8,000 fewer grants awarded, and decimate the economy by eliminating 90,000 jobs at medical institutions across the country.

Do you envision that adoption of the President's budget will have no economic impact?

How do you envision such a dramatic budget cut to the NIH will not yield widespread scientific and economic impacts across this country?

Answer. Thank you for recognizing both the long arc of research and the economic value of NIH investments. The Department supports the administration's agenda of creating a more effective and efficient government and to support economic growth. The FY 2018 budget presents an opportunity for HHS and NIH to reexamine how to optimize Federal investment in a way that best serves the American people. These changes will enhance the stewardship of taxpayer dollars by focusing our resources on innovative scientific research rather than administrative and overhead costs.

INDIRECT COSTS

Question. In your March testimony before the House Energy and Commerce Committee, you commented that the facilities and administration, or indirect costs, covered by NIH grants are "inefficiencies." These "inefficiencies" include essentials like the facilities where research is conducted, utilities that keep freezers and incubators on, and the staff that manage the grants and keep the research enterprise running. Currently, research grants awarded to your former employer, Emory University, put aside approximately 35 percent towards these indirect costs.

One argument I have heard is that many private foundations offer research grants with only 10 percent set aside to cover indirect costs. NIH Director Dr. Collins commented on this in his recent testimony before the House Appropriations Labor, HHS-Education Subcommittee, noting that universities are only able to accept grants with these lower indirect cost rates because of the support they already receive from the NIH. He stated that even NIH grants are not sufficient for covering all indirect costs associated with research projects. Dr. Collins warned that if NIH grants dropped indirect cost rates to 10 percent, many small- to mid-sized universities, especially State schools, would no longer be able to afford NIH-funded research.

If you reduce indirect costs to a cap of 10 percent, how do you expect a medical institution of any size to pick up the slack overnight? Will it be in decreasing the number of staff? Number of medical and graduate students? Number of patients the hospital can take? Increasing tuition?

Answer. The effect on grantees will vary by institution, depending on the current indirect cost rate and a variety of other factors. The impact will likely be greater on institutions that have a higher percentage of NIH funding compared to total funding, or a lower ability to cover indirect costs from other sources (*e.g.*, donations, endowment income, State government, tuition). The Department continues to work on specific details of the NIH indirect cost policy for FY 2018 and will assess the impact on grantees once the policy is finalized.

THE PUBLIC-PRIVATE PARTNERSHIP

Question. Secretary Price, in your nomination hearing QFR responses, you stated that the “NIH plays a leading role in so many public-private initiatives” and that you are “. . . keenly aware of the progress that has been made and still to be made through important research initiatives that are fully or partially funded by the Federal Government.”

I agree that partnerships between academia and the private sector are important, especially for the efficient translation of new research into cures and treatments for patients. I also want to enforce that relying on private funding to cover differences imposed by NIH budget cuts is not a feasible option. In that same House Appropriations Labor, HHS-Education Subcommittee hearing last month, Dr. Collins commented on a recent meeting in the White House, involving biotech CEOs and academic scientists and their descriptions of public-private partnerships. Dr. Collins reflected that the biotech leaders “were quite clear . . . that their stockholders would not necessarily appreciate their putting money into things that are not directly connected to a product.”

What are concrete examples that you can offer to medical schools on how they can “cut corners” when they lose 20+ percent of an NIH grant based on this proposed budget?

How do you expect the United States to maintain its role as a leader in innovation in biomedical research and patient care under these proposed cuts?

Answer. Working with industry is a powerful tool to improving the health of our Nation and our economy. Officials from across the U.S. Department of Health and Human Services (HHS), including leadership of the NIH and FDA, have begun discussions with pharmaceutical companies about developing non-addictive pain medications and new formulations of opioid antidotes. The United States is a leader in biomedical research due, in no small part, to our ability to marshal the strengths of the public and private sectors to address the health-care needs of America. HHS is not currently involved in the budgetary decisions made by medical schools and will continue to defer to medical schools to determine future investment strategies.

Additionally, the FY 2018 President’s budget presents an opportunity for HHS and NIH to reexamine how to optimize Federal investments in a way that best serves the American people. The FY 2018 request changes the reimbursement of indirect costs for NIH grants, which will be capped as a percentage of total research, in order to better target available funding toward high priority research. In addition, Federal research requirements for grantees will be streamlined to reduce grantee burden through targeted approaches as proposed by NIH. HHS is working with NIH to identify strategies to streamline processes and increase efficiencies, including reforming policies to release grantees from the costly and time-consuming indirect rate setting process and reporting requirements. These targeted policies will reduce the time and expenses that grantees must currently spend to comply with overly burdensome Federal grant requirements, thus lowering grantees’ indirect costs and mitigating the impact of lower reimbursements.

LOW-INCOME HEATING ASSISTANCE PROGRAM (LIHEAP)

Question. During your nomination process, I submitted two QFRs about the Low-Income Heating Assistance Program (LIHEAP). I want to share my questions and your answers with you again in light of the new FY18 budget proposal, and then re-phrase my question to you.

As you may know, the LIHEAP program plays a key role in helping low-income families stay warm in the winter and avoid dangerous heat in the summer. It is a program that is critical to nearly 450,000 households in Ohio that otherwise would be forced to choose between keeping warm or going hungry.

If confirmed, will you commit to maintaining the program as currently structured?

Answer. If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible.

Question. Nationwide, nearly 7 million of our Nation's poorest and most vulnerable households rely on the program. Will you commit to maintaining and possibly even supporting an increase in the program's annual appropriation?

Answer. If I am confirmed, I will implement the program dutifully in as effective and efficient manner as possible. Should circumstances on the ground change, and current resources are found to be insufficient, I will inform Congress and work with them on finding solutions.

Question. The President's budget calls for no funding for LIHEAP in FY18. How do you intend to "implement the program dutifully in as effective and efficient manner as possible" without any funding?

Answer. At the time of the confirmation hearing, the administration was in the process of reviewing programs and formulating the administration's budget. LIHEAP has been unable to demonstrate strong performance outcomes. In addition, we reviewed programs and policies of utility companies and State and local governments and found that they provide significant heating and cooling assistance and the majority of States prohibit utilities from discontinuing heating during the winter months. With our limited resources and based on that review, we determined that continued funding of the LIHEAP program is not the best use of taxpayer dollars and have proposed eliminating future funding for this program. However, as long as there continues to be an appropriation of resources for this program, the U.S. Department of Health and Human Services (HHS) will continue to implement the program in as effective and efficient manner as possible.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

Question. Secretary Price, in your testimony you touted HHS's successful history of responding to and protecting Americans from public health emergencies. You talked about your recent trip to Liberia and the incredible work of the Centers for Disease Control and Prevention in the region combatting Ebola. In this increasingly globalized world, serious public health threats are just a plane ride away, as you alluded to in your comments about Ebola.

Given the cuts in the President's budget to public health emergency preparedness and the hospital preparedness program, how will the administration make sure that communities and health systems are prepared to respond to increasingly frequent public health emergencies?

Answer. Public Health Emergency Preparedness: HHS, through the CDC, will continue to support States, cities, and territories through PHEP cooperative agreements. CDC will award PHEP cooperative agreement funds to all current 62 recipients to ensure some level of sustainability and maintenance of public health preparedness and response capacity and capability. The FY 2018 budget proposal achieves program efficiencies by modifying the PHEP funding formula to prioritize funding to areas with greatest risk and by adding a competitive component. The proposed new funding formula is not yet final; however, formula changes will allow PHEP awardees to address capability gaps, identify opportunities, and incentivize innovation. Through PHEP, CDC will continue to provide expertise and support to State and local health departments' efforts to prepare for and respond to more localized emergencies, including those requiring coordinated healthcare and public health responses.

Through increasing efficiencies and streamlining processes, CDC will continue to support critical infrastructure and research to facilitate preventing, and responding to, public health emergencies. Key ongoing activities will include:

- Regulating and monitoring ownership, use, and transfer of dangerous biological agents and toxins;
- Activating CDC's Emergency Operations Center to ensure effective and efficient response operations;
- Developing standard Laboratory Response Network protocols and providing training and quality assurance for testing biological and chemical threat agents;
- Advancing the development of a surveillance system for the timely exchange of syndromic data; and

- Developing and expanding partnerships with other Federal agencies, national organizations, and the private sector to identify opportunities to leverage resources to accomplish common goals.

At the proposed funding level, CDC would be able to replace most expiring Strategic National Stockpile countermeasures in FY 2018. CDC will provide training and exercise support in FY 2018 to sustain State and local capabilities critical to effectively distribute and dispense stockpiled medical countermeasures to ensure access for individuals exposed to public health threats.

In addition to PHEP funding and maintaining the Strategic National Stockpile, CDC will continue to provide rapid epidemiological and laboratory assistance to States during public health emergencies. CDC's unique scientific expertise includes the ability to detect and track a broad range of microbes and respond to disease threats from many different pathogens, including emerging and resistant infections like *Candida Auris*. In FY 2018, CDC will also continue to invest in the Epidemiology and Laboratory Capacity for Infectious Diseases platform, a nationwide cooperative agreement focusing on building the essential epidemiology and laboratory capabilities in all grantees.

Hospital Preparedness Program: The Hospital Preparedness Program (HPP), administered by ASPR, intends to create a lean and effective program in FY 2018 by focusing on those States and jurisdictions with the greatest risk. For health-care preparedness, "risk" will be determined through evidence and science-based tools that consider population, national security issues, and the potential for natural disasters.

Under the Department's proposal, those States and jurisdictions with the greatest risk will be prioritized to receive health-care preparedness and response funding. ASPR strives to assist all jurisdictions with preparing for, responding to, and recovering from emergencies and disasters. When disaster strikes, ASPR provides critical services to protect public health and help communities recover faster. For example, ASPR provides substantive preparedness and response technical assistance to jurisdictions and systems by connecting them with resources and subject matter experts (SMEs) through ASPR's Technical Resources Assistance Center and Information Exchange (TRACIE).

TRACIE provides evidence-based applications, technology, and proven best practices to help States and communities build enhanced capacity and improve their knowledge and effectiveness. TRACIE also provides surge assistance and resources during and after incidents.

With a reduced level of funding, HPP will, through its FY 2018 budget proposal, direct Federal funds to those jurisdictions at greatest risk. Meanwhile, HPP will continue to provide all jurisdictions with technical assistance to inform their preparedness and response efforts.

CDC AND VACCINATIONS

Question. The CDC plays an important role in infectious disease control by releasing guidelines and recommendations for vaccinations, reducing health disparities by ensuring vaccine access to all Americans regardless of insurance status, and conducts research to inform policies and practices involving immunizations. With Minnesota's recent measles outbreak, now totaling more cases in that one State by June than the entire country recorded in all of 2016, it is clear that promoting vaccine education and access is still essential.

Given the deep cut to Immunization and Respiratory Disease in the CDC budget, does the administration support widespread adoption of vaccines as a method of infectious disease prevention?

Answer. Vaccines are one of the greatest success stories in public health and are among the most cost-effective ways to prevent disease. For each dollar invested in the U.S. childhood immunization program, there are over \$10 of societal savings and \$3 in direct medical savings. Childhood immunizations over the past 20 years have prevented 322 million illnesses, 732,000 deaths, and nearly \$1.4 trillion in societal costs.¹¹

¹¹"Benefits from Immunization During the Vaccines for Children Program Era—United States, 1994–2013," Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report*, April 25, 2014/63(16):352–355.

Question. How will the administration ensure people have access to vaccines in light of this financial cut to State and local public health department capacity?

Answer. The discretionary Immunization Program plays a fundamental role in achieving national immunization goals and sustaining high vaccination coverage rates to prevent death and disability from vaccine-preventable diseases. It is the backbone of our Nation's public health immunization system that supports the science that informs our national immunization policy and programs; provides a safety net of vaccines for uninsured, poor adults and use in outbreak response; monitors the safety and effectiveness of vaccines; educates providers and the public about the benefits of vaccines and the diseases they prevent; and conducts surveillance, laboratory testing, and epidemiology to respond to disease outbreaks.

The CDC Immunization Program provides funding to all 50 States, the District of Columbia, 5 major cities and 8 territories. In FY17, Congress appropriated \$607 million for this important program. At the funding level proposed in the FY 2018 President's budget request, CDC will continue to provide vaccines and funding for immunization infrastructure to the 64 awardees at a reduced level. CDC will also continue providing technical assistance and laboratory support to States and local communities responding to vaccine-preventable disease investigations, including outbreaks, at a reduced level.

INDIVIDUAL MARKETPLACE AND THE AFFORDABLE CARE ACT

Question. At your confirmation hearing earlier this year, you repeated to members of this committee over and over again, that every American should have access to health insurance. However, the actions your agency is taking and the proposals in this budget do not live up to that promise.

As you know, earlier this week we learned that Anthem will not be participating in the individual insurance market in Ohio next year. Here's what Anthem said when asked about why they made this decision: "The lack of certainty of funding for cost sharing reduction subsidies, the restoration of taxes on fully insured coverage, and an increasing lack of overall predictability simply does not provide a sustainable path forward to provide affordable plan choices for consumers."

This decision affects more than 66,000 Ohioans, and leaves up to 20 counties in Ohio with no insurer for next year. What's worse, is it leaves more than 10,000 people in my State without ANY access to insurance next year.

You are in charge of the Department of Health and Human Services. Your party is in charge of the House and the Senate and the White House. Your President, who you advise on health-care issues, has the power to help ensure certainty and create a sustainable path forward for insurers in the marketplaces by guaranteeing cost-sharing reduction (CSR) payments, and by pushing regulations that provide consistency and stability as opposed to Executive orders that direct sabotage.

You have the power to fix this and to ensure that the individuals in my State that currently have coverage do not lose it next year.

Why did you let this happen, and what are you going to do to fix it and provide certainty to these Ohio families?

Answer. (See response below.)

Question. What are you going to do to fulfill your promise that the 10,000 Ohioans without any choices next year have access to insurance?

Answer. Obamacare is a disaster, delivering high costs, few options, and broken promises. Americans across the country have seen their health insurance choices disappear and premiums spiral out of control, increasing by double and triple digits. This administration is committed to empowering consumers with providing more choices and access to the health care they want and deserve.

The administration recognizes that States are the primary regulators of health insurance, and it remains imperative for the executive branch to empower States with more flexibility and control. The Department finalized a Market Stability Rule in April, which tightened special enrollment periods, made it more difficult for enrollees to skip premium payments, adjusted the open enrollment period to align with other health-care markets, lifted one-size-fits-all requirements regarding network access, and widened the actuarial value bands within which insurers can offer plans to patients.

Our budget calls for Congress to repeal and replace the Affordable Care Act. In the interim, we are evaluating policy options to relieve Americans from Obama-care's burdensome mandates and to restore choice and competition to the individual and small group markets, increasing availability of health insurance options so that all Americans can purchase coverage that meets their needs.

CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

Question. The Children's Health Insurance Program, or CHIP, is a bipartisan success story. Thanks to the leadership of Senator Hatch and former Senator Kennedy, more than 6 million kids across the country—including approximately 100,000 in Ohio—have access to quality, affordable health care. The program will celebrate its 20th anniversary this August.

Throughout its history, Congress has acted to reauthorize and improve the program several times. Most recently, we extended funding for CHIP for 2 years when we passed MACRA, which passed the Senate by an overwhelming vote of 92–8. Thanks to these efforts, fewer children remain uninsured than ever before.

During your confirmation hearing, I was pleased to hear your enthusiasm for the CHIP program, and I was thrilled when I asked if you would support a 5-year extension of the program and you instead suggested Congress act to extend funding for the program for 8 years.

Much to my disappointment, however, the President's budget only proposes a 2-year extension of the program and compromises the CHIP program by eliminating a provision that helps kids get covered and lowers administrative costs, while cutting support to States. During your recent testimony, you mentioned a meeting with the National Governor's Association. On May 11th, NGA sent a letter to Congress requesting a fast, clean 5-year extension to CHIP. Though you clearly value the Governors' input and have, in the past, spoken out for States' rights, the FY18 budget does not reflect the recommendations of the Nation's Governors regarding CHIP.

If an 8-year extension is better than 5, as you said earlier this year, isn't 8 years also better than the FY18 proposed budget's 2-year extension?

Does the President disagree with your policy recommendation of an 8-year CHIP extension?

Do you agree with his proposal, which could hurt kids and working families, as well as State budgets?

Answer. CHIP funding will expire at the end of FY 2017, and without an extension of funding, children could lose health-care coverage. This proposal would extend CHIP funding for 2 years through FY 2019. The administration remains committed to working with Congress to provide budgetary stability and additional flexibility to States while providing additional help to lower income families.

Question. Despite the recommendations of the National Governors Association and MACPAC, you recommend just a 2-year extension of CHIP in the budget proposal. But you go even beyond that, in making substantial cuts to CHIP and shifting about \$3.5 billion in CHIP costs to States through eliminating the enhanced matching rate. You also propose to repeal the Maintenance of Eligibility requirement that runs through 2019 that requires States to maintain their existing Medicaid and CHIP eligibility levels for children and not make it harder for eligible children to enroll.

Do you think it's a good idea to undermine everything we and the States have accomplished on a strongly bipartisan basis since the enactment of CHIP in 1997?

Answer. This proposal would extend CHIP funding for 2 years to guarantee that the most vulnerable children will continue to have coverage. CHIP has made substantial progress in making health-care coverage available to children, but there is more work to do. Extending CHIP funding for 2 years provides stability to States and families while the future of the program is addressed alongside other health reforms.

Question. The budget proposal ends the 23 percent enhanced matching rate effective almost immediately. This is a significant cut to States, which have planned CHIP implementation based on this matching rate, which was to extend through FY 2019.

Do you expect States to call special sessions for their State legislatures in order to develop an emergency contingency plan if this significant cut is approved and implemented as proposed, by the end of the fiscal year?

Answer. CMS plans to work with States to achieve flexibility in their CHIP programs.

MEDICAID SAVINGS IN CHIP

Question. Your proposed budget assumes over \$16 billion in savings to the Medicaid program through reducing Medicaid payments in a 2 year extension of CHIP. This is a huge cost to States and leaves their hands tied with what services they can offer with a drastically reduced budget.

Can you walk me through the policy proposals you considered to arrive at this level of savings? *Please be specific;* a policy is not just a number, though it is the way that your staff attempted to explain the cuts to Senate health staff at a budget overview briefing in May.

Answer. (See response below.)

Question. The President's budget proposes capping coverage for children on CHIP at 250 percent of the Federal Poverty Level. That's a single mom with two kids trying to support her family on \$50,000 a year. That's a married couple with three kids, working hourly jobs for a combined income of \$70,000 a year.

How will you ensure that these families won't face any higher cost-sharing or any cuts to the benefits that they rely on today if States are given complete control over what they will provide, with no Federal guidance for minimum standards of care?

Answer. (See response below.)

Question. In 2009, the CHIP reauthorization bill included the Express Lane Eligibility tool in order to effectively and efficiently enroll or renew CHIP-eligible children in the program. This tool helps kids get covered while also lowers the administrative cost of running enrollment processes.

Do you not support the effective, cost-saving mechanisms provided through Express Lane Eligibility?

Answer. It is important that every child has access to high-quality health coverage, particularly children in lower income families. This proposal would extend CHIP funding for 2 years to guarantee that the most vulnerable children will continue to have coverage. CMS plans to work with States to achieve flexibility in their CHIP programs, while focusing resources on lower-income families.

The budget proposes a 2-year extension of CHIP through fiscal year 2019, with reforms to rebalance the Federal-State partnership. The score of the CHIP proposal reflects the cost of an extension to the CHIP program (\$13.9 billion). However, because children would move to Medicaid or other Federal programs in the absence of extending CHIP, this proposal results in savings to Medicaid of \$16.7 billion and savings to other Federal programs and accounts of \$3.0 billion. Therefore, this proposal results in net Federal savings over 10 years a result of children remaining on CHIP and not migrating to Medicaid or other Federal programs.

SYRINGE EXCHANGE PROGRAMS OR SYRINGE SERVICES PROGRAMS (SEPS AND SSPS)

Question. You recently conducted a listening tour in States most affected by the opioid epidemic, including a stop in Wilmington, OH. One strategy I did not see you mention in your op-eds following your tour is the use of syringe exchange programs (SEPs) to stop the spread of infectious diseases associated with the opioid epidemic.

I know you conducted a diverse tour geographically and in terms of affected individuals that you met with. Were SEPs discussed as an effective method for decreasing devastating clinical side-effects of opioid abuse?

Answer. Please see answer below.

Question. I asked a few questions of you regarding SEPs following your nomination hearing, and your answers did not convince me that you understood the value of these programs, and would help States most affected by the opioid epidemic to find ways to fund these successful programs. Cuyahoga County in Ohio was awarded a "determination of need" request by CDC in 2016 due to high rates of Hepatitis and HIV resulting from injection drug use. Because of the current limitations on

Federal dollars, the HHS funds going to Cuyahoga County cannot be used to purchase needles or syringes to replace used ones.

You have been the Director of HHS for approximately 4 months now. Your clinical knowledge should allow you to assess SEP program effectiveness without bias. Furthermore, you have the authority to make suggestions to the President and to Congress about effective measures to protect the public health of all Americans, including those with devastating addictions.

Will you urge the President and Congress to consider lifting the funding ban on clean needles and syringes through federally funded SEPs?

Answer. The rising rates of Hepatitis C and other health consequences associated with injection drug use are of great concern. The administration is committed to bringing everything the Federal Government has to bear to address the health crisis opioids pose, and HHS is deploying a comprehensive strategy to address the opioid abuse crisis and opioid-related harms. HHS has identified five specific strategies that we can bring to the fight: improving access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments; targeting availability and distribution of overdose-reversing drugs; strengthening our understanding of the crisis through better public health surveillance; providing support for cutting-edge research on pain and addiction; and advancing better practices for pain management. In recent years, Congress has provided HHS limited authority to support components of syringe exchange programs. HHS looks forward to continuing to work with Congress on this issue and will implement the law as directed.

ADVISORY ROLE OF CABINET MEMBERS

Question. I am frustrated by many of your answers to your nomination QFRs when discussing your role as a Cabinet member. You often commented that you would be an administrator and not a legislator, implying your limited influence on policy changes. However, as a chosen Cabinet member, the President relies on you as a trusted adviser to inform his decisions regarding your areas of expertise; I fully expect that you are indeed serving as a policy adviser and not just waiting in the wings for congressional action.

In developing the FY18 budget, what was your role in informing the President regarding his suggested changes to the HHS budget?

Answer. Anyone who has worked on the President's budget knows it is second only to passing legislation in terms of the compromise, collaboration, and commitment required. Director Mulvaney and the U.S. Department of Health and Human Services (HHS) maintained open lines of communication during the budget process. The President's FY 2018 budget reflects difficult decisions made across the Federal agencies, including at HHS. Implementing this budget is step one in the President's plan to improve our Nation's fiscal stability and HHS supports the President's goals.

Question. During the hearing, I spoke about the huge financial impact that the Medicaid program has on Ohio's ability to fight the opioid epidemic. You have spoken about your recent visit to Ohio, and it seems an unnecessary trip if you are not using that interaction as a way to inform policy changes that the President may suggest. According to the FY18 proposed budget, that "policy change" is a cut of \$618 million from the Medicaid program.

What was your thought process, as an adviser to the President, in arriving at such a drastic cut to the Medicaid program? What is the justification for the cuts, and what are your actual policy suggestions that States can functionally use to absorb these deep cuts and continue to serve their residents?

Answer. The budget provides additional flexibility to States and reforms the fiscal structure of Medicaid, allowing a choice between a per capita cap or a block grant beginning in FY 2020. Rigid and outdated Federal rules and requirements prevent States from prioritizing Federal resources to their most vulnerable populations and from innovating and testing new ideas that will improve access to care and health outcomes. This proposal will free States to advance solutions that best serve their unique populations—for example, encouraging work, promoting personal responsibility, and meeting the spectrum of diverse needs of their Medicaid populations. States, as administrators of the program, are in the best position to assess the unique needs of their populations. The administration is determined to work with Congress to put in place a plan to give States the flexibility they need to achieve better health outcomes for patients while putting Medicaid on a more sustainable fiscal trajectory.

TOBACCO CESSATION

Question. In the QFRs for your nomination, I asked a few questions about tobacco cessation programs and services. In one answer, you noted that the “availability of cessation programs is important.” I agree, as tobacco is the number one cause of preventable deaths in the United States and sees exceptionally high use in Ohio.

The President’s FY18 budget eliminates the CDC’s Office on Smoking and Health, which plays an important role in tobacco use reduction through a variety of cessation campaigns and programs, as well as research initiatives to develop innovative ways to curb tobacco use in the country. The proposed block grant does not sufficiently replace a proven program.

How do you justify the elimination of funding for a program with proven success against the number one cause of preventable death in the United States?

Answer. The President’s FY 2018 budget does not eliminate funding for tobacco control. Instead, it frees CDC and the States to address tobacco use within a holistic chronic disease prevention portfolio and funding structure.

Question. Do you disagree that tobacco cessation programs should be available in every State through a Federal program with funding dedicated to assistance for those fighting tobacco addiction?

Answer. Seven in 10 adult smokers want to quit, and quitting smoking is beneficial at any age. Efforts that combine media campaigns, quitlines, barrier-free tobacco cessation treatments, and environmental and policy approaches are most effective. This includes (1) high-impact tobacco education campaigns such as CDC’s Tips From Former Smokers, which has helped an estimated half a million Americans quit for good; (2) State tobacco quitlines, which have broad reach and are effective with diverse populations; (3) counseling and FDA-approved cessation medications, which are effective for treating tobacco dependence, especially when used together; and (4) smoke-free indoor environments that reduce tobacco consumption and support quitting.

The proposed block grant would allow every State to dedicate Federal funding to tobacco cessation efforts, which are important for preventing and reducing tobacco-related death and disease.

DOMESTIC TUBERCULOSIS (TB)

Question. The proposed HHS Budget in Brief, the description for HIV/AIDS, Viral Hepatitis, STIs and TB Prevention funding only mentions suggested changes for HIV programs, but funds for domestic TB programs through the CDC is decreased by \$11.986 million. TB is the number one infectious disease killer in the world, and increasing globalization threatens to continue the spread of new TB infections in the United States. There is still much work to be done into research for new treatments, especially for multi-drug-resistant TB, as well as better preventive measures including surveillance and other public health methods.

TB is far from eradication, and funding that goes towards better treatments for existing infections and methods to prevent new infections is greatly needed. How do you justify cutting the CDC budget for domestic TB by 10 percent?

Answer. The FY 2018 President’s budget request describes that CDC will continue to focus efforts on maintaining TB control within the United States. CDC will also continue to support States to conduct TB surveillance and contact tracing, focusing on States with the highest prevalence of TB.

Preliminary 2016 TB surveillance data indicate a 2.7 percent decline in reported cases and a 3.4 percent decline in case rate per 100,000 from 2015. Although declines have occurred, progress has stalled, with TB rates remaining at levels 29 times higher than the Nation’s goal of eliminating this disease in the foreseeable future.

CDC has made advances in developing a new short-course therapy for latent TB infection (LTBI) which will provide opportunities to improve efficiency. Randomized controlled trials led by CDC have shown that a new combination regimen of isoniazid and rifapentine administered weekly for 12 weeks is as effective for preventing TB as other regimens and is more likely to be completed than the previous U.S. standard regimen of 9 months of INH daily. Preventing TB by treating LTBI is a cornerstone of the U.S. strategy for TB elimination, so this new regimen offers many advantages.

Over the last 20 years, TB control efforts have prevented as many as 300,000 TB cases across the U.S., averting over \$6 billion in costs.¹² Eliminating TB will require both strengthening systems to diagnose and treat active TB disease and intensifying efforts to identify and treat latent TB infection (LTBI) among Americans infected with TB bacteria who are not yet sick. CDC estimates that up to 13 million Americans have LTBI, which develops in some people exposed to an active case of TB disease; about 5–10 percent of them will develop TB disease later in life without treatment.

CDC STAFFING

Question. In your response to my nominations hearing QFR question about domestic tuberculosis, you commented that you look forward to working with the CDC on combating this disease. I want to remind you of a letter my colleagues and I sent to you last week, highlighting the vacancies of nearly 700 positions at the CDC.

The CDC is a vital agency for protecting the public health of all Americans, including through the prevention of the spread of TB. How do you envision the CDC can continue its programs to combat diverse public health issues by decreasing the budget by 17 percent and allowing the continuation of extensive vacancies?

Answer. The FY 2018 budget request includes a number of programmatic reductions and eliminations, while maintaining key priorities that will allow CDC to advance its core public health mission.

Question. Is it your plan to continue the hiring freeze and continue to stifle the important work of the CDC?

Answer. HHS continues to follow guidance provided by the Office of Management and Budget (OMB) relating to its April Memorandum, Comprehensive Plan for Reforming the Federal Government and Reducing the Federal Civilian Workforce, to ensure efficient and effective delivery of services while continuing its critical health and safety responsibilities.

REFUGEE PROGRAMS

Question. Several Ohio refugee resettlement agencies have had to close their doors or lay off staff as a result of the President's Executive order targeting refugees. The President has also proposed drastic cuts to HHS's refugee assistance programs in the FY18 budget.

In what ways is HHS continuing to support resettlement organizations in light of the President's executive actions and proposed 30 percent budget cut to HHS Refugee Programs?

Answer. HHS continues to support the resettlement of refugees through funding in significant program areas. We continue to issue grant funding to States and non-profit agencies that provide health coverage, cash assistance, medical screenings, and employment services to refugees and other eligible populations. Through grants administered by participating States, we also provide specialized foster care for refugees and other populations of youth, as authorized by law. The proposed cuts to these benefits and services in the President's budget are partially a result of the decrease in projected arrivals.

Additionally, we continue to provide funding to ethnic community-based organizations, non-profit agencies, and resettlement agencies for additional specialized programs, such as services for survivors of torture.

When changes in the program affect our partners, we communicate through Dear Colleague Letters, such as the letter announcing the change in the Cuban and Haitian social services set-aside program, and through in-person meetings and phone calls.

Question. How will you ensure refugee resettlement remains a priority at the Department?

Answer. HHS is increasing efforts to engage receiving communities, and we are working to improve the program. Successful resettlement requires positive collaboration between refugees and receiving communities in multiple environments, in-

¹² Castro, K.G., Marks, S.M., Chen, M.P., Hill, A.N., Becerra, J.E., Miramontes, R., Winston, C.A., Navin, T.R., Pratt, R.H., Young, K.H., and LoBue, P.A., "Estimating tuberculosis cases and their economic costs averted in the United States over the past two decades." *International Journal of Tuberculosis and Lung Disease*. 2016; 20(7):926–933.

cluding workplaces, schools, neighborhoods, and places of worship. We work to facilitate and enhance this collaboration, particularly within the private sector. As part of this community outreach, the Director of the Office of Refugee Resettlement (ORR) visited several agencies that serve refugees in northern California in May, and has visited resettlement agencies in Charlottesville, VA, and Boston, MA, in July.

The ORR Director and staff will continue to participate in meetings with government representatives and NGO participants, like the United Nations' Annual Tripartite Consultations on Resettlement, which the ORR Director attended in June.

PRESCRIPTION DRUG PRICES

Question. President Trump has been outspoken both as a nominee and in his current role about the high costs of prescription drugs, yet there is no indication of this being a priority through the notable absence of funds to address the issue in the proposed FY18 budget. In your budget hearing, you stated that the President has charged your department with developing policy suggestions to combat this issue, and that you have begun holding roundtable discussions with certain stakeholders. You also mentioned that you would like to engage with others interested in lowering drug prices; I am interested in doing so, and have already worked with Senate colleagues to introduce multiple bills this year to combat this issue.

Is there a reason that prescription drug costs did not make it into the President's FY18 proposed budget?

Please share with me the stakeholders who you are including in your discussions to work on this issue, and a timeline of your plan to share your policy suggestions with the President and Members of Congress.

Answer. High drug prices and costs are an issue of major concern for HHS and for the American people. This includes the millions of seniors who rely on Medicare for their drug coverage, and the taxpayers who have to foot the bill for government spending on this program. As you know, the President has made prescription drug prices an absolute priority and has charged the U.S. Department of Health and Human Services (HHS) with making recommendations to his office on reducing drug prices. HHS has been meeting with stakeholder groups from across the health-care spectrum over the past several months in order to understand where there are areas of consensus.

It is important that we move forward quickly, but also carefully, so that our policies do not have unintended consequences. We need to balance the goal of ensuring affordability and access with the mandate to continue supporting development of lifesaving innovations.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR. AND HON. ROB PORTMAN

COMPLEX REHAB

Question. Complex Rehab wheelchairs and accessories are used by a small population of people with high levels of disabilities such as ALS, cerebral palsy, multiple sclerosis, muscular dystrophy, spinal cord injury and traumatic brain injury. For this reason, Congress exempted Complex Rehab Technology from the competitive bidding program established in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008.

Unfortunately, in 2014 CMS announced it intended to apply Medicare competitive bidding program pricing to Complex Rehab wheelchair accessories effective January 1, 2016. We expressed our concern to CMS at the time but the agency chose to move forward. Congress has delayed these reductions through legislation twice; however, the cuts are scheduled to take effect July 1, 2017.

Mr. Secretary, we remain concerned with CMS's interpretation of the competitive bidding program which will reduce access to CRT accessories when provided on complex rehab wheelchairs for people with disabilities. We urge you to use your administrative authority to stop these cuts prior to June 30 and ask what plans you have to provide assistance in this area.

Answer. CMS is committed to providing beneficiaries with access to the services and medical devices they need. On June 23, 2017, CMS issued a new policy on how adjustments to the fee schedule based on information from competitive bidding programs apply to wheelchair accessories and back and seat cushions used with group

3 complex rehabilitative power wheelchairs. As a result, retroactive to July 1, 2017, payment for these items are based on the standard unadjusted fee schedule amounts through December 31, 2018. By continuing these higher payments, this new action will help to protect access to complex rehabilitative power wheelchair accessories on which people with significant disabilities depend.

AGING

Question. Secretary Price, on February 24th, after having traveled across Pennsylvania, I sent you a letter regarding administration proposals that threaten the financial and health security of older Americans and their families, questions that you failed to answer during the confirmation process. On April 4th, I sent you a letter regarding the administration's efforts to undermine the Affordable Care Act through executive action. In that letter, I requested you provide a letter reportedly presented to House Republicans from President Trump outlining the ACA regulations the administration could repeal on its own. On May 8th, I sent you, Treasury Secretary Mnuchin, and OMB Director Mulvaney a letter regarding the administration's efforts to sabotage the ACA. That letter called on the administration to commit to making cost-sharing reduction payments and requested documents and communications. You have not responded to any of these letters.

Do you commit to providing responses to each of these letters in writing as well as producing the documents requested in the letters?

Answer. I have provided responses to all of the letters listed above.

COST-SHARING REDUCTIONS

Question. Secretary Price, you and other members of this administration have repeatedly stated that the ACA marketplaces are failing, yet Pennsylvania's Insurance Commissioner Teresa Miller recently announced aggregate rates for the 2018 plan year, and these increases were in the single digits. Her statement also noted that if the administration eliminated cost-sharing reduction payments, premiums would increase by over 20 percent. She further noted that if Republicans repealed the individual mandate, premiums would increase by over 23 percent. If both of those changes happened, premiums would go up over 36 percent. On May 8th, I, along with Ranking Member Wyden and 11 other Senators, sent you a letter calling on the administration to halt its efforts to undermine the Affordable Care Act and permanently commit to continuing to make cost-sharing reduction payments. The administration has failed to do so. It's clear that Pennsylvania's market would be on path to stability if the administration and Republicans would just stop their sabotage of the ACA. Health insurers, medical providers, and business leaders have all said that continuing cost-sharing reduction payments is key to the success of the health insurance marketplaces and is the "most critical action" the administration could take regarding the ACA.

Will you commit today to permanently funding cost-sharing reductions payments?

Answer. The administration has emphasized the importance of reforming our health-care system to one that works better for patients and their providers. Our budget calls for Congress to repeal and replace the Affordable Care Act. In the interim, we are evaluating policy options to relieve American's from Obamacare's burdensome mandates and to restore choice and competition to the individual and small group markets, increasing availability of health insurance options so that all Americans can purchase coverage that meets their needs.

 QUESTIONS SUBMITTED BY HON. CLAIRE MCCASKILL

Question. On February 17, 2017, I sent a letter to Acting Commissioner Stephen Ostroff asking a number of question regarding the Food and Drug Administration's role in overseeing the dietary supplement industry. To date I have not received a reply. Please provide the date on which I will receive a complete response, including all documents and other requested materials.

Answer. HHS, and all of our component agencies, are committed to providing meaningful responses to correspondence from Members of Congress. FDA is working to provide you with a complete response and they will keep you updated on their progress.

Question. The administration's budget cuts funding for rural health outreach funding. In Missouri, this funding has been used to expand access to services. Will

these cuts result in reduced access to care, if enacted? If not, what steps will the administration take to preserve the expanded access to services?

Answer. The FY 2018 President's budget provides \$51 million to target funding for the Rural Health Network and Quality Improvement Grants Outreach. These investments will support the existing awards and fund new awards to improve access to quality healthcare services in rural and underserved areas.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

This administration, from day one, has preferred "alternative facts" and convenient spin to the truth. One of the most recent examples was its budget proposal, which double-counted \$2 trillion to maintain some whiff of fiscal responsibility while it slashed health programs and protections for basic living standards.

The budget math is fake, but the extreme agenda that would deprive millions of Americans of access to health care and wipe out living standards is not.

Unfortunately, this morning I have to split time between the Finance Committee and the Intelligence Committee, so I'll keep my remarks brief. But there are a few issues in the President's budget and the administration's agenda I'd like to address.

First is Medicaid. Secretary Price is the captain of the President's health-care team. He's been the top advocate for Trumpcare, a bill that cuts Medicaid by \$834 billion to pay for massive tax breaks for the wealthy.

Fourteen million Americans would lose coverage, and millions more would see caps on their care. As if that wasn't enough of a cut, the budget proposal that came out a few weeks ago goes even further, slashing hundreds of billions more from Medicaid. In a program that covers nearly half of all births, 37 million kids, millions of working families and people with disabilities and two out of three nursing home beds in America, that would be an enormous blow to people across the generations.

These facts and figures have been met by a wave of the hand from Secretary Price. When asked if his proposed cuts would result in millions of Americans losing access to Medicaid, he responded, "Absolutely not." He went further, claiming "there are no cuts to the Medicaid program," and he also said, "nobody will be worse off financially." I've heard Secretary Price and others make the baffling argument that people are actually worse off on Medicaid—that their health doesn't improve as a result of gaining coverage. Often this argument is based on a brief, old study performed in my home State.

Here's the bottom line on Medicaid. Seventy-four million Americans rely on this program for health coverage—parents with sick kids, people with disabilities, seniors in nursing homes who have nobody to turn to for help if their benefits disappear, and thousands of Oregonians who are healthier under my home State's model. It would be a tough sell to convince those people that they're worse off being enrolled in Medicaid, or that the program needs more than a trillion dollars in cuts.

And public opinion is clear: two out of three enrollees are happy with the program. Seven out of 10 Americans say Congress should leave it as is—no block grants, no per-capita caps.

Fortunately, the budget proposal hit the wall here in Congress and there's a lot of debate left to be had on Trumpcare. But right now, the administration is causing turmoil in insurance markets, and it's already having disastrous effects for millions of families. The President issued a day-one Executive order undermining the Affordable Care Act. And nobody on the Trump team can give a straight answer about whether the administration will continue making cost-sharing reduction payments that are key to making insurance affordable for working families. And because of that sabotage, insurers are pulling out of markets, and people are left without plans to choose from.

You don't have to take my word for it. The insurers are quite clear about why they're making these decisions.

Furthermore, on the campaign trail, the President said he wouldn't cut Medicare. But the Trumpcare bill shrinks the life of the program, and the budget proposal extends the mandatory cuts under the sequester by more than \$30 billion. The Food and Drug Administration, the Centers for Disease Control and the National Institutes of Health—all slashed in the budget. The same is true in programs aimed at

basic living standards—programs that fund Meals on Wheels, child care, and foster care.

This is the budget you write if you think seniors and working families have it too easy.

I want to thank Secretary Price for joining the committee today. This is never any easy appointment for a Cabinet Secretary, and I'm sure there will be some rigorous debate this morning. As I mentioned, I'm double-booked with the Intelligence Committee, so I want to thank Senator Stabenow for generously offering her time to fill in for me today. Thank you, Chairman Hatch.

COMMUNICATIONS

AMERICAN ACADEMY OF FAMILY PHYSICIANS (AAFP)

AAFP Headquarters
11400 Tomahawk Creek Parkway
Leawood, KS 66211-2680
800-274-2237 • 913-906-6000
fp@aafp.org

AAFP Washington Office
1133 Connecticut Avenue, NW, Suite 1100
Washington, DC 20036-1011
202-232-9033 • Fax: 202-232-9044
capitol@aafp.org

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, thank you for the opportunity to submit a statement for the record to the Committee on Finance regarding the Trump Administration's Fiscal Year 2018 Budget Request.

On the whole, the AAFP is deeply troubled by the Administration's FY 2018 budget, and its implications for patient health, safety, and access to care. The AAFP believes that if implemented, the spending reductions and policy changes requested in the budget would create a domino effect of damage that ultimately will harm the health of America on both an individual and community-wide basis. Below, the AAFP sets forth its principal concerns with the budget, as well as qualified support for selected policies.

1. The Committee Should Reject the Administration's Position on Repeal and Replace of the Affordable Care Act

The AAFP supports health care coverage for all, consistent with the public-health mission of the specialty of family medicine. The AAFP promotes this in the form of "a primary care benefit design featuring the patient-centered medical home, and a payment system to support it," for everyone in the United States.¹ AAFP believes that all Americans should have access to primary-care services without patient cost sharing. This primary care benefit is especially important today in high-deductible health plans. The AAFP believes that universal health care also should include services outside the medical home (*e.g.*, hospitalizations) with reasonable and appropriate cost sharing allowed, but with protections from financial hardship. Supporting access to primary care is also consistent with the "triple aim" of improving patient experience, improving population health, and lowering the total cost of health care in the United States. Research supports the AAFP's view that having both health insurance and a usual source of care (*e.g.*, through an ongoing relationship with a family physician) contributes to better health outcomes, reduced disparities along socioeconomic lines, and reduced costs.²

The AAFP applauded the passage of the Affordable Care Act (ACA) in 2010 as an incomplete yet important step toward the goal of universal coverage. While the AAFP does not oppose repeal and replacement of the Affordable Care Act *per se*, the AAFP has clearly articulated to Congressional leaders its grave concerns with any approach to replacing the ACA that would increase the number of uninsured, degrade the health-care safety net, or eliminate important patient protections in the health-insurance marketplace. After the Congressional Budget Office (CBO) issued its report dated March 13, 2017, projecting that H.R. 1628 (the American Health

¹AAFP, "Health Care for All" (2014), available at <http://www.aafp.org/about/policies/all/health-care-for-all.html>.

²See, *e.g.*, The Robert Graham Center, "The Importance of Having Health Insurance and a Usual Source of Care," *Am. Fam. Physician* (September 15, 2004), available at <http://www.aafp.org/afp/2004/0915/p1035.html>.

Care Act or AHCA) would “increase the number of uninsured people relative to the number under current law . . . to 24 million in 2026,” the AAFP expressed to House leaders its formal opposition to that bill—based in large part on this projection about insurance coverage. The AAFP subsequently expressed “deep disappointment” when the House passed the current version of the AHCA on May 3rd (a later CBO report dated May 24, 2017 projected that under the modified version of the AHCA, the number of uninsured would increase to 23 million, 9 million of whom would have been insured through employer-based or private non-group coverage).

Although the Administration has never precisely articulated its vision for repealing and replacing the ACA, it states in this FY 2018 budget that it “continues to support a repeal and replace approach” to the Affordable Care Act (*see* Budget in Brief at 2) that broadly tracks the AHCA framework of tax credits, expanded health savings accounts, high-risk pools, and changes to Medicaid financing. The Administration proposal “eliminates Obamacare’s onerous taxes and mandates, provides funding for states to stabilize markets and ensure a smooth transition away from Obamacare, and helps Americans purchase the coverage they want through the use of tax credits and expanded Health Savings Accounts,” all of which matches the AHCA. (*Id.*) The Administration has also indicated (through a Statement of Administration Policy dated March 22, as well as a public event held in the White House Rose Garden on May 3rd) that it “strongly supports” the AHCA—both the version approved by the House Budget Committee and the version that the House passed on May 3rd.

Although the Administration has not made its own projection about coverage losses under its repeal-and-replace proposal, it is clear that the Administration’s proposal is equivalent to the AHCA, and thus gives rise to the same concerns about loss of insurance coverage. The AAFP urges this Committee to reject the Trump Administration’s vision for repeal and replace, and instead adopt reforms that extend affordable insurance to more Americans, strengthen the health-care safety net, and lower the overall cost of health care by investing in a stronger primary-care foundation.

2. The Committee Should Reject the Administration’s Proposals to Cap Medicaid Financing

The AAFP and its members are committed to ensuring that all individuals, regardless of their socio-economic status, have access to health care coverage. This commitment is focused on individuals and families who do not have access to employer-based health insurance and/or are economically unable to secure health care coverage through the individual market. Our commitment to low-income individuals and families is reflected in family physicians’ participation in the Medicaid program. More than two-thirds (68%) of AAFP’s members accept new Medicaid patients into their practices. Participation in Medicaid by family physicians is at its highest level since the AAFP began monitoring the issue in 2004.

The Administration’s budget proposal “reforms Medicaid funding to States starting in FY 2020 through either a per capita cap or a block grant” (*see* Budget in Brief at 3). The Administration projects that these changes will reduce federal Medicaid spending by \$610 billion over 10 years. Amazingly, the budget also contemplates “additional savings to Medicaid as a result of the Administration’s plan to repeal and replace Obamacare with solutions that focus Medicaid on the most vulnerable Americans—the elderly people, with disabilities, children, and pregnant women—those Medicaid was intended to serve” (*see* Budget in Brief at 61). Office of Management and Budget (OMB) Director Mick Mulvaney confirmed³ that the Medicaid reductions in the budget proposal are to be added to those found in the AHCA (\$834 billion per the CBO report dated May 24, 2017), yielding a potential total of more than \$1.4 trillion in federal funds removed from Medicaid over 10 years. This strongly suggests that the CBO’s estimate that 14 million Medicaid beneficiaries would lose their health coverage by 2026 is a floor, not a ceiling. President Trump’s proposal would likely significantly reduce support to states, causing even more low-income Americans to lose Medicaid coverage—an unacceptable result to America’s family physicians.

³*See* White House, off-camera briefing of the FY18 budget by Office of Management and Budget Director Mick Mulvaney (May 22, 2017): “We assume the Affordable Health Care Act that passed out of the House passes. That has some Medicaid changes into it. We wrap that into our budget proposals. We go another half a step further and ratchet down some of the growth rates that are assumed in the AHCA. So if you assume growth rates—I can’t remember what the exact measure is—it’s a CPI-plus measure. We take a measure that we think is closer to what the actual growth rates look like.”

The AAFP has consistently stated opposition to the means by which the Administration achieves its budgetary goals in Medicaid (by shifting costs onto states, localities, providers, and patients). Rather, the AAFP supports maintaining the current financing structure of Medicaid: the federal medical assistance percentage (FMAP) system. Capping federal financial participation in Medicaid by definition shifts risk of medical loss to states, localities, and ultimately to patients themselves. Eventually, under the fixed federal contributions with the growth rate set forth in the AHCA, states will be unable to fill funding shortfalls, and will be forced to reduce payments to providers and managed-care organizations (MCOs). Many more providers will drop out of Medicaid, and many MCOs will shrink their provider networks, providing still fewer choices for Medicaid patients, and rendering states unable to fulfill the equal-access mandate of the Medicaid program. As federal contributions cover less and less of the total cost of care over time, some state Medicaid programs may ultimately create waiting lists for patients, and other forms of rationing for non-emergent services. And of course, for the 14 million or more who will lose coverage altogether, they will have no access to care at all save for charity and uncompensated care. The AAFP strenuously opposes such a fundamental undermining of the Medicaid entitlement and the damage that it would do to Americans' public health.

3. Congress Should Provide Long-Term Support for the Teaching Health Center Graduate Medical Education Program

The budget proposal “maintains funding for the Teaching Health Center Graduate Medical Education Program and requests \$60 million in new mandatory funding in both FY 2018 and FY 2019” (see Budget in Brief at 22). The AAFP commends the Administration for its recognition of the importance of the THCGME program, which will expire on September 30, 2017, absent Congressional intervention.

The THCGME currently provides training for 742 medical and dental residents. Residents in the THCGME program train exclusively in primary-care medical specialties and dentistry—two thirds of whom are training in family medicine and pediatrics.⁴ Residents in the program train in community health centers (including federally qualified health centers), and tend to be concentrated in rural and other underserved areas that need access to more providers, particularly primary-care physicians.

THCGME, which funded its first class of residents in 2011, is already achieving Congress's intent to get more doctors practicing in rural and underserved areas. The most effective way to get family and other primary-care physicians into rural and underserved areas is to train them in these underserved areas. American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location.⁵ By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas.⁶

The AAFP stresses to Congress that the Administration's proposal to fund the program at \$60 million per year is not enough to continue financing the program at its current size. The Health Resources and Services Administration (HRSA) has completed a study documenting that “the median overall cost of training a resident in a THC in FY 2017 is estimated to be \$157,602.”⁷ Therefore, the annual cost to maintain the current size of the THCGME program is at least \$117 million per year. The AAFP views this as the bare minimum that the program should receive in order to prevent reductions in existing levels of primary-care training. However, given that Congress devotes some \$15 billion per year to training residents, Congress could fund the THCGME program at \$150 million per year and still account for only one percent of the overall spending on GME. The AAFP urges Congress in

⁴Health Resources and Services Administration, “Teaching Health Center Graduate Medical Education Program, Academic Year 2014–2015,” available at <https://bhwa.hrsa.gov/sites/default/files/bhw/nchwa/teaching-health-center-graduate-highlights.pdf>.

⁵E. Blake Fagan, M.D., et al., “Family Medicine Graduate Proximity to Their Site of Training,” *Family Medicine*, Vol. 47, No. 2, at 126 (February 2015).

⁶Candice Chen, M.D., MPH, et al., “Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions,” *Academic Medicine*, Vol. 88, No. 9, p. 1269 (September 2013).

⁷Health Resources and Services Administration, “Cost Estimates for Training Residents in a Teaching Health Center,” available at <https://bhwa.hrsa.gov/sites/default/files/bhw/grants/thc-costing-fact-sheet.pdf>.

the strongest possible terms to dramatically expand and make permanent this highly successful and bipartisan GME program.

4. The Committee Should Swiftly Approve a “Clean” Long-Term Extension of CHIP Funding

The AAFP urges the Committee to swiftly approve a bipartisan long-term extension of CHIP, in order to promote stability and health security for 8.9 million low-income children⁸ and their families. Time is of the essence in completing this work in order to ensure continuous access to primary and preventive services for this vulnerable population, protect progress in public health and allow States to adequately plan. Although the Administration’s budget “proposes to extend funding for CHIP for two additional years through FY 2019” (see Budget in Brief at 66), the AAFP believes that Secretary Price articulated a better position during his January 24th confirmation hearing in this Committee when he suggested that an 8-year extension would be preferable.⁹

The AAFP has supported CHIP since its inception in 1997, and during each subsequent reauthorization and extension of funding (2007, 2009, and 2015), as a way to extend health coverage to uninsured children whose families do not meet eligibility requirements for Medicaid. Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AAFP has reiterated support for CHIP funding beyond the current end-date of September 30, 2017—through letters to this Committee and to Congressional Leadership. Although the AAFP does not collect member survey data on CHIP participation, we know (due to the close connection between Medicaid and CHIP—including the fact that some states operate combined Medicaid/CHIP programs—and the fact that family physicians perform so many pediatric services) that family physicians are helping to carry out Congress’s intent behind CHIP: treating low-income children, many of whom would be uninsured without the program.

Family physicians play an important role in addressing the health needs of American children. According to the AAFP’s latest member census, published December 31, 2016, over 80 percent of AAFP members care for adolescents, and 73 percent care for infants and children.¹⁰ Other AAFP member survey data reflect that about 20 percent of AAFP’s members deliver babies as part of their practice, with roughly 6 percent delivering more than 30 babies in a recent calendar year.¹¹ Of AAFP active members with full hospital privileges, 70 percent provide newborn care in the hospital, and 64 percent provide pediatric care in the hospital.¹² This is consistent with family medicine’s traditional role of practicing in the entire scope of the physician license, in order to meet the needs of the community in which the family physician practices. A family physician who serves a small rural community without a pediatrician, for example, will often perform most or all pediatric care for that community.

The AAFP urges the Committee to pass a “clean” extension of CHIP with a minimum of unnecessary policy changes. Accordingly, the Committee should extend the current enhanced federal medical assistance percentage (FMAP), as well as the current maintenance of effort (MOE) provisions, which are both in effect through September 30, 2019, in order to align with an extension of CHIP funding. For example, if Congress extends CHIP funding for 8 years, then it should extend the enhanced FMAP and MOE provisions for 6 years. The Administration proposal does quite the opposite—it “ends the 23 percentage point increase in the enhanced Federal match rate and the current law maintenance of effort requirement after FY 2017” (see Budget in Brief at 66), which would terminate these important policies this year—two years earlier than Congress had envisioned. The AAFP opposes scaling back what our current bipartisan commitments to the nation’s most vulnerable children.

5. The AAFP Welcomes Efforts to Expand Direct Primary Care in Medicaid

The Administration proposes to “expand Medicaid Direct Primary Care (DPC), which provides an enhanced focus on direct physician patient relationships through

⁸ Centers for Medicare and Medicaid Services, *2016 Enrollment Report*, available at <https://www.medicare.gov/chip/downloads/fy-2016-childrens-enrollment-report.pdf>.

⁹ During his testimony, then-Representative Price stated about CHIP (in response to Senator Brown): “Well, if we could extend it for 8 [years] it would probably be better than 5 [years].”

¹⁰ AAFP Member Census (December 31, 2016), available at <http://www.aafp.org/about/the-aafp/family-medicine-facts/table-13.html>.

¹¹ AAFP, *2015 Practice Profile Survey* (July 15, 2016).

¹² *Id.*

enrolling Medicaid patients in DPC practices. These practices enhance physicians' focus on patient care by simplifying health care payments for patients and physicians" (*see* Budget in Brief at 62). The AAFP supports the physician and patient choice to, respectively, provide and receive health care in any ethical health care delivery system model, including the DPC practice setting.

Payments in all primary-care models should be appropriate to ensure an adequate supply of participating family and other primary-care physicians. Just as the fee-for-service payments in Medicaid should be at least at Medicare levels, periodic payments in Medicaid DPC should be comparable to payment levels from other third-party payers such as employers and Medicare Advantage plans, in order to allow family physicians to appropriately serve this patient population in this unique model.

6. The Committee Should Work to Ensure That CMS is Adequately Funded in Order to Implement the Many Programs Under the Committee's Jurisdiction

The Administration proposes to reduce CMS program management by \$379 million in FY 2018—a 13-percent reduction in the agency's FY 2017 budget (*see* Budget in Brief at 71). Given that CMS is responsible for the administration of Medicare, Medicaid, CHIP, and the Affordable Care Act federal marketplaces, as well as over one trillion dollars in corresponding annual payments, the AAFP advises the Committee to work with the Appropriators to resist such a large and unwarranted reduction to the CMS operating budget in FY 2018. The vast majority of AAFP members participate in one or more of Medicare, Medicaid, and CHIP, and the millions of newly insured under the ACA have looked to America's family physicians for primary care—many for the first time in their lives. Accordingly, ensuring the smooth functioning of CMS is critical to the ability of so many Americans—the elderly, the low-income, those insured in the marketplaces, and others—to receive high-quality primary care.

Moreover, the AAFP continues to invest significant resources preparing its members for the Medicare Quality Payment Program (OPP), established in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and launched on January 1, 2017. AAFP members are now reorienting their practices to prepare to report quality and other measures to CMS through the Merit-Based Incentive Payment System (MIPS) or one of the advanced alternative payment models (A-APMs) such as the Comprehensive Primary Care Plus (CPC+) model, rolled out earlier this year by the Centers for Medicare and Medicaid Innovation (CMMI). The AAFP has also submitted an original primary-care advanced payment model proposal to the Physician-Focused Payment Model Technical Advisory Committee (PTAC)—an expert panel established in MACRA to help review and approve new models for use under the OPP. These efforts to make the OPP a success will be compromised unless CMS receives adequate funding to implement them. The FY 2017 funding level of \$2.82 billion already represents less than one-half of one percent of the \$1 trillion in program payments flowing through the agency this year; the AAFP fails to apprehend the rationale for such a steep cut to program management in FY 2018 when it accounts for such a tiny fraction of the agency's overall budget.

The AAFP commends the administration for its statement that it wants to “work to reduce provider burden [under the OPP] while providing incentives for providing high quality care” (*see* Budget in Brief at 53). However, in the AAFP's experience, depriving CMS of resources to implement the QPP and other programs is not conducive to implementing bold initiatives like regulatory reform. Accordingly the AAFP urges Congress to reject a draconian cut to CMS program management.

7. Title X Funding

The Administration's FY 2018 Budget Request “provides \$286 million—the same level as the FY 2017 Continuing Resolution—to support low-income individuals with comprehensive family planning and related preventive health services through the Title X Family Planning Program” (*see* Budget in Brief at 24). The AAFP agrees that this important program should, at a minimum, receive \$286 million for the upcoming fiscal year, in order to continue supporting existing Title X clinics, which offer preventive services such as: screening for sexually transmissible infections, cancer screenings, HIV testing, and contraceptive care.

NATIONAL FAMILY PLANNING AND REPRODUCTIVE
HEALTH ASSOCIATION (NFPRHA)
1025 Vermont Avenue, NW, Suite 800
Washington, DC 20005

Testimony of Clare Coleman, President and CEO

My name is Clare Coleman; I am the President and CEO of the National Family Planning and Reproductive Health Association (NFPRHA), a national membership association representing providers and administrators committed to helping people get the family planning education and care they need to make the best choices for themselves and their loved ones. Many of NFPRHA's members receive federal funding from Medicaid and through Title X of the federal Public Health Service Act, the only federally funded, dedicated family planning program for low-income and uninsured people. These cornerstones of the nation's public health safety net are essential resources for those providing access to high-quality services in communities across the country. As a result, NFPRHA respectfully disagrees with the administration's priorities laid out in its fiscal year (FY) 2018 budget.

Publicly funded family planning services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers, and other private nonprofit organizations. For decades, these diverse provider networks have helped ensure that millions of poor and low-income individuals as well as those who are underinsured or uninsured receive access to high-quality family planning and other preventive health services in all 50 states, the District of Columbia, and U.S. territories.

Oppose Cuts to Medicaid

The President's proposal advances congressional proposals that, if enacted, would cut more than \$627 billion from Medicaid, alter the structure and financing of the program, and dismantle the provider network, deepening a crisis in public health. NFPRHA opposes the end to or rollback of Medicaid expansion, either of which would reduce the number of people with access to Medicaid, thereby leading to fewer people getting health care, even-greater increases in rates of sexually transmitted diseases, and a reversal of the reduction in rates of unintended pregnancy.

Furthermore, these proposed changes to the structure and financing of Medicaid will compound the demands being placed on the publicly funded family planning safety net. NFPRHA opposes both per capita caps and block grants. Both proposals would inevitably shift costs to states, forcing them to make choices about program eligibility, benefits, and provider payments in order to adapt to new funding constraints. Medicaid beneficiaries would also likely face new barriers to coverage, such as pre-emptive and other cost-sharing requirements.

Increase Support for Title X

An analysis published in the *American Journal of Public Health* last year found that, in order for publicly funded providers to meet the needs of all low-income, uninsured women of reproductive age for family planning services, the Title X program would need to be supported with approximately \$737 million annually. This estimate is based on the presumption that the Medicaid expansion resulting from the Affordable Care Act remains unchanged. The president's budget requests only level funding (\$286.5 million), a fraction of what is needed to serve low-income, uninsured women across the country. It is also important to note that the Title X program also supports men, so the resource needs identified in the analysis are extremely conservative. Since FY 2010, Title X has dropped from \$317.5 million annually to \$286.5 million annually, leading to a loss of approximately 1.2 million patients from the network.

The ongoing threat of the Zika virus has only increased demand on Title X providers. The CDC confirmed causal linkage between babies born with microcephaly and pregnant women infected with the Zika virus reinforced the simple concept that in a time of public health emergency, women will turn to Title X-funded providers for thorough counseling, risk assessment, and access to family planning services. As summer returns throughout the United States, public health experts expect the Zika virus to continue to spread domestically and demand for education and services to rise again.

Oppose Cuts to Other Safety Net Programs

NFPRHA is further troubled by proposals to eliminate several maternal-child health programs, the Social Services Block Grant, and the Teen Pregnancy Prevention Pro-

gram. Each of these programs is a vital part of the federal government's role in fostering healthy women, children, and families. NFPRHA also opposes the harmful reductions to the National Center for HIV/AIDS, Viral Hepatitis, STIs, and TB Prevention; Temporary Assistance for Needy Families; Special Supplemental Nutrition Program for Women, Infants, and Children; Ryan White HIV/AIDS program; and rural health programs. Budgets for each of these programs are already stretched thin, and these further reductions will harm the patients our providers serve.

Oppose Harmful Budget Riders

NFPRHA is deeply concerned by the harms to the Title X network and other health care programs that would be caused by the budget rider that seeks to prohibit any funding in the Labor-HHS appropriations bill from going to essential community providers that provide abortions or contract with abortion providers and that received more than \$23 million in Title X funding in FY 2016. The implicit intention of this proposed rider is to exclude Planned Parenthood affiliates, which are key networks within the publicly funded family planning safety net. A recent analysis by the Guttmacher Institute found that Planned Parenthood serves 32% of all safety-net contraceptive clients despite having just 6% of the nation's safety-net family planning providers. Our members, from federally qualified health centers to local public health departments to universities and school-based programs to private nonprofits, rely on Planned Parenthood to offer patients high quality services and share the patient load in communities with high levels of need for publicly funded family planning.

Conclusion

Millions of low-income women and men depend on the safety-net programs for affordable access to the family planning and preventive health services that help them stay healthy. However, this budget would jeopardize the capacity of our nation's public health infrastructure to help these vulnerable individuals and families as well as the broader social services and health care safety net. NFPRHA urges the Committee to reject the President's budget proposal.

ORAL HEALTH AMERICA
180 N. Michigan Avenue, Suite 1150
Chicago, IL, 60601
www.oralhealthamerica.org
phone (312) 836-9900
fax (312) 836-9986

June 19, 2017

The Honorable Orrin Hatch
Chair
U.S. Senate
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
U.S. Senate
Committee on Finance
219 Dirksen Senate Building
Washington, DC 20510

Re: CHIP Reauthorization is Essential to Children's Oral Health and Well-being

Dear Chairman Hatch and Ranking Member Wyden:

On behalf of Oral Health America (OHA), a leading nationwide organization dedicated to changing the lives by connecting communities with resources to increase access to care, education, and advocacy for all, especially those most vulnerable; I write to submit a statement for the record following the Senate Committee on Finance's June 8, 2017 hearing on "The President's Fiscal Year 2018 Budget." OHA requests the importance of extending funding for the Children's Health Insurance Program (CHIP) be taken into strong consideration by the Committee as the September 30 deadline approaches. Specifically, OHA urges Congress to support a five-year extension through to fiscal year 2022 as has been widely-recommended. OHA is deeply concerned the president's FY 2018 budget cuts CHIP by an estimated \$6 billion, or a 20% cut, despite the program being extended through to 2019.

Since 1997, CHIP has helped children whose families have incomes too high to qualify for Medicaid, but too low to afford private health insurance. CHIP has reduced the number of uninsured children by more than 50% while improving health outcomes and access to care for children and pregnant women across the nation. **Of direct interest to the oral health community is the fact CHIP is the only insurance that guarantees eight million children a dental health benefit**

that includes coverage for screenings and exams, cleanings, fluoride, and sealants. Untreated tooth decay can cause pain that may lead to difficulty eating, sleeping, and concentrating in school, leading to poor school attendance, and academic performance. Without CHIP, these children would lose much needed medical and dental coverage. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), without CHIP some families would be susceptible to additional premiums and cost sharing to access dental services in marketplace plans and/or employer-sponsored insurance. This is particularly concerning for low-income families and children. Furthermore, CHIP contributes to overall cost-savings to the system by decreasing the number of emergency room visits that are 10-times more expensive than routine, preventative care.¹

Historically, CHIP has had bipartisan support. It gives states flexibility in designing their programs, allowing them to implement the program by expanding Medicaid, creating a separate program, or a combination of both approaches.² With that flexibility, states can design a program that works best for their state and its children. Simply stated, CHIP provides states needed “certainty” in planning their budgets. MACPAC estimates all states would exhaust federal CHIP funding at some point in FY18, with four states and the District of Columbia running out of federal funds as early as December 2017.³ Therefore, time is of the essence. OHA urges Congress to act soon with a five-year CHIP funding extension.

Respectfully submitted,

Beth Truett
CEO and President



¹Health Policy Institute American Dental Association, Thomas Wall, Marko Vujicic, “Emergency Department Use for Dental Conditions Continues to Increase,” April 2015.

²<https://www.hhs.gov/about/budget/fy2017/budget-in-brief/cms/chip/Index.html>.

³<https://www.macpac.gov/topics/chip/>.