

United States Senate Committee on Finance

September 15, 2026

Hearing to Consider the Nominations of Gerard Klomp, of Utah, to be Deputy Secretary of Health and Human Services, vice James O'Neill, resigned; James Gadwood, of Maryland, to be Chief Counsel for the Internal Revenue Service and an Assistant General Counsel in the Department of the Treasury, vice Marjorie A. Rollinson; Ge Bai, of Virginia, to be an Assistant Secretary of Health and Human Services, vice Richard G. Frank; and Andrew A. De Mello, of Virginia, to be a Judge of the United States Tax Court for a term of fifteen years, vice Maurice B. Foley, resigned.

Questions for the Record submitted to Ge Bai from Senator Grassley.

Question 1: My oversight has revealed fraud, waste, and abuse across our health care system. Starting with my decades-long crusade to empower whistleblowers, my updates to the False Claims Act have recouped more than \$85 billion for taxpayers. In July 2026, I introduced the bipartisan Health Care Fraud Prevention and Enforcement Act to improve and invest in the Health Care Fraud and Abuse Control Program. I am willing to partner with the executive branch to provide more tools and resources to go after health care fraud and prevent it. At the same time, federal agencies must be smarter about how they use existing tools and resources. To name a few things, I encourage the administration to listen to whistleblowers about health care fraud, publish the annual Health Care Fraud and Abuse Control Program reports more timely, hold states accountable for complying with Medicaid asset verification requirements, better manage the Medicare Advantage risk adjustment model and conduct timely audits, and update the advanced premium tax credit fraud risk assessment and antifraud strategy. How will you effectively use existing tools and resources to go after health care fraud, waste, and abuse?

Response: The Office of the Assistant Secretary for Planning and Evaluation (ASPE) serves as the Secretary's principal policy analysis and evaluation office. ASPE provides objective, evidence-based analysis and advice to the Secretary and senior HHS leadership on health, human services, economic, and social policy issues. If confirmed, I commit to relying on data-driven analysis to bolster the Department's broader efforts to combat healthcare fraud, waste, and abuse.

Questions for the Record submitted to Ge Bai from Ranking Member Wyden

Letter from Ranking Member Wyden on ASPE Report Inaccuracies

On September 10, 2026, I sent you a letter identifying factual inaccuracies in analyses published by the Office of the Assistant Secretary for Planning and Evaluation (ASPE) under your leadership and requesting information about ASPE's research and clearance processes. The letter followed your September 2 meeting with Committee staff, at which you committed to reviewing several of these matters and following up. I did not receive a response before your hearing. To ensure the committee receives a response to these questions, I am submitting them into the record.

1. In reference to your remarks during your meeting with Committee staff, please identify the evidence on which you base the conclusion that loss of health coverage does not result in reduced access to care. Please cite specific studies.

Response: I would not characterize the conclusion as being that loss of health coverage never reduces access to care.

2. In reference to your remarks during your meeting with Committee staff, please identify the evidence on which you base the conclusion that loss of health coverage does not affect health outcomes. Please cite specific studies.

Response: I would not characterize the conclusion as being that loss of health coverage does not affect health outcomes.

3. Are you aware of peer-reviewed research finding that Medicaid coverage is associated with increased access to care, reduced financial strain, or improved health outcomes?

Response: While there is peer-reviewed research finding that Medicaid coverage is associated with increased access to care, reduced financial strain, and some improved health outcomes, the findings vary by outcome, population, and study design.

4. Has ASPE, under your leadership, produced or commissioned any analysis of the relationship between coverage loss and health outcomes?

Response: As of the hearing date, ASPE had not produced or commissioned an analysis specifically examining the relationship between coverage loss and health outcomes.

- a. If so, please provide it.

Response: Not applicable.

- b. If not, please explain why not.

Response: ASPE has multiple statutory and Departmental analytical responsibilities and must prioritize work based on available staff, data, timing, and Department needs.

5. If the Medicaid provisions of H.R. 1 do not constitute cuts, how would you characterize the reduction in projected federal Medicaid spending over the ten-year budget window?

Response: According to the Congressional Budget Office, Medicaid spending increases from \$668 billion in Fiscal Year 2025 to \$950 billion in Fiscal Year 2034—that's over a 40 percent increase in spending over the next 10 years.

6. You co-authored a brief entitled: "Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce Poverty."¹ This brief contains a literature

¹ Danielle Berman, Jennifer Burnszynski, Robin Ghertner, Suzanne Macartney, Kendall Swenson, Casey B. Mulligan, and Ge Bai. "Medicaid Work Requirements Incentivize Employment and Are Estimated to Reduce

review but includes a simulation analysis that uses assumptions not drawn from that review. Why review the evidence and then not use it?

Response: The assumptions used in the simulation are based on prior evidence that underlies the literature review in the brief.

- a. Your brief says the estimates are illustrative rather than predictive. HHS released it the day of the Interim Final Rule on Medicaid work reporting requirements under a headline saying work reporting requirements are “estimated to reduce poverty.” Is that headline an accurate representation of an illustrative simulation?

Response: The estimate was generated by an illustrative simulation using specified assumptions and was not a prediction of what would necessarily occur.

- b. Did you, HHS political leadership, or the White House write the headline?

Response: All ASPE publications have the authors listed who are responsible for the brief.

- c. Who selected the release date, and was the timing coordinated with the publication of the Interim Final Rule?

Response: ASPE publications are only released publicly once undergoing a thorough internal clearance process.

- d. CBO estimated 5.7 million people will lose coverage under H.R. 1’s Medicaid work reporting requirements provisions. Your brief presents a poverty-reduction number and no coverage-loss number. Did ASPE produce a coverage-loss estimate that was not published?

Response: ASPE did not produce such analysis.

- i. If ASPE did not produce one, please explain why the analysis estimated the projected benefit of the policy but not its projected cost.

Response: The brief was designed to examine potential employment, income, and poverty effects under specified assumptions. It was not designed as a comprehensive estimate of all effects of the statutory provisions.

- e. The scenarios in the brief assume job availability. What happens to the estimate in a recession?

Response: The estimate would not directly capture recession conditions because the simulation held labor-market parameters, including job availability, constant.

- i. Please provide any sensitivity analysis run under alternative labor market assumptions. If none was performed, state that.

Response: The analysis held labor-market parameters constant.

- f. Arkansas is one of two states to have fully implemented Medicaid work reporting requirements. Your brief does not mention it. During your meeting with Committee staff, you suggested that the reason Arkansas was not included in your analysis of work reporting requirements was because the participants subjected to the work reporting requirement already had very high employment or met the requirement in another way. If employment is so high already among Medicaid beneficiaries, how can you defend the claim that work reporting requirements will reduce poverty by pushing people into work?

Response: The brief did not rely on the premise that all Medicaid beneficiaries subject to work reporting requirements are currently unemployed. Its simulation examined how income and poverty could change for affected individuals who increase work under the specified assumptions.

- i. Did any draft of the brief include a discussion of Arkansas or Georgia?

Response: No.

1. If so, who removed it, and at whose direction?

Response: Not applicable.

- ii. Please provide all internal review comments received on drafts of the brief.

Response: ASPE does not disclose pre-deliberative and internal review documents.

- iii. During the passage of H.R. 1, CBO stated that 50 percent of the coverage loss estimated from Medicaid work reporting requirements would be due to administrative burden or friction. Please explain the disconnect between this brief and CBO's analysis.²

Response: The brief addressed employment, income, and poverty effects under its stated assumptions and did not attempt to reproduce the Congressional Budget Office's coverage-loss estimate.

² Email from CBO, June 12, 2025: "50 percent of the loss of Medicaid coverage from the community engagement requirement would be due to the "friction effect," which represents coverage loss related to applicant confusion over the process for verifying work and exemption status, as well as challenges in providing sufficient evidence of such status... This estimate is based on reports and studies regarding the coverage loss observed in the Arkansas and Georgia community engagement 1115 demonstrations, among other relevant studies related to the effect of additional administrative requirements"

- g. Medicaid covers roughly four in ten births in this country. Pregnant women are exempt from the work reporting requirement, but the exemption still has to be documented, and evidence suggests that the majority of people who meet the requirement who lose coverage do so because they cannot keep up with the paperwork demand.
 - i. Does your brief's poverty estimate disaggregate effects of the work reporting requirement for pregnant and postpartum women?
 - ii. Does the brief consider other effects of H.R.1 on pregnant women, such as funding cuts for family care clinics, cuts to maternity care provider payments, and closures of rural labor and delivery units?³

Response: Those effects were outside the scope of the brief.

- iii. Has ASPE analyzed the effect of H.R. 1's Medicaid provisions on maternity care access (e.g., labor and delivery closures, obstetric workforce, travel distance to a birthing facility)?

Response: If confirmed, I look forward to working with Congress on analysis that helps inform policy planning and evaluation that improves the health of all Americans.

- iv. Researchers outside ASPE have identified 131 rural hospitals with labor and delivery units at risk because of H.R. 1.⁴ Does HHS accept that estimate?

Response: As of the hearing date, ASPE has not had an opportunity to conduct a careful review of the study and cannot determine its quality or whether to accept the estimates.

- 1. If not, what is ASPE's estimate?

Response: As of the hearing date, ASPE has not had an opportunity to conduct a careful review of the data.

- 7. You co-authored a brief entitled, "An Overview of State-Directed Payments and Medicaid Provider Taxes: History and Potential Effects of the Working Families and Tax Cut Legislation on Health Care Costs," claiming that provider taxes and state-directed payment policies passed in H. R. 1 are expected to reduce non-Medicaid prices by up to 3.5 percent in markets with provider taxes and reduce spending on Medicaid, commercial and Medicare coverage. Researchers have asserted that these policies will drive up

³Senate Finance Committee Democrats and House Energy and Commerce Democrats. "Republicans Are Slashing Maternal Health Care – As Their Cuts Begin to Take Hold, More Maternity Care Providers are Closing Their Doors Than Ever Before." (Joint Report.) July 14, 2026.
<https://www.wyden.senate.gov/imo/media/doc/07082026maternalhealthreport.pdf>

⁴ Rolonda Donelson, Maia Eng, and Marla Guerra. "Republican's New Health Care Law Will Impact Over 130 Rural Labor and Delivery Units." *National Partnership for Women and Families*. June 2025.
<https://nationalpartnership.org/wp-content/uploads/npwf-medicaid-cuts-and-rural-labor-and-delivery-units.pdf>

uncompensated care and thus increase prices for all health care consumers.⁵ How do you explain the disconnect between your findings and those of the broader research community?

Response: The ASPE analysis used a specific economic framework to estimate potential price and spending effects from provider taxes and state-directed payments. Other analyses may focus on different mechanisms, including uncompensated care. The estimates should therefore be understood as model-based results that depend on their assumptions rather than as direct observations of causal effects.

- a. In this analysis, the elasticity of demand for inpatient care appears to be assumed at -0.33. However, this estimate is significantly more elastic than the consensus in the empirical literature. Meta-analyses of health economics literature generally find the elasticity for inpatient care to center around -0.17.⁶ Please explain the rationale for using an elasticity assumption that is twice as large in magnitude as the established literature.

Response: The -0.33 value is the midpoint of the -0.2 to -0.5 range reported in the sources used by the analysis. Figure 4 shows that if elasticity is closer to zero, state-directed payments increase healthcare prices even more than reported.

- i. In your response to this question, please provide the source for the -0.33 assumption, all sensitivity analyses run using alternative values, and the results of those analyses. If no sensitivity analysis was performed, please explain why.

Response: The paper already supplies the source trail: references 42-46, including the RAND Health Insurance Experiment, Ellis et al. on service-specific elasticities, Brot-Goldberg et al., and Einav et al. The paper fully discloses its methods and provides sensitivity analysis including, but not limited to, Table 2, Figure 4, Appendix Figure 1, and Appendix Figure 2.

8. On September 29, 2025, you wrote an op-ed in the Wall Street Journal encouraging Republicans in Congress to end enhanced premium tax credits that people used to purchase insurance.⁷ In this op-ed you cite a family of four in Arizona making \$600,000 as being eligible for premium tax credits.

- a. Is this a real family that you identified or met, or was it hypothetical?

⁵ Rob Nelb. "Additional Hospital Uncompensated Care Costs Projected Under Proposed Senate Revisions to H.R.1." *America's Essential Hospitals*. (Policy Brief.) June 2025. <https://essentialhospitals.org/wp-content/uploads/2025/06/Additional-Hospital-Uncompensated-Care-Costs-Projected-Under-Proposed-Senate-Revisions-to-H.R.-1.pdf>

⁶ Ringel, Jeanne S., Susan D. Hosek, Ben A. Vollaard, and Sergej Mahnovski. "The elasticity of demand for health care." *A review of the literature and its application to the military health system* (2002). https://www.rand.org/content/dam/rand/pubs/monograph_reports/2005/MR1355.pdf

⁷ Ge Bai. "Let the ObamaCare Enhanced Premium Subsidies Expire." *The Wall Street Journal*. September 29, 2026. <https://www.wsj.com/opinion/let-the-obamacare-enhanced-premium-subsidies-expire-16ef7e1b>.

Response: It was hypothetical.

- b. If this is not a real family, how did you arrive at this hypothetical?

Response: I used publicly available premium tax credit calculators to construct the hypothetical example.

9. At around the same time you published your op-ed, the Joint Committee on Taxation (JCT) found that no families making \$600,000 were receiving ACA tax credits.⁸

- a. Do you agree with their findings?
- b. If not, please provide data demonstrating why JCT was incorrect.

Response: My example was hypothetical and illustrated potential eligibility under the expanded premium tax credit formula.

10. You emphasized throughout our meeting that ASPE provides independent and objective analysis for the Department and is not subject to undue influence from people outside of ASPE when generating reports and findings. However, a senior CMS official is listed as the first author of the report on ACA enrollment, which analyzes the effectiveness of policies that CMS was responsible for developing and implementing.

- a. What role did CMS have in producing this report?

Response: Mr. Nelson, along with the other coauthors, contributed to the analysis and drafting of the brief.

- b. Did ASPE approach CMS about co-authoring this report?

Response: ASPE and CMS relied on collective technical expertise to co-author the report.

- c. Who made the determination that a CMS official would co-author an ASPE report evaluating CMS policies?

Response: ASPE and CMS relied on collective technical expertise to co-author the report.

- d. Do you believe the inclusion of a senior CMS official as a primary author of an ASPE report evaluating CMS policies leads to reasonable questions about the objectivity of this report?

⁸ Internal Memorandum from the Joint Committee on Taxation, September 18, 2025. The memo identified no revenue effects for households with income over \$500,000, indicating no tax credits went out to these families. “This memorandum is a response to your request dated September 10, 2025, for a distributional analysis of a one-year and permanent extensions of the temporary premium tax credit structure enacted by the American Rescue Plan Act of 2021 (Public Law 117-2) and later extended through calendar year 2025 in Public Law 117-169... Distributional analysis excludes effects due to changes to Medicaid/CHIP, the basic health program, the employer mandate penalties, and the small business health insurance general business credit. Individuals who are dependents of other taxpayers, and taxpayers with negative income are excluded from the analysis.”

Response: I do not believe interagency co-authorship by itself determines whether an analysis is objective. The appropriate test is whether the methods, data, assumptions, and conclusions are transparent and supported by the evidence.

- e. Please provide all communications between ASPE and CMS concerning the drafting, review, or clearance of this report.

Response: ASPE does not disclose pre-deliberative and internal review documents.

11. On page 1 of the report, the first bullet under “key points,” refers to “phantom enrollment” in ACA plans.

- a. Where does the term “phantom enrollment” come from?

Response: The term has been used in media, public discourse, and other policy discussions.

- b. Has it been used in peer-reviewed literature on this topic?

Response: The underlying phenomenon has been described in peer-reviewed literature, including literature using the terms ‘phantom coverage’ and ‘phantom enrollees.’

- c. What is the rest of the body of evidence on the topic of “phantom” enrollment?

Response: The brief was intended to contribute evidence to what it described as an emerging topic. The underlying enrollment data and methodology, rather than the label, should be the basis for evaluating the analysis.

- d. Will you commit to removing mentions of phantom enrollment from this and future analyses?

Response: I commit to ensuring that ASPE defines terminology clearly and that its findings rest on the underlying data and methodology rather than on labels.

12. On page 1, the report notes that the 2025 Marketplace Integrity and Affordability rule took “significant measures” to address fraud in the ACA marketplace. As you know, a significant majority of this rule was vacated by a federal judge and never went into effect. Which specific provisions of this rule does ASPE assert had a significant effect on fraud in the ACA Marketplace?

Response: The rule was not vacated in full, as clearly outlined in the brief. Many provisions and related CMS program-integrity operations remain in effect.

13. On page 3, the first finding in the report is that “zero premium plans were never part of the ACA Exchange design.”

- a. Were zero premium plans available on the ACA Marketplace before the establishment of enhanced premium tax credits in 2021?

Response: The ACA originally set a minimum premium contribution threshold of 2% for the lowest income enrollees for a benchmark plan.

- b. Are zero premium plans available on the ACA Marketplace in plan year 2026?

Response: For 2026, the minimum premium contribution threshold is once again 2% for the lowest income enrollees for a benchmark plan.

- c. When does ASPE plan to update this finding to account for its inaccuracy?

Response: The claim reflects the original design of the exchanges.

- 14. On page 3, the second header under findings includes a section on the “the top ten federal policies that weakened program integrity.”

- a. Did ASPE run a causal analysis for each one of these policies and its impact on program integrity or enrollment?

Response: ASPE did not conduct a separate causal analysis for each of the ten policies.

- b. Was the analysis ordinal in nature, i.e. able to compare all 10 policies against each other and develop a ranking?

Response: The list was not an ordinal ranking of the ten policies.

- i. If so, please detail the precise methodology for generating these analyses, and include the metrics on the size of impact.

Response: Not applicable.

- ii. If ASPE did not run these causal analyses, why has ASPE published causal conclusions?

Response: The section should be read as identifying policies ASPE assessed as weakening program-integrity safeguards, not as reporting ten separately estimated causal effects.

- c. Will you commit to removing all causal statements from this and all other analyses that are not backed up by causal analyses?

Response: If confirmed, I will ensure that ASPE's language accurately reflects the methods used and does not characterize an association or descriptive analysis as a causal estimate when the analysis does not support that conclusion.

- 15. On page 5, the paper states that “Over the past three years (2024-2026), around 50 percent of those newly subject to a premium are estimated to have failed to pay and became termed out of coverage, suggesting a substantial portion were unaware they were enrolled, did not exist, or did not derive sufficient value from their coverage.” You cite internal analyses of CCIIO data to back up this claim.

- a. Did ASPE or CCIIO estimate how many were unaware they were enrolled, or measure how many people ended coverage because it was too expensive?

Response: The analysis cited in the report did not separately estimate how many individuals were unaware of their enrollment or how many ended coverage because of affordability.

- b. Are there plans to run such an analysis, and if not, why?

Response: The Center for Consumer Information and Insurance Oversight (CCIIO) continues to monitor ACA enrollment that is fraudulent or improper.

16. On page 6, the report references CMS's estimate that 4.4 million people were improperly enrolled in ACA coverage in 2024, and that "CMS estimates this number grew to 5.6 million in 2025." The report then cites a CMS press release from March 2025 announcing the Marketplace Integrity Rule to support this claim, but the press release contains no information about the data analyses CMS conducted to arrive at this number. The only reference to data in the press release is the citation of a Paragon Health Institute study – which has since been debunked in federal court.⁹

- a. Did CMS provide ASPE with any actual data to support its claims of 4.4 and 5.6 million people "improperly" enrolled in ACA plans in 2024 and 2025 respectively?

Response: The 4.4 million figure was based on the Centers for Medicare & Medicaid Services calculation in Table 14 of the Marketplace Integrity and Affordability rule preamble.

- i. If so, please provide the supporting documents in your response.

Response: The 4.4 million figure was based on the Centers for Medicare & Medicaid Services calculation in Table 14 of the Marketplace Integrity and Affordability rule preamble.

- b. If not, did ASPE attempt to independently verify these CMS claims with its own data and analyses?

Response: ASPE's responsibility is to provide independent, unbiased analyses of HHS agency actions.

- i. If so, what analyses did ASPE run, and what were the results?

Response: ASPE's responsibility is to provide independent, unbiased analyses of HHS agency actions.

- ii. If not, why did ASPE accept these data and include them in its own report?

Response: Not applicable if the estimates were based on the CMS calculation and the study's own analysis.

- c. Is it ASPE's role to parrot agency and external organization talking points, or is it ASPE's responsibility to provide independent, unbiased analyses of HHS agency actions?

⁹ City of Columbus et al v. Kennedy et al. United States District Court for the District of Maryland. August 22, 2025.

Response: ASPE's responsibility is to provide independent, unbiased, evidence-based analysis of HHS policies and programs.

17. On page 9 in Figure 6, the report claims that all 2.9 million people who ended enrollment in ACA marketplace coverage between February 2025 and February 2026 were the result of removing people who were improperly enrolled.

- a. Did ASPE work to ground-truth this information by meeting with patients, providers, plans, or other health care leaders?

Response: All ASPE work is based on evidence, which can include empirical data, economic analysis, research reports, prior case documentation, and field interviews.

- b. How does ASPE square its finding with the widespread reporting that millions of people who were legitimately enrolled dropped coverage because it became too expensive?¹⁰

Response: The figure in the report should not be interpreted as establishing the reason every individual ended enrollment.

- c. Did ASPE attempt to measure, through its own or other data sources, how many people who unenrolled from ACA coverage became uninsured?

Response: ASPE did not estimate that number in this analysis.

18. Please provide all internal review comments received on drafts of this report, and identify every individual outside ASPE who reviewed it prior to publication.

Response: ASPE does not disclose pre-deliberative and internal review documents.

19. Please provide the date on which the corrected report will be published. If ASPE will not correct findings that are demonstrably inaccurate, please explain the basis for that decision.

Response: ASPE stands by the findings in the report.

20. Please describe the review and clearance process that is involved with releasing an ASPE report.

Response: ASPE reports undergo substantive review within ASPE and Departmental clearance before publication.

- a. Who within ASPE gives final approval?

Response: Within ASPE, final approval is currently provided by the Ms. Goss, who is performing the delegable duties of the Assistant Secretary for Planning and Evaluation (ASPE).

¹⁰ Greg Iacurci. "9% of ACA health-care plan enrollees go uninsured after enhanced subsidies expire, poll finds." CNBC. <https://www.cnbc.com/2026/03/19/aca-enrollees-uninsured.html>

Acting Assistant Secretary for Planning and Evaluation.

- b. Who outside ASPE gives approval?

Response: HHS leadership participates in the Departmental clearance process.

- 21. What analysis has ASPE done on uncompensated care and rural hospital finances under H.R. 1?

Response: If confirmed, I look forward to working with Congress on analysis that helps inform policy development that improves the health of all Americans.

- a. Has ASPE completed or considered analyses that assess the combined effect of the Medicaid work reporting requirements and the expiration of the enhanced premium tax credits?

Response: If confirmed, I look forward to working with Congress on analysis that helps inform policy development that improves the health of all Americans.

- b. If no analyses have been conducted, why hasn't this been a priority for ASPE?

Response: ASPE has multiple statutory and Departmental analytical responsibilities and must prioritize work based on available staff, data, timing, and Department needs.

- 22. What is ASPE's role in the Food and Drug Administration's review of evidence on mifepristone?¹¹

Response: As of the hearing date, I am not aware of ASPE playing a direct role in FDA's mifepristone review.

- 23. Has ASPE evaluated or is it considering evaluating the WISeR model?

Response: As of the hearing date, I was not aware of ASPE playing a direct role in reviewing the WISeR model.

- 24. Has ASPE evaluated or is it considering evaluating Medicare Advantage auto-enrollment?

Response: As of the hearing date, I was not aware of an ASPE evaluation of Medicare Advantage auto-enrollment.

- 25. Has ASPE evaluated or is it considering evaluating the Medicare Part D demonstration?

Response: ASPE staff support CMS in evaluating the Medicare program, including market conditions for the Part D program.

¹¹ Michael Kaplan. "FDA moves ahead with safety study of abortion pill mifepristone." CBS News. June 5, 2026. <https://www.cbsnews.com/news/fda-launches-safety-study-for-abortion-pill-mifepristone/>.

- a. Please share the evaluation framework and any findings related to the Part D demonstration that were shared with the Government Accountability Office, as referenced in their February 2026 report entitled “Medicare Part D: Implementation of Beneficiary Premium Stabilization Demonstration.”

Response: GAO reported that it received the finalized evaluation framework from CMS in January 2026.

26. The GAO report noted that “ASPE officials told GAO that they plan to continue their evaluation efforts into fiscal year 2026.” Please confirm whether ASPE continued its evaluation efforts and share any findings from the continued evaluation.

Response: ASPE continued to support CMS’s evaluation work in Fiscal Year 2026.

27. Has ASPE produced any analysis used to justify Medicaid payment deferrals to states?

Response: ASPE has multiple statutory and Departmental analytical responsibilities and must prioritize work based on available staff, data, timing, and Department needs.

28. You have written extensively on hospital pricing and charity care. Does ASPE have plans to evaluate nonprofit hospital community benefit standards or financial assistance policies?

Response: If confirmed, I look forward to working with Congress on analysis that helps inform policy development that improves the health of all Americans.

29. What has ASPE determined would be the price impact on patients who use TrumpRx?

Response: As of the hearing date, I was not aware of an ASPE analysis determining the price impact on patients who use TrumpRx.

- a. Secretary Kennedy told Senator Warren that TrumpRx stores no patient, health, or prescription information. Is this true?

Response: I do not have sufficient information as of the hearing date to independently verify that statement.

- i. If it is, how can savings be calculated?

Response: Savings could be estimated without storing identifiable patient information if the methodology uses aggregate transaction, utilization, price, or manufacturer data.

30. What is ASPE evaluating regarding Health Savings Accounts (HSAs) and patients paying for care directly?

Response: If confirmed, I look forward to working with Congress on analysis that helps inform policy development that improves the health of all Americans.

- a. Who asked for such an analysis?

Response: ASPE sets its research agenda in carrying out its role as HHS's policy analysis and evaluation office, informed by Departmental priorities and HHS leadership.

- b. Will future reports on this evaluation discuss and compare the usefulness of these tools as a substitute for comprehensive insurance versus a complement to insurance used for out-of-pocket cost sharing?

Response: Because ASPE did not have such an evaluation underway as of the hearing date, I cannot characterize the contents of a future report. If ASPE undertakes such an analysis, it should clearly identify the policy question and evaluate relevant alternatives using appropriate evidence.

31. Who sets ASPE's research agenda?

Response: ASPE sets its research agenda in carrying out its role as HHS's policy analysis and evaluation office, informed by Departmental priorities and HHS leadership.

32. During your meeting, you expressed repeated interest in the topic of regenerative farming. What is ASPE's statutory role in agriculture policy?

Response: ASPE may analyze agricultural or food-system issues when they bear on health or human-services matters within HHS's responsibilities.

- a. How many staff are working on regenerative farming at the Secretary's request?

Response: The ASPE brief was published on June 25, 2026, and clearly lists the authors.

- b. How much of their time is being spent on this?

Response: ASPE does not maintain project-level timesheets that would allow me to provide a reliable percentage of staff time devoted to this topic.

33. How many career analysts has ASPE lost since January 20, 2025, and how many positions are currently vacant?

Response: I did not know the verified number as of the hearing date.

- a. What effect has that had on ASPE's analytic capacity?

Response: Based on my experience since joining ASPE, the office continued to perform its core analytical responsibilities.

34. During your meeting, you stated that political leadership at the White House or within HHS should not determine ASPE's research methodology or findings. Please confirm that position in writing and respond to the following:

Response: ASPE's research methods and findings should follow the evidence and appropriate analytical methods rather than a predetermined outcome.

- a. Has any official at the White House or in HHS political leadership requested that ASPE change a finding, alter an assumption, or modify a methodology?

Response: ASPE's research methods and findings should follow the evidence and appropriate analytical methods rather than a predetermined political outcome.

- i. If so, please describe each instance.

Response: Not applicable.

- b. Are there completed ASPE analyses that have not been published?

Response: ASPE has a variety of analyses actively underway at various stages of development and review.

- i. If so, how many, on what subjects, and who decided not to publish them? Please provide a list.

Response: Not applicable as there were no such completed unpublished analyses.

- c. Has ASPE been asked to undertake an analysis that it previously declined to undertake, or to withhold a completed analysis?

Response: Not to my knowledge as of the hearing date.

- d. Will you commit to publishing ASPE analyses whose findings are unfavorable to the administration's policy positions?

Response: ASPE's findings should follow the evidence. I support publication of completed ASPE analyses based on their methodological quality and relevance, not whether their findings are favorable or unfavorable to an Administration policy position, subject to applicable review and legal requirements.

Questions for the Record submitted to Ge Bai from Senator Bennet.

Rural Health

Question 1: Across the country, and particularly in rural Colorado, the reality facing rural health care is stark: more than half of rural counties lack access to hospital-based obstetrics, 20 percent have no hospital at all, and over 40 percent of rural health providers nationwide are operating in the red. When these health care providers shut down, rural families will be stranded in care deserts. ASPE plays a central role in conducting research, policy analysis, and strategic planning to guide Department decision-making. What specific analytical tools, research priorities, and policy initiatives will you direct ASPE to undertake to prioritize rural health across the agency?

Response: Rural health is an important area for ASPE analysis. If confirmed, I would support rigorous evaluation of rural hospital finances, service availability, maternity-care access, and other measures of access using appropriate data and methods.

Question 2: How does ASPE plan to evaluate the negative effects of H.R. 1 and how it disproportionately affects rural health access, and will you commit to sharing those internal economic impact analyses with Congress?

Response: ASPE should evaluate effects on rural access using appropriate measures such as hospital financial condition, service availability, maternity-care access, workforce, travel distance, and coverage.

Question 3: Will you commit to publicly posting all information gathered, used, or otherwise considered when evaluating the Rural Health Transformation Program?

Response: I support transparency in ASPE's methods, data sources, assumptions, and findings.

PASTEUR Act

Question 4: Antimicrobial resistance is a serious threat and requires new therapeutic development, diagnostics, and treatment. What specific analytical and policy actions will ASPE take to evaluate the economic value of how provisions within the bipartisan PASTEUR Act can be operationalized to strengthen domestic AMR preparedness and response?

Response: ASPE analysis could focus on evaluating the economic incentives affecting antimicrobial development, access, and stewardship and by assessing the expected effects of proposed payment models using rigorous economic and program-evaluation methods.

Questions for the Record submitted to Ge Bai from Senator Warren.

Ethics

Question 1: Will you commit to recuse from any particular matters involving your former clients and employers for at least four years?

Question 2: Will you commit to recuse from any particular matters, including particular matters of general applicability, that have a direct and predictable impact on the financial interests of your former clients and employers for at least four years?

Response to Questions 1-2: I will comply fully with my ethics agreement and all applicable federal ethics and conflict-of-interest and impartiality requirements, including required recusals.

Question 3: Will you commit to setting up a screening process that would involve a third-party staff member screening each of your matters, before you learn of the matter, to determine whether the matter would trigger a conflict of interest?

Question 4: If you do create a screening process to comply with your recusal requirements, who would be responsible for identifying particular matters from which you should recuse?

Response to Questions 3-4: I will follow the screening and recusal procedures recommended by HHS ethics officials to ensure compliance with my ethics obligations.

Question 5: What role, if any, do you intend to personally have in identifying particular matters from which you must recuse?

Response: I will remain responsible for complying with my ethics obligations and will consult HHS ethics officials whenever a matter may implicate a recusal requirement.

Question 6: If confirmed, will you commit to not seeking employment or board membership with, or any other form of compensation from, a company involved in a matter pending under HHS's responsibility or that lobbied HHS during your tenure for at least four years after leaving office?

Question 7: If confirmed, will you commit to not lobby HHS — including through unregistered “shadow” or behind-the-scenes lobbying” — for at least four years after leaving office?

Response to Questions 6-7: I will comply with all applicable post-government employment and lobbying restrictions.

Retaliation and Protecting Whistleblowers

Question 8: Do you believe that HHS personnel should be protected from any form of retaliation for coming forward about an illegal order, sexual assault or harassment, negligence, misconduct, or any other concern that they wish to raise?

Response: HHS personnel should be protected from unlawful retaliation for raising concerns through lawful channels.

Question 9: Have you ever retaliated against any individual for coming forward about an illegal order, sexual assault or harassment, negligence, misconduct, or any other concern that they wish to raise?

Response: No.

Question 10: If you are confirmed, will you commit to protecting whistleblowers? If so, please specify how you will do so.

Response: I will comply with applicable whistleblower-protection laws and ensure employees can raise concerns through appropriate channels.

Question 11: If you are confirmed, will you commit to preventing retaliation against any individual for coming forward about an illegal order, sexual assault or harassment, negligence, misconduct, or any other concern that they wish to raise?

Response: If confirmed, I will follow and enforce applicable protections against unlawful retaliation for employees who make protected disclosures or report misconduct through appropriate channels.

Question 12: Will you ensure your staff complies with any Inspector General deadlines established for requested communications, documents, and witnesses, and that staff will be protected from reprisal for their testimony?

Response: If confirmed, I will expect my staff to cooperate with lawful Office of Inspector General requests and deadlines consistent with applicable law, and I will not tolerate unlawful reprisal against employees for protected testimony or cooperation.

Private Equity in Health Care

Question 13: You stated that an outright ban on private equity in health care could "be counterproductive, because that means a lot of struggling hospitals will have no buyers, no chance to reorganize, and that might mean more need from taxpayers to put in money"¹² at potentially higher rates and worse outcomes. However, you have also stated that "once you are owned by [private equity] firms, your objective is purely to make money. It's all about maximizing profits."¹³

- a. Do you believe private equity belongs in health care?

Response: I have studied incentives associated with private-equity ownership while also recognizing that ownership changes can provide capital or a path to reorganization for some financially distressed providers.

Child Care

Question 14: In early August, HHS proposed a rule that will eliminate hundreds of key Head Start regulations. Some of the many changes include loosening class ratios, weakening staff and teacher credentials, reducing services for children with disabilities, and eliminating requirements for staff to ensure children get access to medical care are a few of the many regulations that are being loosened or fully eliminated. Child care policy experts warn this deregulation will jeopardize Head Start's renowned safety and quality, and reports indicate that these changes are laying the groundwork for the administration to eliminate the program entirely.

- a. If finalized, how would this rule affect the quality of Head Start's services?
- b. If finalized, how would this rule impact the accessibility of Head Start, especially among low-income families and families in rural communities?

Response: As of the hearing date, I was not aware of an ASPE analysis quantifying the proposed rule's effect on Head Start access for low-income or rural families.

Question 15: Prior to this rule, HHS proposed a separate Head Start rule in May that would rescind wage standards for child care workers at Head Start. These standards require Head Start to update its pay scales, promote wage comparability across its programs and with public preschool teachers, and ensure salaries covered basic costs of living. Together, these wage standards were estimated to increase the majority of Head Start teachers' wages by \$10,000. This rule also rescinds benefit standards that require Head Start programs to provide their staff with health care coverage, paid leave, and behavioral health services. Child care policy experts claim that the proposed changes risk further destabilizing Head Start programs by deepening an existing supply crisis, which risks worsening coverage gaps and pushes affordable child care options further out of reach for the families who need them most.

- a. How will this rule affect Head Start's overall workforce? Will it cause a reduction in Head Start's workforce?
- b. How will this rule affect Head Start's ability to retain early childhood educators and attract new educators?

¹² <https://www.axios.com/newsletters/axios-future-of-health-care-b1b84930-3956-11ef-857a-3719553a102a>

¹³ <https://www.axios.com/newsletters/axios-future-of-health-care-b1b84930-3956-11ef-857a-3719553a102a>

Response: As of the hearing date, I was not aware of an ASPE analysis estimating the proposed rule's effect on the size of the Head Start workforce.

Question 16: Also in May, HHS finalized a rule that rescinds key Child Care Development Fund (CCDF) regulations that target affordability, including the cap on families' co-payments for their child care subsidy at no more than seven percent of income. Child care is already a major expense for families receiving subsidies, and the seven percent cap helped to make that expense more manageable. Without it, families' child care costs will soar at the same time costs across the board are rising for families – and states will no longer be obligated to reduce copayments. HHS offered no alternative plan to lower family co-payments in place of the seven percent cap. If finalized, how would rescinding this cap impact families' child care costs?

Response: The final rule removes the federal requirement that family copayments be capped at seven percent of income. The effect on a particular family's costs will depend on the copayment policy adopted by that family's state or territory.

- a. Would this new rule cause child care costs for families to rise and by how much?
- b. What states would be most impacted by this change?

Response: As of the date of the hearing, I am not aware of an ASPE analysis capturing these metrics.

Question 17: This final CCDF rule from May also eliminates requirements for states to pay child care providers prospectively and based on enrollment. Doing so will make funding less reliable and predictable, limiting child care providers or centers' ability to determine their staffing needs. Providers have warned that this will destabilize the child care workforce – which already faces a shortage and struggles to retain workers. What effect will these changes have on the child care sector?

Response: The effect will depend on how states choose to structure provider payments after the federal requirements are removed. I am not aware of an ASPE analysis as of the hearing date quantifying the sector-wide effect of the final rule.

- a. Will this change exacerbate existing workforce shortages in the child care sector?

Response: I am not aware of an ASPE analysis as of the hearing date establishing whether or by how much the change will affect child-care workforce shortages.