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ENCOURAGING HEALTHY COMMUNITIES: PERSPECTIVE FROM THE SURGEON GENERAL

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING ENCOURAGING HEALTHY COMMUNITIES, FOCUSING ON PERSPECTIVE FROM THE SURGEON GENERAL

NOVEMBER 15, 2017

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C O N T E N T S

STATEMENTS

WEDNESDAY, NOVEMBER 15, 2017

ENCOURAGING HEALTHY COMMUNITIES: PERSPECTIVE FROM THE SURGEON GENERAL

Wednesday, November 15, 2017

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The Committee met, pursuant to notice, at 10:05 a.m., in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, Chairman of the Committee, presiding.

Present: Senators Alexander [presiding], Cassidy, Young, Murray, Casey, Franken, Bennet, Whitehouse, Murphy, Warren, Hassan, and Kaine.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

Today, we're holding a hearing with the Surgeon General, Dr. Jerome Adams, to hear his priorities on how to encourage people to lead healthier lives. Senator Murray and I will each have an opening statement. Then we'll introduce Dr. Adams. After his testimony, Senators will each have 5 minutes of questions.

When Dr. Adams and I met before his confirmation hearing, I said to him that if, as Surgeon General, he threw himself into one important problem with everything he has, he could have a real impact on the lives of millions of Americans. At his confirmation hearing, he said, "I would make wellness and community, and employer engagement a centerpiece of my agenda if confirmed. Our health starts in the communities where we live, learn, work, play, and go to school."

Dr. Adams has said his first Surgeon General's Report will focus on health and the economy. So it makes sense for that to be his focus, because there is a remarkable consensus that wellness—lifestyle changes like eating healthier and quitting smoking—can prevent serious illness and reduce healthcare costs. This is important because the United States spends about $2.6 trillion treating chronic diseases. This accounts for more than 84 percent of our healthcare costs—$2.6 trillion treating chronic diseases, 84 percent of our healthcare costs.

Today, Dr. Adams will talk to us about what local communities, businesses, and other organizations can do to encourage people to live healthier lives, which will help reduce healthcare spending on chronic diseases. The Cleveland Clinic has said if you achieve at least four normal measures of good health, such as a healthy body

mass index and blood pressure, and you see a primary care physician regularly and keep immunizations up to date, you will avoid chronic disease about 80 percent of the time.

At a hearing we held last month on wellness, I said that it is hard to think of a better way to make a bigger impact on the health of millions of Americans than to connect the consensus about wellness to the health insurance that 178 million people get on the job.

One of our witnesses last month, Steve Burd, talked about an employee wellness program he implemented while CEO of Safeway that has reduced the biological age of employees by 4 years.

He said, "Given that 70 percent of healthcare spending is driven by behaviors, employers can have a powerful impact on both employee health and healthcare cost. Healthcare costs continued to decline by 9 percent per year as Safeway with no material changes to plan design. Safeway's health actuaries reported this continued cost reduction was due predominately to improved health status.".

Many employers have developed similar wellness programs to incentivize people to make healthier choices.

These programs may reward behaviors such as exercising, eating better or quitting smoking, or offer employees a percentage off their insurance premiums for doing things like maintaining a healthy weight or keeping their cholesterol levels in check.

Last month, we heard that while both employees and employers benefit from lower healthcare costs, both also can benefit in other ways when people live healthier lives.

Michael Roizen, the Chief Wellness Officer at the Cleveland Clinic, told us, quote, "The culture of wellness at the Cleveland Clinic has generated remarkable results that have led to shared benefits: healthier, happier employees, as well as lower costs for their self-funded insurance program, and lower costs for our employees and the communities and patients we serve." In other words, a healthier workplace translates to the greater community being healthier.

In recent years, a growing number of organizations and communities have developed innovative programs to incentivize individuals to engage in healthy behaviors.

For example, BlueCross BlueShield of Tennessee partnered with local, state, and private organizations to fund community level initiatives across the state, such as Fitness Zones in Chattanooga, programs in rural counties to promote healthy habits, and an interactive elementary school program to keep kids moving. An overall healthy community is more economically productive. There are fewer workplace accidents, less absenteeism, and a higher rate of engagement.

At his confirmation hearing, Dr. Adams also said not all national problems should have a response from Washington, DC. I agree. We don't get any smarter flying to Washington each week. Dr. Adams' motto as Surgeon General is, quote, "Better health through better partnerships," and I hope this Committee can be one partner going forward.

I look forward to hearing how community level partnerships and engagement can lead to healthier individuals, higher quality healthcare, and lower healthcare costs.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, Mr. Chairman.

Before we begin today's conversation, I do want to comment on the decision by Senate Republicans to once again attempt to raise families' costs and take away their healthcare, this time to fund tax cuts for massive corporations and the rich, while using the bipartisan agreement that Chairman Alexander and I and Members of this Committee reached as nothing more than political cover.

First, let's be clear about the policy. Tacking Alexander-Murray onto the partisan Republican tax reform effort is like trying to put out a fire with penicillin. It will not do anything to help. The Alexander-Murray Bill was intended to lower costs and stabilize the market, but millions of people will still be left paying more and losing coverage if Senate Republicans sabotage families' healthcare to help millionaires and billionaires get more tax breaks they probably don't need.

Second, the way this was done, by sneaking devastating healthcare changes into a partisan bill at the last minute, is completely counter to the bipartisan spirit in which we worked on this stabilization bill. Many of us agreed in the wake of the partisan repeal efforts earlier this year that jamming partisan policy through before anyone has a chance to see it is absolutely not the right way to get things done. It is especially disappointing to see this happen because in working on our bill and reaching an agreement, we proved that we can work under regular order and find common ground.

Finally, Mr. Chairman, I've said many times before how much I appreciate your willingness to work across the aisle after Trumpcare failed in July to try to get a result that actually helps families rather than burdening them with higher costs and causing millions to lose coverage. think the work that we and this Committee are able to do together when we focus on what's best for patients and families is exactly what people want to see happening in Congress.

What Senate Republicans are proposing now is the exact opposite and the wrong direction for families' health and financial security. It would be deeply disappointing for people who are looking to Congress for leadership, not partisanship, if this latest partisan Republican effort undermined both the policy and the spirit of the agreement that we were able to reach.

Now, having said that, Dr. Adams, I do want to welcome you. It's good to see you again, and I want to focus on this hearing. As you know, several weeks ago, this Committee held a hearing focused primarily on supporting health and wellness through employee wellness programs. I, for one, was very encouraged by our discussion on workplace wellness, as well as on the importance of protecting workers' civil rights and privacy. I'm glad that we're continuing that discussion today by exploring the role of community prevention programs. Disease prevention and health promotion is a critical part of improving families' well-being, and we also know it can help yield better health outcomes and lower costs.

Now, one thing I look forward to talking about more about is the diverse role that stakeholders have in supporting healthy communities. As I have said before, we all have an important role to play in supporting health and wellness. That means supporting public health at all levels, including initiatives that promote physical activity, increase access to healthy foods, expand on science-based ways to reduce tobacco use, and a lot more.

Again, not only is this an important aspect of improving the health of families, but it's also our local economies that stand to benefit from the increased engagement of stakeholders and businesses in partnership with government at all levels in health promotion efforts.

This is something I know that you, Dr. Adams, are very interested in, and I am encouraged that you are seeking input on how the business community can do more to contribute to community health.

Now, as you know, many businesses are already working hard on this, and they are taking steps to invest in public health efforts. It's something I've seen in my home State of Washington, and I know it's happening in many states, where we have businesses searching for ways to better support the health and wellness of their workers, and where we have businesses reaching out to our most at-risk populations of all ages, as well as partnering with health departments and other partners in the health community.

Needless to say, we want to encourage and build on these efforts.

Now, I'm looking forward to today's discussion on how we can continue to bring communities together to prioritize public health. I am appreciative of your focus on this, Dr. Adams, and I stand committed to working with you and all of my colleagues.

But I couldn't let a hearing about encouraging healthy communities take place without pointing out that, on the whole, it's hard to imagine what else the Trump Administration could be doing right now to undermine the health of our communities.

I hope you agree that the following are all essential to supporting public health and well-being: first, investing in public health and prevention rather than slashing investments in the Prevention and Public Health Fund; helping women get the reproductive healthcare they need; supporting services that allow people with disabilities and aging adults to remain in their home and part of their communities; making sure people struggling with opioid use disorders get comprehensive healthcare coverage, including through Medicaid; and responding effectively to urgent threats of disease and unsanitary conditions in the wake of natural disasters like we've seen in Puerto Rico and nationwide. Unfortunately, the Trump Administration has failed profoundly in these areas and many others.

As we move forward with these discussions, I want to be clear. I will continue to urge the Trump Administration to reverse its course and put the health and well-being of children, women, and families ahead of politics. That certainly includes any efforts to sabotage the bipartisan legislation many of us in this Committee worked so hard to agree on in favor of yet another partisan healthcare repeal effort that will leave families paying more and losing coverage.

Mr. Chairman, before I close, I do want to submit a statement by the American Association for Family Physicians for the record. Thank you.

[The information referred to follows:]

On behalf of the American Academy of Family Physicians (AAFP) thank you for the opportunity to submit this Statement for the Record for the U.S. Senate Health, Education, Labor, and Pensions Committee's hearing, Encouraging Healthy Communities: Perspectives from the U.S. Surgeon General.

The AAFP appreciates the Committee's interest in examining health through the lens of community health. Consistent with the World Health Organization's definition, the AAFP believes that health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity." As the largest society of primary care physicians, we are committed to helping patients achieve health and in supporting initiatives that build healthy communities. It is also our view that community health does not occur by coincidence. Healthy communities develop through robust research as well as investments from citizens, community-based organizations, educational institutions, governments, and the private sector.

Primary Care is Associated With Healthier Communities

The AAFP acknowledges that physicians play an important role in community health, both as clinicians, but also as community partners who understand that what takes place outside of the doctor's office (the social determinants of health) impacts patients' health and the health of a community. Still, primary care (comprehensive, first contact, whole person, continuing care) is the foundation of an efficient health system. It is not limited to a single disease or condition, and can be accessed in a variety of settings. Primary care (family medicine, general internal medicine and general pediatrics) is provided and managed by a personal physician, based on a strong physician-patient relationship, and requires communication and coordination with other health professionals and medical specialists. The benefits of primary care do not just accrue to the individual patient.

Primary care also translates into healthier communities.[1] For instance, U.S. states with higher ratios of primary care physician-to-population ratios have better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health. This is true even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).[2]

The dose of primary care can even be measured—an increase of one primary care physician per 10,000 people is associated with an average mortality reduction of 5.3 percent, or 49 fewer deaths per 100,000 per year.[3] High quality primary care is necessary to achieve the triple aim of improving population health, enhancing the patient experience and lowering per capita costs.[4]

Patients, particularly the elderly, with a usual source of care are healthier and have lower medical costs because they use fewer health care resources and can resolve their health needs more efficiently.[5] In contrast, those without a usual source of care have more problems getting health care and more often do not receive appropriate medical help when it is necessary.[6] Patients who gain a usual source of care have fewer expensive emergency room visits, unnecessary tests and procedures.

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[1] Shi L, Macinko J, Starfield B, Politzer R, Wulu J, Xu J. Primary Care, Social Inequalities, and All-Cause, Heart Disease, and Cancer Mortality in U.S. Counties, 1990. American Journal of Public Health. 2005a;95:674-80.

[2] Shi L, The relationship between primary care and life chances. J Health Care Poor Underserved. 1992 Fall; 3(2):321-35

[3] Macinko J, Starfield B, Shi L. Quantifying the health benefits of primary care physician supply in the United States. *Int J Health Serv*. 2007;37(1):111-26.

[4] Shi L, Starfield B, Primary care, income inequality, and self-rated health in the United States: a mixed-level analysis. *Int J Health Serv. 2000; 30(3):541-55*.

[5] Gilfillan, R. J., Tomcavage, J., Rosenthal, M. B., Davis, D. E., Graham, J., Roy, J. A., & ... Steele, J. D. (2010). Value and the Medical Home: Effects of Transformed Primary Care. American Journal of Managed Care, 16(8), 607-615

[6] Ibid.

They also enjoy better care coordination.[7] We believe it is in the national interest to support programs with the potential to help improve patient access for this population.

The Nation's Primary Care Shortage is a Community Health Issue

The current physician shortage and uneven distribution of physicians impacts population health. A U.S. Centers for Disease Control and Prevention study indicated that patients in rural areas tend to have shorter life spans, and access to health care is one of several factors contributing to rural health disparities.[8] The report recommended greater patient access to basic primary care interventions such as high blood pressure screening, early disease intervention, and health promotion (tobacco cessation, physical activity, healthy eating).[9] The findings highlighted in the CDC's report are consistent with numerous others on health equity, including a longitudinal study published in JAMA Internal Medicine, indicating that a person's zip code may have as much influence on their health and life expectancy as their genetic code.[10] Therefore, it is imperative that physician care is accessible for all.

The current primary care physician shortage and its maldistribution remain significant physician workforce challenges. An Annals of Family Medicine study[11] projects that the changing needs of the U.S. population will require an additional 33,000 practicing primary care physicians by 2035. A 2017 Government Accountability Office (GAO) report indicates that physician maldistribution significantly impacts rural communities.[12] The patient-to-primary care physician ratio in rural areas is only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas.[13] According to GAO, one of the major drivers of physician maldistribution is that medical residents are highly concentrated in very few parts of the country. The report stated that graduate medication education (GME) training remained concentrated in the Northeast and in urban areas, which continue to house 99 percent of medical residents.[14] The GAO also indicated that while the total number of residents increased by 13.6 percent from 2001 to 2010, the number expected to enter primary care decreased by 6.3 percent.[15]

Primary care workforce programs, such as the Teaching Health Center Graduate Medical Education Program and the National Health Service Corp Program, are essential resources to begin to increase the number of primary care physicians and to ensure they work in communities that need them most. The THCGME program appropriately trains residents who then stay in the community. THCGME residents are trained in delivery system models using electronic health records, providing culturally competent care, and following care coordination protocols.[16] Some are also able to operate in environments where they are trained in mental health, drug and substance use treatment, and chronic pain management.[17] Residents who train in

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[7] Liaw, W., Jetty, A., Petterson, S., Bazemore, A. and Green, L. (2017), Trends in the Types of Usual Sources of Care: A Shift from People to Places or Nothing at All. Health Serv Res. doi:10.1111/1475-6773.12753

[8] Moy E, Garcia MC, Bastian B, et al, Leading Cause of Death in Nonmetropolitan and Metropolitan Areas - United States, 1999 - 2014, MMWR, Surveil Summ, 2017; 66 (No.SS-1); 1-8. DOI: *https://www.cdc.gov/mmwr/volumes/66/ss/ss6601a1.htm*

[9] MMWR, 2017

[10] Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Mackenbach JP, van Lenthe FJ, Mokdad AH, Murray CJL. Inequalities in Life Expectancy Among US Counties, 1980 to 2014Temporal Trends and Key Drivers. JAMA Intern Med. 2017;177(7):1003-1011. doi:10.1001/jamainternmed.2017.0918

[11] *http://www.annfammed.org/content/13/2/107.full*

[12] U.S. Government Accountability Office, May 2017, GAO 17-411, *http://www.gao.gov/assets/690/684946.pdf*

[13] Hing, E, Hsiao, C. US Department of Health and Human Services. *State Variability in Supply of Office-based Primary Care Providers: United States 2012*. NCHS Data Brief, No. 151, May 2014

[14] GAO, 2017

[15] Ibid

[16] Candice Chen, Frederick Chen, and Fitzhugh Mullan. "Teaching Health Centers: A New Paradigm in Graduate Medical Education." *Academic Medicine: Journal of the Association of American Medical Colleges* 87.12 (2012): 1752-1756. PMC. available at *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3761371/*

[17] David Mitchell, Residency Directors Tout Benefits of Teaching Health Center GME Program, AAFP News, (September 6, 2013), available at *http://www.aafp.org/news/education-professional-development/20130906thcroundtable.html*

underserved communities are likely to continue practicing in those same environments. [18]

American Medical Association Physician Masterfile data confirms that a majority of family medicine residents practice within 100 miles of their residency training location. [19] By comparison, fewer than 5 percent of physicians who complete training in hospital-based GME programs provide direct patient care in rural areas. [20] Thus, the most effective way to encourage family and other primary-care physicians to practice in rural and underserved areas is not to recruit them from remote academic medical centers but to train them in these settings. Similarly, the National Health Care Corps (NHSC) offers financial assistance to recruit and retain health care providers to meet the workforce needs of communities across the Nation designated as health professional shortage areas (HPSAs). The NHSC is vital for supporting the needs of our Nation's vulnerable communities. The AAFP believes building the primary care workforce is an important return on investment. We also believe that workforce programs help ensure high quality, efficient medical care is more readily available. By reducing physician shortages and attracting physicians to serve in communities that need them, these programs also help improve the way care is delivered and help meet the Nation's health care goals.

Disease Prevention and Population Health

Mental Health and Substance Use Issues

Family physicians have traditionally focused on treating the whole patient, and recognize the mind, body and spirit connection. Promotion of mental health, diagnosis and treatment of mental illness in the individual and family context are integral components of family medicine. Mental health is also fundamental for patient and health and community well-being. The AAFP believes that access to increased mental health and substance use funding is a national imperative. According to SAMHSA's 2014 National Survey on Drug Use and Health (NSDUH), an estimated 43.6 million (18.1 percent) Americans ages 18 and up experienced some form of mental illness. [21] In the past year, 20.2 million adults (8.4 percent) had a substance use disorder. Of these, 7.9 million people had both a mental disorder and substance use disorder. [22]

Social factors, such as early life experiences, poverty, racial and ethnic minority status, and exposure to violence, put patients at greater risk of developing mental illnesses. Mental illness is associated with increased occurrence of chronic diseases such as cardiovascular disease, diabetes, obesity. [23] Research found that among elderly patients with high depressive scores, the risk of coronary heart disease increased 40 percent while the risk of death increased 60 percent compared with elderly patients with the lowest mean depressive scores. [24]

The AAFP commends Congress mental health reform efforts, but there is still significant progress needed to fully implement the Mental Health Parity and Addiction Equity Act and to eliminate barriers for primary care and behavioral health integration. People with mental or substance abuse disorders were more likely to get treatment from a primary care physician/nurse or other general medical doctor. [25] We urge continued progress to address this issue.

The AAFP shares the administration's commitment to addressing the Nation's opioid crisis through public education, substance use treatment, overdose prevention, and improved prescription drug monitoring. In 2015, the AAFP joined partners in the public and private sector in announcing a unified effort to address the Nation's epidemic of opioid abuse and heroin use. The AAFP, along with the more than 40 stakeholder groups, pledged to increase opioid abuse prevention, treatment, and related activities. Over the next few years, medical and health stakeholders have

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[18] Elizabeth Brown, MD, and Kathleen Klink, MD, FAAFP, Teaching Health Center GME Funding Instability Threatens Program Viability, Am Fam Physician. (Feb. 2015);91(3):168-170. Available at *http://www.aafp.org/afp/2015/0201/p168.html*

[19] E. Blake Fagan, MD, et al., Family Medicine Graduate Proximity to Their Site of Training, Family Medicine, Vol. 47, No. 2, at 126 (Feb. 2015).

[20] Candice Chen, MD, MPH, et al., Toward Graduate Medical Education (GME) Accountability: Measuring the Outcomes of GME Institutions, Academic Medicine, Vol. 88, No. 9, p. 1269 (Sept. 2013).

[21] Substance and Mental Health Services Administration, *https://www.samhsa.gov/disorders*

[22] SAMHSA, Substance Use and Mental Health Disorders

[23] AAFP, Mental Health Care Services by Family Physicians,

[24] Ibid

[25] Ibid

committed to having more than 540,000 physicians and health care professionals complete opioid prescriber training in the next 2 years; double the number of physicians certified to prescribe buprenorphine for opioid use disorder treatment—from 30,000 to 60,000—in the next 3 years; double the number of clinicians who prescribe naloxone; double the number of physicians and health care professionals registered with their State Prescription Drug Monitoring Programs in the next 2 years; and, reach more than 4 million physicians and health care professionals with awareness messaging about opioid abuse.

Chronic Diseases

Chronic diseases are the leading causes of mortality and morbidity in the United States adult population. According to the CDC, the leading chronic conditions are heart disease, cancers, stroke, obesity, diabetes, and arthritis.[26] As of 2012, about half of all adults–117 million people-had one or more chronic health conditions.[27] One in four adults had two or more chronic health conditions and seven of the top 10 causes of death in 2014 were chronic diseases.[28] Two of these chronic diseases-heart disease and cancer-together accounted for nearly 46 percent of all deaths.[29] These conditions are mostly preventable; therefore, it is vital that as a country we invest in preventive health efforts.

Preventive health is essential for adults, especially with the aging of the U.S. population. By the year 2050, the number of people 65 years of age and older will nearly double increasing the population of Medicare patients, 82 percent of whom have chronic health conditions.[30] As a country, we will only succeed at caring for this population by strengthening primary care, a specialty that is highly skilled in addressing the needs of patients with chronic diseases and multiple conditions. Better chronic care management is associated with fewer trips to the hospital and appropriate utilization of less expensive medical care.[31] Making strides in this area will require a serious commitment to patient education, health care access, and community support.

Programs, such as those that increase access to healthy foods and to increase opportunities to walk through improvements to the built environment have the capacity to help lower the risk of disease such as heart disease, stroke, and diabetes.

Tobacco use is the single largest cause of preventable disease in the United States. Cigarette smoking kills more than 480,000 Americans each year, with more than 41,000 of these deaths from exposure to secondhand smoke[32] The AAFP supports these initiatives through its Tar Wars Program, a community-based effort to encourage family physicians to educate school-age youth about the dangers of smoking. The program began and has been particularly supportive of programs to reduce smoking and to increase access to cessation programs. The AAFP has also supported the Family Smoking Prevention and Tobacco Control Act's full implementation, including efforts to restrict adolescents from using tobacco programs. The AAFP supports restrictions on the sales of specialty and flavored tobacco products, regulations on electronic nicotine delivery devices, and prohibits on the sale of tobacco products for those under 21 years of age.

Immunization and Infectious Diseases

Immunizations are a 21st century public health success, yet 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.[33] A 2016 report published in Health Affairs indicates that the economic costs of vaccine-preventable disease for adults is between $4.7 billion and $14 billion per

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[26] CDC, Chronic Diseases, *https://www.cdc.gov/chronicdisease/overview/index.htm*

[27] Ibid

[28] Ibid

[29] Ibid

[30] Tricia Neuman, Juliette Cubanski, Jennifer Huang, Anthony Dominco, Kaiser Family Foundation, Report, Rising Cost of Living Longer (January 2015), accessed online at:*http://kff.org/medicare/report/the-rising-cost-of-living-longer-analysis-of-medicare-spending-by-age-for-beneficiaries-in-traditional-medicare/*

[31] Reid B. Blackwelder, MD, Leaders Voices Blog, (October 2014), We're Doing Our Part to Keep SGR Issue On Congress' Radar, *http://blogs.aafp.org/cfr/leadervoices/entry/we—re—doing—our—part*

[32] CDC, *https://www.cdc.gov/tobacco/campaign/tips/resources/data/cigarette-smoking-in-united-states.html*

[33] Office of Disease Prevention and Health Promotion, Healthy People 2020, *https://www.healthypeople.gov/2020/topics- objectives/topic/immunization-and-infectious-diseases*

year.[34] Although vaccines are available in many different locations, such as pharmacies and in workplaces, primary care physicians play an important role as immunizers. The doctor-patient relationship can be instrumental in helping patients overcome their hesitancy or educating them when new immunizations are recommended.

Doctors also understand patients' medical histories and risk factors. For example, primary care physicians can help diabetes mellitus patients understand how the condition compromises their immune system and why their vaccinations should be up-to-date. Health experts also agree that global cooperation is an important value, but it is also important note that infectious disease knows no boundaries. The AAFP supports programs that increase access to vaccines, such as the CDC's Section 317 Immunization Grant program. The program provides funding to states to immunize underserved populations. The AAFP also supports policies to improve immunization information system interoperability to allow physicians to access state data bases and to allow for better interstate communication.

The AAFP recognizes the importance of addressing the spread of antibiotic resistant bacteria. AAFP has committed to reducing the use of unnecessary antibiotics in medicine, but there is still significant progress needed within animal agriculture. Currently, 70 percent of the antibiotics used in the US are used for food-producing animals. It is our hope that progress continues under the U.S. Food and Drug Administration's current initiatives to reduce the over-utilization of antibiotics in animals.

Child Health

Disease prevention is an import issue for pediatric populations. Children are not little adults, which means that their health needs are unique. Most children are healthy and spending on this population represents a small portion of overall healthcare investments, but supporting child well-being can ensure that our Nation has a healthier future. Initiatives that build health early in life include pro-conception care, home visiting, early nutrition, vaccine access, health care, child care, and early education. Medicaid is particularly vital for children because it provides coverage for such a large proportion of the child population (close to one in three US children are covered by Medicaid or CHIP). Child patients with Medicaid coverage are also entitled to any benefit that is "medically necessary," which includes hospital care, physician services immunizations and early, periodic, screening, diagnostic, and treatment (EPSDT) for those under the age of 21[35] Medicaid also covers family planning, and other maternal health services for women across the country. Medicaid is also the predominant source of health coverage for children in the foster care system. These are among the most vulnerable children in society because of their unique social and emotional needs.

Violence prevention is an important child health and lifespan issue.[36] An estimated 702,000 children were confirmed by child protective services as being victims of abuse and neglect in 2014.[37] At least one in four children have experienced child neglect or abuse (including physical, emotional, and sexual) at some point in their lives, and one in seven children experienced abuse or neglect in the last year.[38] Children who have suffered abuse or neglect may develop a variety of short-or long-term behavioral and functional problems including conduct disorders, poor academic performance, decreased cognitive functioning, emotional instability, depression, a tendency to be aggressive or violent with others, post-traumatic stress disorder (PTSD), sleep disturbances, anxiety, oppositional behavior, and others[39]

According to the landmark Adverse Childhood Experience Study (ACES), children who are exposed to traumatic life experiences are more likely to experience adult

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[34] Modeling The Economic Burden Of Adult Vaccine-Preventable Diseases In The United States. Health Aff (Millwood). 2016 Nov 1;35(11):2124-2132. Epub 2016 Oct

[35] Kaiser, Medicaid Benefits, 1997, *https://kaiserfamilyfoundation.files.wordpress.com/2013/05/mrbbenefits.pdf*

[36] AAFP, Violence Position Paper, *http://www.aafp.org/about/policies/all/violence.html*

[37] CDC, Child Abuse and Neglect, *https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html*

[38] Ibid

[39] Holbrook TL, Hoyt DB, Coimbra R, Potenza B, Sise M, Anderson JP. Long term trauma persists after major trauma in adolescents: new data on risk factors and functional outcome. J Trauma. 2005;58 (4):764 -771

diseases later in life.[40] The Among those adults who had experienced the highest levels of childhood trauma and thus had the highest "ACES" score, those individuals were: five times more likely to have been alcoholic; nine times more likely to have abused illegal drugs; three times more likely to be clinically depressed; four times more likely to smoke; 17 times more likely to have attempted suicide; three times more likely to have an unintended pregnancy; three times more likely to report more than 50 sexual partners; two times more likely to develop heart disease; and two times more likely to be obese.[41]

Violence prevention is not only a child health issue, as many children survive violence in the home that has impacts across their lifespan. It is important to invest in initiatives that reduce violence and promote child well-being such as domestic violence prevention, parenting education, evidence-based home visiting, and early childhood support. Furthermore, there is a growing movement within the medical community to address these issues, like toxic stress, and to help patients access mental health and trauma-informed services. In addition, gun safety policies have the potential to decrease accidents and violence that result in thousands of injuries, disabilities, and deaths each year. The AAFP supports research and common-sense policies, such as improved background checks, to reduce the risk individuals may pose to themselves or to others within their communities.

Equity and Health Barriers

The mission of the AAFP is to improve the health of patients, families, and communities by serving the needs of members with professionalism and creativity. In their patient-centered practices, family physicians identify and address the social determinants of health for individuals and families, incorporating this information in the bio psychosocial model to promote continuous healing relationships, whole-person orientation, family and community context, and comprehensive care. Social determinants of health are the conditions under which people are born, grow, live, work, and age. To that end, the AAFP established its Center for Diversity and Health Equity to provide opportunities to become a more thoughtful and visible leader for diversity and health equity.

Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location all contribute to an individual's ability to achieve good health. Experts agree that successfully achieving measurable outcomes is possible with a "health in all policies" strategy that examines the multiple factors that contribute to or detract from a patient's health. We must seek to understand how issues such as race, ethnicity, sex, age, disability, economic status, and geographic location influence health, but also acknowledge that access to housing, safe drinking water, and clean air also impact our patients.

The AAFP believes Federal, state, and local policymakers should acquaint themselves with these social determinants of health and embrace equality as vital to community health. Policy makers should also eliminate barriers that prevent individuals from accessing the care, information, and social supports that they need to reach optimal health. One barrier that raises concerns for health equity is the persistent passage of Federal laws that interfere with the doctor/patient relationship. These efforts often manifest in policies that create barriers for women's ability to access contraception and abortion. The AAFP opposes legislative interference in the doctor/patient relationship its replacement of scientific evidence and its undermining of patient autonomy.

The AAFP is also concerned about the state of Federal funding and the implications for patients' health, safety and access to care. Growing Federal funding cuts potentially create a domino effect of damage that ultimately will harm the health of America on both an individual and community-wide basis. Reducing funding for agencies that oversee the health care industry—17 percent of the U.S. economy—destabilizes the foundation of services on which patients depend. Damage to one agency can impact the viability and effectiveness of others. The system is only as strong as the agencies and programs that undergird it. The AAFP encourages Congress to ensure stability of programs that are foundational to an effective, efficient health care system.

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[40] Felitti VJ, Anda RF, Nordenberg P, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. Am J Prev Med. 1998;14 (4):245 -258

[41] Jones R, Flahery EG. Clinicians' Description of Factors Influencing Their Reporting of Suspected Child Abuse: Report of the Child Abuse Reporting Experience Study Research Group. Pediatrics. 2008;122(2):259-266

Health care access is also a significant barrier, especially for low-income individuals. The AAFP first adopted a policy supporting health care coverage for all in 1989. For the past 28 years the AAFP has advanced and supported policies that would ensure a greater number of Americans had health care coverage. The AAFP appreciates the bipartisan support for the Medicare Access and CHIP Reauthorization Act's (MACRA) landmark reforms that have the potential for improving patient care outcomes by emphasizing value over fee-for-service. We welcome the opportunity to work with policymakers to evaluate MACRA's implementation process. enactment and the potential to improve patient outcomes.

It is also important to acknowledge that passage of the Patient Protection and Affordable Care Act represented a sea change for millions of patients. We are pleased the Committee has engaged in bipartisan hearings on how to improve individual market as well as proposals to maintain the cost-sharing reduction payments. Medicaid expansion and the law's Essential Health Benefits were particularly important for vulnerable populations. Medicaid assists the most vulnerable patients who are members of minority groups, homeless, formerly incarcerated, foster and former foster youth, mentally ill, addicted, and military families. Insurance coverage rates among minorities are lower than rates among the non-Hispanic white population.[42] Minorities experience disproportionate rates of illness, premature death, and disability compared to the general population.[43] In addition, virtually all of the estimated individuals nationally who are homeless could be eligible for Medicaid. Many in this population would benefit from the mental health and addiction treatment requirement included under the law.[44] Forty percent of our Nation's veterans who are under 65 years of age have incomes that could qualify them for Medicaid under the ACA's expanded coverage.[45] In general, family members of veterans are not covered by the Veteran's Administration, but may seek coverage through Medicaid or the marketplace.[46] Many patients in this category are unaware that they qualify for health benefits.

A New England Journal of Medicine article indicates that the law's coverage expansion was associated with higher rates of having a usual source of care, greater access to primary care access, and, higher rates of preventive health screenings.[47] Anecdotal evidence among family physicians also reveal that health care access is saving lives and improving patient health for those who are accessing much-needed care for chronic diseases or detecting conditions in the initial stages. Again, achieving optimal health does not occur by accident. Realizing the vision of healthy communities, like other national priorities, requires that we identify goals, invest resources, and eliminate barriers, especially for vulnerable citizens.

Conclusion

The AAFP appreciates the opportunity to share these comments on community health and welcomes the opportunity to work with policymakers to achieve positive outcomes on these and other policies. For more information, please contact Sonya Clay, Government Relations Representative, at 202–232–9033 or *sclay@aafp.org*.

The CHAIRMAN. Thank you, Senator Murray. It will be included.

I'm pleased to welcome the Surgeon General, Dr. Jerome Adams, to today's hearing. He oversees the U.S. Public Health Service Commissioned Corps, a group of over 6,500 public health professionals working throughout the Federal Government for the advancement of public health.

Dr. Adams previously served as the Indiana State Health Commissioner. Before that, he served as Staff Anesthesiologist and Assistant Professor of Anesthesia at the Indiana University School of Medicine. He holds a B.S. in biochemistry, a B.A. in biopsychology

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[42] Center for Health Care Statistics (CHCS), Reaching Vulnerable Populations Through Health Reform, April 2014, available at—*http://www.chcs.org/media/Vulnerable-Populations—April-2014.pdf*

[43] Center for Health Care Statistics, April 2014

[44] Id.

[45] Id.

[46] Id.

[47] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., N Engl J Med 2017; 377:586-593

from the University of Maryland, Baltimore County; a Master's in Public Health from the University of California at Berkeley; and an M.D. from the Indiana University School of Medicine, where he also completed his anesthesia residency.

Welcome again, Dr. Adams. We appreciate you summarizing your testimony in about 5 minutes. That'll leave more time for questions.

Welcome.

STATEMENT OF VICE ADMIRAL JEROME ADAMS, M.D., MPH, SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE, WASHINGTON, DC

Dr. ADAMS. Absolutely. Thank you so much. It is good to be here again. It's a little bit lonelier up here than what it was the last time I was here. But I'll tell you, it's good to be back. I'd like to thank Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee for hosting these very important hearings on the topic of wellness.

I'm going to sidetrack just for a little bit and go over my time just for a bit, because I have to say to each and every one of you thank you so much for confirming me. Thank you so much for being willing to work with me, both to the Senators and to all of the staffers.

I was coming in the building this morning and I was reading about Senator Dirksen. He was beloved by all of his colleagues, and I think that the HELP Committee really epitomizes the bipartisan—from my point of view, health is nonpartisan—nature of how we need to look at problems. I want to say thank you so much for your support getting me here, and I look forward to your support moving forward.

Back to my testimony. The United States is the undisputed global leader in medical research and medical care. However, despite spending over $3.2 trillion annually on healthcare, we continue to rank below many countries in life expectancy and in other important indicators of health. Chronic diseases like heart disease, cancer, diabetes, and lung disease are the leading causes of death and disability in the United States and among the most costly. Yet we know they are preventable.

While there's been some stabilization in mortality from most chronic diseases, we are now facing an unprecedented number of lives lost due to suicides and drug overdoses largely involving prescription or illicit opioids. These so-called deaths of despair are affecting all Americans across the country and are brought on in part by a lack of hope and a lack of opportunity. This is why it is so important that the President called for the declaration of the opioid crisis as a public health emergency. At HHS, we are committed to using all possible resources to attack this epidemic head-on.

Not only is the opioid epidemic impacting our families and communities, but it is also taking a significant toll on our economy. The economic burden of the opioid crisis is $78.5 billion, with a B, in healthcare, law enforcement, and lost productivity.

There is good news, however. Research showed that for each dollar invested in evidence-based prevention programs, up to $10 is saved in treatment costs. Furthermore, these prevention programs

have also been shown to prevent high school delinquency, teen pregnancy, school dropout, and violence. We can turn the tide.

Effective public health interventions and policies that target chronic diseases and deaths of despair lead to a healthier population with lower healthcare spending, less school and workplace absenteeism, increased economic productivity, and an improved quality of life. What's the key to effectiveness and efficiency? Well, scientists have found that the conditions in which we live, learn, work, and play can have an enormous impact on our health long before we ever see a doctor.

A community suffering from poor health is all too often a home to local businesses with workforce shortages and work-related illnesses and injuries. There are declines in productivity and issues with workforce recruitment and retention, which lead to decreased profitability. Productivity losses as a result of employees who don't come to work or who work while sick, cost U.S. employers more than $225 billion annually. This equates to almost $1,700 per employee per year due to our country's unwellness.

As I travel around the country, I constantly hear that businesses are struggling to fill open positions because applicants are unable to pass a drug test. Businesses that recognize addiction as a chronic disease and help their employees access treatment avoid the high cost of termination, recruitment, and retraining new staff. Businesses that recognize the downstream cost of community inactivity, poor nutrition, and tobacco use demonstrate lower healthcare costs and boast larger profits.

While the government must play a role in prevention and treatment, we cannot do it alone, as Senator Alexander mentioned. The business sector is a critical partner in helping achieve gains in the wellness of all Americans. The private sector pays for about half of total healthcare spending in the United States.

But rather than viewing health merely as an insurance expense to be controlled, more companies are seeing the building of a community culture of health as a true business opportunity. Why? Because mental, physical, and economic health in communities are strongly and inextricably correlated. Healthier communities tend to be more economically prosperous, and more prosperous communities tend to be healthier.

Improved community conditions for health, such as clean and safe neighborhoods, access to healthy food options, and opportunities for exercise and physical activity can help influence positive health behaviors and lead to a more productive and a more profitable workforce. While workplace wellness programs are fortunately becoming more prevalent amongst corporations—and a lot of the initial testimony that you had previously focused on those—the most innovative businesses are implementing initiatives that go well beyond an onsite focus on employees to incorporating community health as a whole.

For example, Target is putting wellness at the center of its corporate social responsibility strategy, investing $40 million in more than 50 nonprofits which focus on increasing the physical activity and healthy eating habits of local children and their families. GSK, Costco, Cummins, and many others have invested in their commu-

nities as a means of investing in their most valued asset, their employees.

In closing, I'd say that recognizing the role of wellness in our country's safety, security, and prosperity is why I'm focusing my term as Surgeon General on better health through better partnerships. This means we will strengthen ties with existing public health and healthcare partners. But it also means we will forge new partnerships with the business, law enforcement, education, and defense sectors, as well as the religious, faith-based, and other community organizations and sectors.

For this reason, my signature report will focus on the intersection between health and the economy, how businesses are able to thrive by investing in the health of their employees and communities. Achieving wellness at the community level is paramount to eliminating chronic disease, improving quality of life, reducing healthcare costs, and increasing life expectancy. By working together across the public and private sectors, I am confident that we will achieve HHS's goal of healthier people, stronger communities, and a safer Nation.

With that, I'm happy to take your questions.

[The prepared statement of Dr. Adams follows:]

PREPARED STATEMENT OF JEROME M. ADAMS

Value of Wellness

I would like to thank Chairman Alexander, Ranking Member Murray, and Members of the Senate HELP Committee for hosting hearings on the topic of wellness.

The U.S. is the global leader in medical research and medical care. However, there are reasons for concern. Despite spending over $3.2 trillion annually on healthcare—which is significantly more than any other country—we continue to have room for improvement when it comes to life expectancy and other indicators of health.

Chronic diseases—like heart disease, cancer, diabetes, and chronic obstructive pulmonary disease (COPD)—are the leading cause of death and disability in the U.S. and among the most costly, yet these afflictions may be preventable. The World Health Organization reports that at least 80 percent of all heart disease, stroke, and type 2 diabetes and up to 40 percent of cancer could be prevented if people ate better, engaged in more physical activity and ceased to use tobacco. [1]

While there has been some stabilization in deaths from some chronic diseases, we are now facing unprecedented increases in deaths due to suicide, liver cirrhosis from alcohol consumption, and drug overdoses, largely due to overdose deaths involving prescription or illicit opioids. The President recently called upon Acting Secretary Hargan to declare the opioids crisis plaguing our communities a nationwide Public Health Emergency. These so-called deaths of despair are affecting all Americans across the country, and are brought on in part by a lack of hope and opportunity. The opioid epidemic impacts our families and communities, and it is taking a toll on our economy. The economic burden of the prescription opioid crisis is $78.5 billion in healthcare, law enforcement, and lost productivity. The good news is that research shows that for each dollar invested in evidence-based prevention programs, up to $10 is saved in treatment for alcohol or other substance misuse-related costs. [2] These prevention programs go beyond preventing or lowering the risks of addic-

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[1] *Preventing chronic diseases: a vital investment*, World Health Organization, 2005, *http://www.who.int/chp/chronic—disease—report/full—report.pdf*;*Noncommunicable diseases country profiles*, World Health Organization, July 2014, *http://www.who.int/nmh/publications/ncd-profiles–2014/en/*

[2] Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health, Office of the Surgeon General, U.S. Department of Health and Human Services, November 2016, https://addiction.surgeongeneral.gov/

tion—they also have been shown to prevent delinquency, teen pregnancy, school dropout, and violence.[3]

Effective public health interventions and policies that target deaths of despair and chronic diseases lead to a healthier population with lower health care spending, less school and workplace absenteeism, increased economic productivity, and an improved quality of life.

By investing in the prevention and treatment of the most common chronic diseases, one estimate shows the U.S. could decrease treatment costs by $218 billion per year and reduce the economic impact of disease by $1.1 trillion annually.[4]

Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. Wellness starts in our families, our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink.

Wellness and the Business Sector

Productivity losses as a result of employees who don't come to work, or work while sick, cost U.S. employers $225.8 billion annually, or about $1,685 per employee each year. For example, obesity and obesity-related illnesses, like diabetes, cost the Nation over $153 billion per year in lost productivity.[5]

As an administration, we are focused on the opioid crisis currently impacting our country, and with good reason. Prescription opioid addiction and non-fatal overdoses cost $20.4 billion in lost productivity in 2013.[6] According to the National Safety Council, a worker with a substance use disorder is not as productive, is more likely to make a mistake, and may take twice as many sick days. Companies that recognize addiction and support their staff have found that employees in recovery have lower turnover rates, are less likely to miss work, and are less likely to be hospitalized and have fewer doctor visits.

A community with poor health results in local businesses with workforce shortages; absenteeism; presenteeism, when workers are on the job but are not fully functioning due to illness or other medical conditions; work-related injuries and illnesses; declines in productivity and profitability; and issues with workforce recruitment and retention. As I travel around the country, I have heard that businesses are now struggling to fill open positions because applicants are unable to pass their drug tests. Businesses that recognize addiction and help employees get into treatment allow employers to keep valued employees. Furthermore, employers also avoid the high costs of termination, recruitment, and retraining new staff.

The business sector is a critical partner in helping achieve gains in the wellness of Americans. The private sector pays for about half of total healthcare spending in the United States. Rather than viewing health merely as an insurance expense to be controlled, more companies are seeing the building of a health culture as a business opportunity.

After CVS removed tobacco products from store shelves and renamed itself CVS Health, new revenues more than made up for lost sales while also reducing the purchases of cigarette packs by at least 95 million at "all retailers" by at least 95 million at "all retailers."by at least 95 million at "all retailers."[7] General Dynamics Bath Iron Works, a large full-service shipyard in Maine employing over 6,000 employees, extended a successful in-house diabetes prevention initiative into the wider community. It expects to cut participants' future healthcare costs over five years by 60 percent on average.

The health and economy of communities are often strongly correlated. Healthier communities tend to be economically more prosperous and vice versa. Improved community conditions for health, such as clean and safe neighborhoods, access to healthful food options, and opportunities for exercise and physical activity, can help positively influence health behaviors and lead to a more productive workforce.

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[3] *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, Office of the Surgeon General, U.S. Department of Health and Human Services, November 2016, *https://addiction.surgeongeneral.gov/*

[4] *An Unhealthy America: The Economic Burden of Chronic Disease—Charting a New Course to Save Lives and Increase Productivity and Economic Growth*, Milken Institute, 2007, *http://assets1b.milkeninstitute.org/assets/Publication/ResearchReport/PDF/chronic—disease—report.pdf*

[5] Stewart WF, Ricci JA, Chee E, Morganstein D. Lost productive work time costs from health conditions in the United States: results from the American productivity audit. *J Occup Environ Med*. 2003;45(12):1234–1246

[6] Florence, Curtis S., Chao Zhou, Feijun Luo and Likang Xu. "The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013." *Medical Care* 54 10 (2016): 901–6

[7] *CVS*; *Forbes, 2015*

Several businesses are implementing health initiatives that go beyond workplace wellness programs to support community health. For example, Target is putting wellness at the center of its Corporate Social Responsibility strategy, having invested $40 million dollars in more than 50 non-profit organizations around the U.S., which focus on increasing the physical activity and healthy eating habits of children and their families in local communities.

Wellness and National Security

As a United States Public Health Service (USPHS) Commissioned Corps officer and member of the uniformed services, I know that wellness is at the heart of the safety and security of our Nation. It is estimated that seven in ten youths (ages 17–24) would fail to qualify for military service due to obesity, educational deficits, or behavioral health issues/criminal history. [8]

In order to ensure a strong national defense, we need to ensure threats to service member recruitment, retention, readiness, and resilience are mitigated. As Surgeon General, I am working to bring awareness to this issue by publicizing my annual physical fitness test for the USPHS, which evaluates four key components of fitness: cardiorespiratory endurance, upper body endurance, core endurance, and flexibility. I will be working with members of the PHS Commissioned Corps, National Guard, and other Department of Defense reserves to work with local schools in order to implement evidence-based programs to increase physical fitness. Not just because our youth deserve to be healthy, but also for their educational benefit and the benefit of teachers and their classrooms as well. Research demonstrates that students who engage in physical activity have greater attention spans in class and higher test scores in addition to the health benefits.

Surgeon General Priorities

Recognizing the role of wellness in our country's safety, security, and prosperity is the reason I will focus my term as Surgeon General on "Better Health through Better Partnerships." This means we will strengthen ties with existing public health and healthcare partners, while forging new partnerships with the business, law enforcement, education, and defense sectors, as well as religious and faith-based, and other community organizations.

It is for this reason I have decided my signature Surgeon General's report will focus on the intersection between health and the economy, and how businesses are able to thrive by investing in the health of their employees and communities. By partnering with non-traditional sectors and helping them recognize their role in wellness at the community level, we allow everyone to have a fair chance for good health and opportunities for better health choices. Achieving wellness at the community level is paramount to eliminating chronic disease, improving quality of life, reducing healthcare costs, and increasing life expectancy. By investing in communities, we can ensure the U.S. Department of Health and Human Services' goal of healthier people, stronger communities, and a safer Nation.

The CHAIRMAN. Thank you, Dr. Adams. We'll now begin a 5-minute round of questions, and I'll start.

Senator Murray mentioned the tax bill, and I'll briefly comment on that before I go to wellness. Senator Murray knows how much I respect her leadership and the work we did most recently on the Alexander-Murray legislation, which has growing support in both the Democratic and Republican sides of the Senate and I think the House, and, hopefully, eventually with the President.

But it's in a different bill in a different committee. It's in the Tax Reform Bill, and it cannot—the Alexander-Murray proposal, under the rules of the Senate, cannot be made a part of the Tax Reform Bill. It has to stand on its own. It'll be considered separately and must be considered separately. I imagine there will be other provisions in the Tax Reform Bill, as it makes its way through the Finance Committee today, that Democratic Members of the Senate

[8] Unfit to Serve, *CDC infographic*; Ready, Willing, and Unable to Serve, *Mission: Readiness Report, 2009*

don't like, and they'll have a chance to vote against those provisions.

No. 2, the Tax Reform Bill is moving through committee. It's being amended this week, or amendments are being offered. It will go to the floor, where there'll be an unlimited number of amendments that can be offered.

No. 3, it's true that if the individual mandate is repealed in 2019, the Congressional Budget Office has said that rates could go up 10 percent in that year, but that the markets would be stable during the decade. The Congressional Budget Office has also said that, quite aside from that, if we don't pass Alexander-Murray with the cost-sharing provisions that we'll have a 20 percent increase in rates this year, and that increase will go up to 25 percent in 2020.

I know there are differences of opinion about what the Finance Committee is doing. My only point is that's a different committee, a different bill, and the work we did on Alexander-Murray can't be considered as a part of the Tax Reform Bill under the rules of the Senate.

Senator MURRAY. Mr. Chairman, could you just yield to a question?

The CHAIRMAN. Sure.

Senator MURRAY. Do you agree with me that the Alexander-Murray Bill was not designed to deal with the disruption in the marketplace, though it increased costs by 10 percent, as you just identified, where more people lose their coverage under the individual mandate repeal?

The CHAIRMAN. Well, it was designed to deal with disruption in the marketplace. The CBO found that repealing the individual mandate will not create instability in the market. It will raise rates 10 percent.

Senator MURRAY. But our bill was never designed—we did not have hearings, we did not have input, we did not have any discussion about what the marketplace would look like if the individual mandate was repealed.

The CHAIRMAN. Well, no, we didn't, because the individual mandate is a tax, and that's not in our jurisdiction.

Senator MURRAY. Yes. My point is that our bill was not designed to——

The CHAIRMAN. It's in the Finance Committee's jurisdiction.

Senator MURRAY.——deal with the current provision that's being proposed.

The CHAIRMAN. Well, our bill is in this Committee, and it's one set of issues, and if it doesn't pass, we'll have a big increase in premiums, the CBO has said. The Finance Committee is working on another bill, which our bill can't be a part of under the rules of the Senate.

Dr. Adams, in our last wellness hearing, someone suggested that there might be a wellness program for the Department of Health and Human Services since it has 80,000 employees and millions of people work across all the Federal agencies. Would such a pilot program—does one exist, a wellness program now for HHS? Would it be possible to have one?

Dr. ADAMS. Well, I certainly appreciate that question, Chairman, and I can tell you that the Department of Health and Human Serv-

ices has a number of wellness programs for their employees. We offer free gym memberships. We offer free flu shots. We have a variety of healthful food options. When you go to the cafeteria, and when you're wearing the uniform, and you walk in——

The CHAIRMAN. But I mean the kind that the Cleveland Clinic has, where it's a structured program, where employees are given incentives and opportunities to have reduced—some benefits for an improved lifestyle. Do you have that?

Dr. ADAMS. Well, I certainly think that Cleveland Clinic is the ideal, and there's an opportunity for us to grow at HHS and to become even better at incentivizing healthy behaviors. The answer to your question, very directly, sir, is we have a number of programs, but we could do better, and we need to look at examples such as the Cleveland Clinic, and then take that to all of our corporations and businesses across the country.

The CHAIRMAN. Well, models and pilot programs sometimes set good examples. The bully pulpit is a good way to lead, rather than mandates from Washington sometimes. Another example of that is the Malcolm Baldrige National Quality Improvement Act of 1987 that was created to encourage businesses, nonprofits, and others to compete for performance-based awards to improve the quality of what they were doing.

I knew David Kearns very well. I recruited him to be the Deputy Secretary of the Department of Education in 1991. He was the CEO of Xerox, and Xerox is one of the companies that had gone through the Baldrige competition and won it. Companies all over America signed up for that and improved their quality without any Federal orders to do it. That was the incentive, the honor of it all.

I wondered if you had ever considered a Baldrige type award for wellness for employers who want to improve the lifestyle of their employees.

Dr. ADAMS. Senator, I think that is a wonderful idea. The states that have been really innovative in this arena have had awards sponsored by their local chambers of commerce to recognize businesses that are not only doing onsite workplace wellness but also reaching out into the communities. I think the more we can highlight those programs, the more we can applaud folks for doing what we know is the right thing, the better. I think that's wonderful idea.

The CHAIRMAN. Thank you, Dr. Adams.

Senator Murray.

Senator MURRAY. Your testimony speaks to the critical role that employers can have in supporting the health and well-being of their communities and employees. Now, as you know, the Trump Administration recently took the extreme action of allowing practically any employer or university to claim a religious or morale exemption to avoid covering birth control for their employees without ensuring they have an alternative source of coverage.

Rather than promoting the health of their workers, that would actually allow employers to prevent female employees from having coverage through their employer sponsored insurance that is required today under the ACA, taking away, actually, healthcare options for millions of women nationwide and undermining their economic well-being. I wanted to ask you, do you agree that having

access to birth control is critical to the health of women across our country?

Dr. ADAMS. Senator, I believe that women's health and family planning are extremely important parts of health and wellness in our communities, and I hope that the folks here in this room can come together and help institute reasonable laws, and at HHS, we're always searching to come up with reasonable compromises that are acceptable to communities and states to be able to emphasize women's health.

Senator MURRAY. Do you believe that's an appropriate way for employers to influence healthcare decisions of their employees?

Dr. ADAMS. I'm sorry, believe what is appropriate?

Senator MURRAY. The new mandate—or the new rule from the Administration that pretty much says any employer or university can opt out. Is that an appropriate way if employers opt out?

Dr. ADAMS. I certainly appreciate the question, Senator, and when I am talking to folks about health, there's the science, but the science has to be implemented as one variable into a complicated policy equation. What I've found is that mandates rarely are accepted by the community and by the people who we're trying to help. As Surgeon General, what I want to do is make sure folks understand the science, and I believe what we're trying to do is give corporations the flexibility to determine what is best for their employees. I want to make sure I'm there to help them understand what the science says.

Senator MURRAY. Thank you. My point is that if we are telling employers that they can decide how a woman's healthcare can be covered, and in a hearing where we're talking about employers helping the well-being of their employees, that seems really at odds with me.

Now, as you've heard today, there are many promising examples where private sector engagement can improve both health and economic growth at local levels. We've seen that in some of the most successful initiatives that involved efforts where the private sector investments complement our Nation's public health backbone. One great example of that is in my home State of Washington where child care providers, public water system operators, residential property managers, and others are working with their state health department to eliminate childhood lead exposure.

Now, this would not be possible without state and local public health departments, which provide the services and infrastructure to protect kids from lead poisoning, which is why the private sector can't and should not be expected to go it alone. Whether we're talking about lead poisoning prevention or combating heart disease, our public health system really depends on sustained Federal funding from CDC and others. Yet time and again, we have had to fight back proposals from this Administration that would slash Federal funding for public health.

In your written testimony, you spoke to the value of investing in prevention. Do you think Federal funding for CDC supported state, local, tribal, and territorial public health programs is adequate?

Dr. ADAMS. Ma'am, as a public health advocate, I always want more money for public health. I also realize that tax revenues that come in from increased businesses in a society also can contribute

to state and local funding for public health, and I think that's a complicated policy equation that doesn't fall under my purview.

What I want to do is make sure folks understand we need to invest in prevention and public health. We need to make sure that that total number continues to increase, and that's going to come from private, that's going to come from Federal, that's going to come from state. But, ultimately, it does need to increase if we're going to lower our costs in the long term.

Senator MURRAY. Okay. I just have a half a minute left. But we all know the opioid epidemic is going to take long-term sustained investments in prevention and treatment and recovery. As Surgeon General, I know you're less directly involved with on-the-ground response to the opioid epidemic than you were as a state health commissioner. But you do have a unique ability to speak to the country about how community stakeholders must come together.

I wanted to ask you how you're using your role as Surgeon General to help communities overcome some of the divisive issues, like needle exchange, so they can really address the opioid crisis.

Dr. ADAMS. Well, thank you so much for that question. One of the things that I've already done is participated in a forum for the HHS Neighborhood and Faith-Based Partnerships Division. I'm reaching out to those communities and helping folks understand that sometimes controversial interventions that are scientifically based can and should be considered in the toolkit when you're looking at how to respond to the opioid epidemic.

I met with Chief Justice Loretta Rush just last night, the Chief Justice of Indiana. She's heading up the Judicial Opioid Task Force, and we're looking at ways to bring in the judicial community for diversion programs or pre-trial programs. We've also reached out to the police and the law enforcement community. I was in Atlanta last week and met with the sheriff down there, and we talked about ways to decrease violence by making sure folks get access to treatment.

That's why, again, my motto is better health through better partnerships. Einstein said the definition of insanity is doing the same thing and expecting a different result. We've got to break out of our siloes. We've got to start speaking languages that resonate, including the language of business, including the language of the faith-based community, and an understanding for where they are, and we've got to meet people where they are.

Senator MURRAY. Thank you very much.

Dr. ADAMS. Thank you to you and your staff. You have been a tremendous help. Please share with me your examples from Washington, because we want folks to know you all are doing some great work out there.

The CHAIRMAN. Thank you, Senator Murray.

Senator Cassidy.

Senator CASSIDY. Hey, Dr. Adams.

Dr. ADAMS. Hello.

Senator CASSIDY. I'm going to follow-up on what Senator Murray just said, because you're also a pain doc.

Dr. ADAMS. I am.

Senator CASSIDY. If there's something that unites us, it's we've got to do something about opioids. It appears that overprescribing

by physicians and dentists is part of what's driving the opioid epidemic. This may be in your current position, or it may be in your state position, or it may be in your pain doc position. But is there anything that we could do, legislatively, that you could specify that would help with this opioid epidemic, from any of the hats you have worn?

Dr. ADAMS. I certainly appreciate that. I want to highlight one of the things we're doing at HHS, and that's the Committee on Alternatives for Pain Management, and we're going to have our first meeting either in late December or early January. Thank you all for giving us the opportunity to come up with those opioid alternatives.

But something that all of you can do—you can invite me to your communities to help speak about wellness and the economy. Why does that matter, and why is that an answer to your question? Because I framed these in my opening testimony as deaths of despair. If you ultimately want to get upstream, we've got to make sure communities are more prosperous so that people don't lose hope. If they can see that there's an opportunity to go to something else besides self-medicating, ultimately, that's the most upstream that we can go.

Senator CASSIDY. That Princeton study by Anne Case, the Death of Despair—from Despair, specifically, middle-aged white males, but now also other groups—if you will, tracing that opioid epidemic back to if the folks have no vision, they despair.

Dr. ADAMS. Absolutely. As I said, a healthier community is more prosperous, and a more prosperous community is, in turn, healthier and is not going to suffer as much from the opioid epidemic or cancer or diabetes or what-have-you.

Senator CASSIDY. We actually address opioids not collaterally, but as part of an overall approach. Now, we spoke beforehand about some of the stuff you've done—were involved with in Indiana——

Dr. ADAMS. Yes.

Senator CASSIDY.——and with some of the preventive programs that we previously heard about from business have been implemented for folks who are not—through business. Can you elaborate on that? Again, what can we take as guidance from what you all have done successfully to bring better health to groups who, statistically, are more likely to suffer from chronic illness?

Dr. ADAMS. Well, we know a lot of our folks who suffer from chronic illness, who suffer from infant mortality, who suffer from the opioid epidemic are covered by Medicaid. I don't want to go too far down the rabbit hole here, but I will say that in Indiana, with our Healthy Indiana plan, we've been able to incentivize wellness and healthier behaviors——

Senator CASSIDY. How did you do that, may I ask?

Dr. ADAMS. Well, we have a health savings plan, and folks pay a deductible each year. They get a discount on their deductible if they participate in wellness activities that have been scientifically validated, like getting your colon cancer screening, like getting your breast cancer screening, like participating in immunizations.

We found that by having a program that gave the state the flexibility to experiment—you mentioned pilot programs, sir—to be able

to do that in an innovative way, giving the state the flexibility, we've been able to increase the participation in wellness initiatives by folks who people did not believe would do it. I can tell you I lived through it. Folks didn't believe it was going to work.

Senator CASSIDY. Just to put a point on it—because my experience as a physician was working in a hospital for the uninsured, which just socioeconomically tended to be poor—there's always a kind of bias that folks such as you and I are speaking of who are not sophisticated enough to respond to such incentives or otherwise have obstacles which do not allow it, and you're saying, absolutely, they will respond appropriately in their self-interest in a way which isn't mandated, because I'm not—believe me, the American people hate to be told to do anything, but they love being incentivized, and they responded to incentives.

Dr. ADAMS. You said two things there, sir, that I want to draw out. You said that people believe that they can't or they're not sophisticated enough to do it. That is absolutely false. If we set up a program that incentivizes them, they will respond to those——

Senator CASSIDY. By the way, the same incentives as I would have through the workplace incentive program.

Dr. ADAMS. Exactly. There's something else you said, too, though, that I think is very important. You mentioned obstacles. If we're going to do this, we need to make sure folks are aware of the real obstacles people face in terms of being healthier. I talk about my kids all the time. I live in a nice neighborhood. We've got sidewalks. We've got—nobody smokes. There's grocery stores right down the street. That's very different than the community where I work. I work in a hospital with a lot of people who are uninsured.

Again, it's not as easy as saying go out and exercise when there's not complete streets. It's not as easy as saying eat healthy when there's only fast food restaurants. We have to take those obstacles into account, and there are a lot of great programs that mesh the two, and I hope that that's what you all can do as Senators from some very different ways of thinking. I hope you all can come together, and we can help promote the best practices.

Senator CASSIDY. Thank you, Doctor, and I yield back.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Warren.

[No verbal response.]

The CHAIRMAN. Oh, she's not here.

Senator Hassan.

Senator HASSAN. Thank you, Mr. Chair, and thank you, Ranking Member Murray, and welcome, Doctor.

Before I get to my questions, I do want to say how disappointed I am about reports that Republicans are now threatening to use their tax bill to pursue a partisan goal of repealing health coverage. The Trump Administration's sabotage attempts are already raising healthcare premiums and squeezing hard-working people in New Hampshire and across the country, and this partisan plan would cause healthcare premiums to rise an additional 10 percent a year in the individual market and about 10 percent through most of the budget window that the tax bill deals with, all to give tax breaks to corporate special interests and the wealthiest few.

Instead of raising costs, we should be working together to pass the bipartisan stabilization package led by Senators Alexander and Murray that would lower costs. If Republicans move forward with their plan on the tax bill, the efforts of the Alexander-Murray Bill are for naught, because we are going to destabilize it in a different committee, in a different room, while also taking away health insurance, according to the CBO, from approximately 13 million people, which gets me to the point of this morning's hearing, which is it is very hard to promote wellness when people can't get primary care because they don't have insurance coverage, or where Medicaid expansion is threatened, and it's very hard to talk about wellness when people can't afford care and can't get care.

I hope very much that the group that is crafting this tax bill will decide not to try to repeal the individual mandate and cause premiums to go up and rip care away from people.

I do have a number of questions about wellness efforts. But I did also want to just comment a little bit on the discussion that we've already had on the opioid epidemic, because I appreciate your work very much. You know that New Hampshire has been one of the hardest hit states in the country. We all share a bipartisan commitment to addressing the opioid crisis.

I was encouraged by the President's commission's recommendations. There are a number of things that are evidence-based that a lot of us have been doing in our states. But we are still waiting for the Administration to actually identify what implementing those recommendations is going to cost, and then identifying a number that we could all work to appropriate to get treatment and prevention efforts and recovery efforts out into our community.

I hope very much that you will urge the Administration to actually identify what it would cost. Some of us have a bill that says let's start with $45 billion, which was an amount that friends on the other side of the aisle agreed would be an appropriate start this summer, and I think we really need to focus on getting resources to our communities. With an epidemic of this scope, this size, it does not seem to me that not spending additional dollars on it is going to do the trick.

So I hope very much that you will be a voice for that. Can I have your commitment to helping the Administration identify real resources?

Dr. ADAMS. You absolutely do. HHS has its foot on the gas, and we are not taking it off until we start to see some progress. I promise you that.

Senator HASSAN. Thank you. One other quick point that I would just ask you to think about, going back to Senator Murray's discussion on coverage for birth control. I cannot imagine that if an employer told male employees that they could not have certain kinds of healthcare that men would tolerate it.

I really do believe that it is totally inappropriate for any employer to tell any employee how they can spend or apply healthcare coverage. That should be between the employee and her doctor, and if she needs access to birth control, and she is working and getting the benefit an employer-sponsored health insurance coverage, she should be able to make healthcare decisions without interference

from her employer, and I just hope you will take that position into account.

Dr. ADAMS. Thank you very much for that, Senator. Again, family planning is critically important to wellness. We also have to factor in the employers and the faith-based community, where some of those objections come from. I can promise you I will always be there to tell folks about the science, and the science says family planning is an important part of wellness.

Senator HASSAN. Thank you. Birth control also treats women for conditions other than family planning.

Last issue—we are seeing in the annual sexually transmitted disease surveillance report that STD rates have increased by more than 2 million cases in 2016. What can communities do to address the rising rates of STDs and how should the Federal Government assist with these efforts?

Dr. ADAMS. Well, HHS is focused on that. The CDC is focused on that. I was just down there last week talking with individuals. But it all, again, comes back to wellness. There are folks who are engaging in activities that are leading to increased transmission of sexually transmitted diseases for reasons due to lack of education, lack of opportunity.

I think that if we can invest in wellness from both a Federal and a private point of view, you will see lower STD rates. You see that in communities that are more prosperous, the STD rates are lower. How can we engage businesses to participate in what we know are proven public health interventions and are a definite health problem.

Senator HASSAN. Thank you, and thank you, Mr. Chair, for your indulgence, and thank you Dr. Adams.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Young.

Senator YOUNG. Dr. Adams.

Dr. ADAMS. Hello.

Senator YOUNG. I enlisted in the United States Navy as a Seaman Recruit. It took me a decade in the military. I finally became an O3, a Captain in the U.S. Marine Corps, and here you sit as a Vice Admiral in the Navy, and I couldn't be happier. You're going to be a great Surgeon General.

I'd like to ask you some questions related to evidence-based prevention programs. You touched a bit on it earlier—the Indiana model with respect to our Medicaid program, targeting people of modest means. There's certainly some evidence-based prevention programs that were put to use there.

But you've indicated in your testimony that for each dollar invested in some of these programs, we can see $10 saved in treatment on mental health issues, on alcohol abuse challenges. What specific programs would you like to bring to light in this Committee and all who are watching, whether it's in the public realm or in the private sector, that you think have been incredibly impactful and ought to be scaled up nationally?

Dr. ADAMS. Well, I certainly appreciate that question, and again, it's partnerships. It's collaboration between the private and the public entities. We know that in South Carolina, Nikki Haley, when she was Governor there, shepherded a program that was a

public-private partnership to address infant mortality, and they've seen their infant mortality metrics improve.

Senator YOUNG. Was that the Nurse-Family Partnership?

Dr. ADAMS. That was involving Nurse-Family Partnership, absolutely, and we've invested in Nurse-Family Partnership in Indiana also under my tenure as Health Commissioner there. We know that every $1 invested in biking and walking trails can return benefits up to $12, and for every $1 invested in food and nutrition, there's a $10 return in healthcare costs.

How do we get companies to invest in community building? We've seen this, and again, in Indiana—as Health Commissioner, I keep referring back—we built bike trails there throughout the city, and it actually improved the economy, and it also improved the health of individuals because they were able to participate in physical activity.

Senator YOUNG. Now, the things you mentioned—they strike me as powerful. They intuitively seem to advance health and wellness. Have they been rigorously evaluated? For example, you cite bike trails. Do we know that bike trails increase health and wellness, or is there just a correlation between the existence of bike trails and healthy persons who live in the surrounding area, which is not causal, per se?

Dr. ADAMS. Well, there's two things I would say there. There is a fair amount of evidence that investing in wellness increases prosperity. The web-based diabetes prevention program lowers 5-year risk for diabetes by 30 percent, stroke by 16 percent, and heart disease by 13 percent, and that's a program that Costco actually put in place. HEB Supermarket chain did research on their investments in wellness and found that their healthcare costs were less than half of the national average.

There is evidence out there. But what I want to say to you all is that's why it's so critically important that I'm able to do the Surgeon General's Report on health and the economy, because we want to compile the evidence that exists showing the links between health and the economy, and we want to give the businesses and the public health entities in your state the tools to be able to say, "This is evidence-based. We want to replicate this in our communities."

Minnesota is doing a great job, and Senator Franken didn't show on me again, so you tell him I miss him. Tell him he's got to get here next time. They're doing some great work there with Target and with the other businesses in their communities to promote health and wellness.

Senator YOUNG. It's great that you're looking nationally, clearly, at various examples in the private realm and also in the public sector. I think it's really important as you compile your Surgeon General's Report that we ensure—we indicate the level of certainty we have about the effectiveness of these different interventions and policy approaches. That is, have things been studied using the gold standard of evaluation, randomized control trial across multiple sites, or, instead, do we just have sort of a decent level of confidence, based on some longitudinal study that something is working well?

If we have a very high level of confidence, I think those are the programs we're more inclined, as government officials, to invest in and to scale up. I say, we, meaning not just the Federal Government, but also state and local authorities. They need to begin maybe stepping up in a health prevention and wellness way that they haven't in the past.

The last point I'd like to make, with the Chairman's indulgence, is some of the answers here may lie in behavioral science. If we can change the choice architecture people have, if we can organize our policies and also perhaps even our physical environment in a way that makes people more inclined to make individual choices in furtherance of the health outcomes that they want, then that could be very, very powerful. I hope you'll be consulting with behavioral scientists as you put together that report and work with this Committee.

Thank you.

Dr. ADAMS. Behavioral scientists, health economists—we want to make sure we bring everyone into the fold. To your point about the evidence, that is why it is so critical that I have your support for the Surgeon General's Report, because that's what we want to do. We want to look at it and say, "This is top tier. Go with it." This one, maybe not so.

At HHS, in regards to the opioid epidemic, with your indulgence, sir, we're evaluating 42 different evidence-based programs to respond to the opioid epidemic, because right now, folks are throwing spaghetti at the wall to see what sticks, and we want to make sure we're funding the most evidence-based, the best programs, in order to be able to most efficiently and effectively tackle the opioid epidemic.

Senator YOUNG. I look forward to working with you, Vice Admiral. Thank you.

Dr. ADAMS. Thank you.

The CHAIRMAN. Thank you, Senator Young.

Senator Murphy.

Senator MURPHY. Thank you very much, Mr. Chairman.

Good to see you, Dr. Adams, again.

Mr. Chairman, you're hearing our frustration about the way in which this tax bill has turned into a healthcare bill in the last 48 hours. I was so proud of this Committee when we held, I think, three or four hearings to study how we could stabilize the individual market and so proud of how you and Senator Murray worked together to develop that plan.

But the impact of Alexander-Murray, should it pass, or had it passed, will be dwarfed by the impact of repealing the individual mandate, and it is potentially going to come up for a vote in the U.S. Senate without a single hearing in this Committee, maybe a markup in the Finance Committee, but no serious attempts to understand what the impact is.

CBO admitted that it's very hard to understand what happens when the mandate disappears. It could be catastrophic in the sense that if you keep the requirement that plans continue to price without respect to medical acuity, but you don't require that people buy insurance, the rational individual would not buy insurance until they become so sick that they need care, knowing that they'll never

pay any more for it. A rational healthy person simply would not buy insurance with the protection in place and no mandate. At the very least, CBO says that premiums are going to go up 10 percent compounding, year over year, simply because of the piece of legislation that the Senate is potentially going to pass.

The reason I say that this bill is becoming a healthcare bill instead of a tax bill is because from what we understand, the individual income tax relief, which will help about two out of every three middle class families, is temporary. It disappears in 7 years, and by 7 years from now, premiums will have doubled, according to CBO, because of the repeal of the individual mandate.

7 years from now, an average family will get almost no individual income tax relief, because their tax cuts will have expired, and their premiums will be potentially $10,000 higher than they are today, according to CBO. Seven years from now, a doubling of annual premiums for the average family will mean an increase in cost of $10,000.

To most middle class families, yesterday, this bill stopped being a tax bill and started being a healthcare bill, and this Committee, again, is not reviewing it.

Dr. Adams, thank you for being here. I have one question for you. Dangerous neighborhoods are not healthy neighborhoods. What we know about the biology of trauma and toxic stress is that if you're walking to school every day fearing for your life, if you live in a neighborhood in which gun shots are your bedtime music, as is the case in a lot of neighborhoods in this country, your brain is bathed in adrenalin and cortisol, which, from what I understand, fundamentally alters the way in which your brain works.

As we're talking about trying to build healthy communities, how important is it to make sure that we're building safe communities? Because if kids fear violence, if they fear gun homicides, then all of the work we do to build resources and healthcare equity doesn't really matter because their brains have been altered. I know you've thought a lot about this, have done a lot of work around this issue. Talk about the connection between safe communities and healthy communities.

Dr. ADAMS. Thank you so much for bringing up that point, because community safety is a critical part of wellness. I'll give you a quick example. I was in Atlanta last week, and the East Lake Community in Atlanta had some of the highest high school dropout rates, some of the worst crime, some of the lowest employment rates in the Nation.

They brought together multiple different sectors, different partners, around the idea of economic wellness and productivity, and now, they are above the state average for high school completion, their crime rates have gone down, and they've become a more prosperous and a safer community, which leads back to the point that I originally made that health and the economy are intimately connected, and embedded in that is safety. If you're a more prosperous community, you're going to be a safer community and a healthier community, and vice versa.

Senator MURPHY. When we talk about gun violence, we tend to think of the impact as being on the victims and on the victims' immediate close set of friends and family. But the fact of the matter

is the impact in these neighborhoods is felt by everyone who has this fight or flight mechanism that sets off in their brain. It's a public health issue, and I appreciate your comments on that.

Thank you, Mr. Chairman.

Dr. ADAMS. Thank you, sir.

The CHAIRMAN. Thank you, Senator Murphy.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman. I echo my colleague's concerns about yesterday's decision by the Senate Republicans to use their tax bill to rip healthcare coverage away from 13 million Americans. Republicans have apparently decided that it is not enough for their tax bill to raise taxes on millions of middle class families. Now it will also raise insurance premiums on millions more and take away healthcare coverage from people who desperately need it.

Insurers, doctors, hospitals, patient groups—they have all been crystal clear. This will destabilize the insurance market, and it will hurt people, plain and simple. Republicans should not use their tax bill as a way to take away people's health insurance.

Dr. Adams has come here to talk about an important topic, and I want to take an opportunity to ask him some questions about this. When it comes to health outcomes in this country, there are some really clear patterns. Life expectancy is lower for black Americans than for white Americans, lower for people without a high school degree than for those who complete college, lower for people at the bottom of the income distribution than those at the top. Because where we live is often segregated by these same factors, one recent study found a 20-year difference between counties with the highest and lowest life expectancies in America. That is deeply shocking.

Dr. ADAMS. We've seen that even in Indiana.

Senator WARREN. That is deeply shocking in America. These disparities are persistent, but for decades, the story has been that all groups are living longer. Unfortunately, we're seeing some worrying new trends on that front. The CDC recently reported that the death rate so far in 2017 is up compared with last year, and research suggests that death rates are flat or even increasing for middle-aged white Americans who have not graduated from college.

Dr. Adams, what do we know about what might be driving this troubling shift in mortality rates in America?

Dr. ADAMS. Well, again, we had a discussion earlier about deaths of despair, and the reality is that when you look at the communities where those death rates are going up for middle-aged white Americans, there is a lack of hope and there is a lack of opportunity.

Hello, Senator Franken. How are you, sir?

Senator FRANKEN. Very good. How are you?

Dr. ADAMS. I'm well.

What we want to do is we want to make sure we're engaging the business sector, the faith-based community sector, the people in those communities who can provide that hope and opportunity, because that's the only way we're going to turn this around. We're not going to turn it around simply by looking at it as a medical

problem or a health problem. We've got to look at it as a hope and an opportunity problem.

Senator WARREN. I see this as health and economic security go hand in hand, that having a good job with decent pay and health insurance means that if somebody gets sick, they can still go to the doctor and they can have a few months cushion until they get back on their feet. If addiction hits someone in the family, there's a better chance of accessing treatment.

But if someone is injured on the job because their employer isn't following the law, or they can't get a hernia surgery because they don't have health insurance, or their paycheck barely covers their monthly rent, then—I'll be blunt about this—their chances of staying healthy and free from chronic pain simply aren't as good.

Dr. ADAMS. They're a higher cost to their employers often.

Senator WARREN. That's exactly what I want to go to. Do you agree that improving health outcomes in this country and addressing these disturbing trends that we're talking about is going to take economic policies as well as public health policies?

Dr. ADAMS. I think it's going to take economic policies, both in the private and the public sector, and I think that as public health advocates, we need to do a better job of helping corporations and businesses understand that connectivity so that they invest in their communities and their employees up front instead of paying on the back end for workplace accidents, for higher healthcare costs, for retraining people when they've got to fire the person who doesn't show up for work, or they just don't come back anymore.

Senator WARREN. Good. Well, I really appreciate your comments on this. These are very serious problems, literally life and death, and we're not going to solve them with any one hearing or any one policy. But we need to underline that a person's chances of growing up healthy or staying healthy or getting help when they need it should not depend on their zip code, and help should not be reserved for the wealthy few and the well connected. It means we have to be willing to fight for fair economic policies and an effective safety net as well as good public health programs.

Dr. ADAMS. That's not just on the Federal level, but it's got to be on the private and on the state level also to make sure we have a comprehensive package of policies that put people in the best position for better health and communities in the best position for economic prosperity.

Thank you.

Senator WARREN. Thank you.

The CHAIRMAN. Thank you, Senator Warren.

Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Welcome, Dr. Adams.

Dr. ADAMS. Good to see you again.

Senator WHITEHOUSE. Good to see you again. First of all, thank you for mentioning CVS in your testimony. CVS is headquartered in Woonsocket, Rhode Island, and we're very proud of that company, and we're particularly proud of that company's decision to take cigarettes out of its stores, all of its stores, and indeed, they quit the United States Chamber of Commerce when it was discovered that the United States Chamber of Commerce was attacking

tobacco regulations around the world. They have really dialed in on the health concerns about tobacco, and I think your recognition of that is a very nice thing for them and for Rhode Island. I appreciate that.

Dr. ADAMS. Even though they took an initial hit, they actually are more profitable because they made a healthy decision. I think that's important for folks to understand. This wasn't just something that benefited the health of folks and it wasn't just a philanthropic endeavor. It was something that actually made economic sense for them to do in the long run, and that's what we want folks to understand and why the CVS story is so powerful.

Senator WHITEHOUSE. You also mentioned the discrepancy between the amount we pay for healthcare in this country and the outcomes that we get. You mentioned life expectancy, but there are plenty of metrics. I always have in my mind the graph of the OECD countries that shows the chart of them measured by life expectancy and by per capita cost, and America is like way out here, highest per capita cost by a ton over all of our competitors, and yet for all that extra money we're not getting gains. We're below the midpoint of the pack, as I recall, lined up with Croatia and Greece for life expectancy.

What's interesting to me about that is that it suggests that there's real opportunity for good bipartisan work to be done here in this Committee to try to cure that problem, and, instead, we seem to be in this relentless groundhog day horror fight trying to undo healthcare for Americans, and to hell with the collateral damage in individual Americans' lives, and it's frustrating because I think we could be much more productive than this endless repeal and replace zombie that keeps coming out of the grave to no good that anybody can identify other than the political good, I guess, of putting the Affordable Care Act up as a sort of political trophy for the big Republican donors. The whole thing is very frustrating.

But I want to focus on one particular area, because you spoke with a lot of passion about this when you and I met in my office, and that is the area when people are getting to the end of their life, when they have very advanced illnesses. As you know, there's a group called CTAC, the Coalition of Transformed Advanced Care, that is engaged with a lot of the business community, big business community leaders, to try to provide a better way of managing that time.

In Rhode Island, we've done a lot of work that I told you about to try to take better care of people who are in that period of their lives. Very often, what we see, tragically, is that somebody who wants to be treated a certain way doesn't get that choice honored, partly because we haven't actually documented what their choice should be well enough and partly because the healthcare machinery just grabs them and grinds them along, and by the time you've been able to intervene, it's too late and they've had procedures they didn't want, and they've been in the ICU when they didn't want to be, and they weren't at home where they did want to be, and all of those things have gone wrong.

In many respects, I think, the way we pay drives the care we get, and I encourage you to continue looking at ways that you can be an advocate for people suffering advanced illness in their last

months of life who, I think, are very often casualties of our healthcare system because their voices simply aren't heard. I'd renew my invitation to you to come up to Rhode Island and let me show you what we're doing. You said you were interested in doing that when we met, and I renew the invitation today. If you could respond to that point.

Dr. ADAMS. Absolutely, sir. I'm looking forward to coming up there. I've been in touch with your health commissioner constantly.

By focusing on end of life care, we will be able to save tremendous dollars in terms of healthcare costs. But I'm going to show you an amazing display of message discipline. I'm going to show you how that fits into wellness. Folks who are healthier, who live a lifestyle of wellness, are going to not only live longer, but they're going to live healthier, they're going to have less healthcare cost, and they're not going to spend that much money on end of life care.

But as you mentioned, just as importantly, part of wellness is having a plan for how you want to die. If it's going in and talking to your primary care physician about what you want and making sure it's documented in a way that folks understand and that can be communicated when the time actually comes. Even this, when you move upstream, comes back to focusing on wellness and making sure we're concentrating on that as a community instead of waiting until someone gets that terminal illness and then trying to sort it all out on the back end financially and philosophically.

Senator WHITEHOUSE. My time has expired. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Whitehouse.

Senator Kaine.

Senator KAINE. Thank you, Mr. Chair, and thank you, Dr. Adams.

Dr. Adams, Indiana, under the Affordable Care Act, chose to expand—to embrace the Medicaid expansion designed in its own way. Isn't that correct?

Dr. ADAMS. We got a waiver to actually accept the Medicaid expansion funding through the ACA to expand our Healthy Indiana plan.

Senator KAINE. Has the uninsured rate in Indiana come down fairly significantly because of that and also because of Obamacare subsidies that Indianans have been able to avail themselves of?

Dr. ADAMS. We've been able to increase access to over 400,000 people, and it's important to understand that the Healthy Indiana plan was also a partnership between the public and the private entities, which is why I keep saying partnerships are so critically important——

Senator KAINE. Do you know, sitting here, what the reduction in the uninsured rate was, like pre-Affordable Care Act, and post-Affordable Care Act, when you include both the Obamacare subsidies to Indianans and the expansion of Medicaid that Indiana did?

Dr. ADAMS. I can get you those specific numbers.

I know I worked at a county hospital, and our uninsured rate went down significantly, and again, 400,000 is the number of folks who we've been able to increase access to coverage to.

Senator KAINE. In your opinion, is Indiana a healthier community? The title of this hearing is Investing in Healthy Communities.

Is Indiana a healthier community because fewer people are uninsured today?

Dr. ADAMS. Indiana is a healthier community because we were given the flexibility to be able to design our own state program and actually implement it in a——

Senator KAINE. Which many states have done under the Affordable Care Act. Correct?

Dr. ADAMS. Yes, sir.

Senator KAINE. You do believe that Indiana is a healthier community today as a result of both the Medicaid expansion that you designed and other aspects of the Affordable Care Act?

Dr. ADAMS. I believe we're a healthier community today, sir.

Senator KAINE. Would you say, generally, for purposes of the report that you're doing, looking at what makes a healthier community, that, all things being equal, as a general matter, the lower percentage of people who are uninsured, the healthier the community is?

Dr. ADAMS. Yes, I would agree with that.

Senator KAINE. You might find an exception here or there. But as a general matter, reducing the uninsured rate would be one sign of a community that is likely to be a healthier community.

Dr. ADAMS. I would agree with that, sir.

Senator KAINE. There's surveys every year that get put out by groups like United Health Association that rank the healthiest and least healthy states in the United States. In the most recent version that I've seen, the 10 healthiest states in the United States all have done the Medicaid expansion, and of the 10 least healthy states in the United States, only four have done the Medicaid expansion, and I think that's additional evidence of the proposition that you're testifying to today.

I'll just add my own concern about what's happening in the Finance Committee now. If, as you testify and as the statistics would seem to suggest, one evidence of being healthier is reducing the percentage of uninsured, why would we want in a tax bill to do something that would increase the number of uninsured? It suggests that tax is more important than people's health. A tax break to some at the top is more important than people's health.

It's kind of a left hand-right hand problem. We're here in the HELP Committee trying to do things that improve people's health, and you're testifying about healthy communities with some great testimony, and it would seem from the statistics and Indiana's own experience that if you reduce the uninsured rate, you're going to have healthier communities. That's the purpose of the hearing. But in the Finance Committee today, there's going to be an action taken that would reduce the number of people in this country by potentially 13 million who have health insurance. I just don't get it.

Let me ask you this, switching gears. We had a hearing about 2 weeks ago, and we had a number of witnesses, including Francis Collins from NIH, a really great leader, a Virginian—I'm a little proud of him for that reason—and I asked him this question, and I would be curious as to your answer about this question.

If we were to set a goal as a Nation, like a big goal, and say we want to be addiction free by 2030, is the state of our knowledge

about addiction, is the state of our treatments and technology such that we could make that kind of a bold statement, like John F. Kennedy said we're going to be on the moon at the end of the decade? Could we make that kind of a bold commitment if we really put our minds to it? Do you, as Surgeon General of the United States, think we can meet that goal?

Dr. ADAMS. I wouldn't only say that we can. I would say that we must. We never would have gotten to the moon, even though folks didn't believe it was possible, unless JFK declared that we were going to do so. We are not going to solve this crisis unless we are definitive that it's an absolutely must that we achieve that goal, and I'm confident that we can if we work toward better partnerships.

If I may, to your point earlier, I don't want to debate your point. It's clear that higher insurance rates correlate with healthier communities.

Senator KAINE. Higher percentages of people with insurance.

Dr. ADAMS. Yes. But there is primary, secondary, and tertiary prevention, and you're talking about tertiary prevention. As a public health advocate, I would be remiss if I did not say that we can focus all we want on healthcare, but as long as we're over-consuming it because of a lack of wellness, we aren't going to solve the problem.

The states that you mentioned that are in the top 10 and the states that you mentioned that are in the bottom 10—they were in the top 10 and the bottom 10 before the Affordable Care Act. Why? Because they are states who invested in wellness and health and had their communities—Senator Franken and I talked a lot about Minnesota before you came, doing a great job there of engaging the corporations and the businesses in health, and Minnesota has been in that top in terms of health outcomes. I think it's important that we always remember we need to focus on wellness and that healthcare and health insurance coverage is one part of the equation, but it's not going to solve the problem if we don't focus upstream and keep——

Senator KAINE. But you would agree with me, though, that the percentage of people with health coverage is a pretty important component of the health of a community.

Dr. ADAMS. I would agree with you that the science shows that in communities that have higher rates of coverage, they tend to be healthier than ones that don't.

Senator KAINE. Right. Thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Franken.

Senator FRANKEN. Yes, I definitely agree with that, and in Minnesota, we have—we cut in half the numbers that were uninsured. I'm glad that you brought up the National Diabetes Prevention Program in your testimony or at some point earlier. I'm sorry——

Dr. ADAMS. I was giving you shout-outs left and right, Senator.

Senator FRANKEN. That's what I understand, including mentioning that I didn't show on you again. Let me explain. I really wanted to be at your confirmation hearing. The day of that confirmation hearing, I was at Arlington Cemetery speaking at—I

spoke at the funeral of Captain Luis Montalvan, who was an inspiration to me on—he had a dog, a service dog, and we can talk about the service dog program at some point. But I'm really sorry I wasn't able to be there, but I was doing something else.

Dr. ADAMS. No, thank you for that. One of the honors of my life was marching in the New York City Veterans Day parade this past weekend. It's extremely important that we honor our veterans for their service, and thank you for that.

Senator FRANKEN. He was a friend of mine.

I do want to mention this, in the finance bill, this idea of taking away the mandate. We know what the results of that would be, and it would be antithetical to what you're talking about. The more people insured, the healthier we are. We know that. We saw a survey study in JAMA about the benefits of more—that we've had because of the Affordable Care Act and more people insured.

To me—and another thing that that does, which is inserting that into a tax bill, I think is just—it's not helpful. It poisons the well on cooperation on healthcare and the wonderful compromise that the Chairman and the Ranking Member came up with. I just would hope that the—we've been shut out of so many things, and it hasn't—there hasn't been a good result because of that. The best results, to me, are when we do things in a bipartisan way, which the Chairman does.

But I want to move on to something that we do in Minnesota. You highlight that in the U.S., we spend more on healthcare than any other country, around $3.2 trillion each year, and in many cases twice the amount that other countries that cover everybody, and yet there's so much more that needs to be done to improve our outcomes. It's estimated that 50 percent of costs are used by just 5 percent of the population, and according to a piece in the Journal of the American Medical Association, an overwhelming portion of these top healthcare users are poor and housing insecure.

Recognizing the connection between housing and health, some healthcare organizations have begun working to address housing needs in order to improve the overall health of their patients. In Minnesota, Hennepin Health, an accountable care organization in the Twin Cities, developed a program that paired healthcare, housing, and social services. Just 1 year after participants in the program were placed in supportive housing, Hennepin Health saw significant reductions in emergency room visits, hospitalizations, and psychiatric care.

A study on a similar program in Los Angeles found that government spending was 79 percent lower for people in supportive housing than for people who were homeless.

Vice Admiral Adams, what will you do to encourage healthcare providers and other stakeholders to work together to deliver healthcare interventions that are paired with housing and other social supports?

Dr. ADAMS. Senator, thank you so much for that question. I have been in touch with Secretary Carson. I think we have a tremendous opportunity having a physician as head of HUD, and he and I both firmly believe housing is health. We know one of the No. 1 predictors of whether or not you're going to be successful in recov-

ering from addiction is whether or not you've got permanent supportive housing to go back into.

We know that you're not going to take your diabetes medication or your hypertension medications or get your screenings if you're worried about where you're going to sleep that night. Housing is absolutely health, and I think that the folks who represent the housing community need to be at the table when we're discussing how we build a healthier community.

With a bit of your indulgence, Senator Alexander, I would be remiss if I did not say that I detected an insinuation from several folks that the current administration is against coverage for folks. I do agree that there is a direct link between the health of a community and the number of people who are insured. The administration is not against people being insured. We have a different mindset about how we can achieve that.

I can tell you that in Indiana, folks did not believe we would be able to increase coverage to people through our Healthy Indiana plan. Folks didn't believe it. We were able to expand coverage to over 400,000 people. This administration is not anti-coverage. It's about giving states the flexibility to decide how that coverage is going to be delivered, and I think that's an important distinction without going too far down that rabbit hole, because, again——

The CHAIRMAN. We need to wrap up, Dr. Adams.

Senator FRANKEN. Can I just respond to that in one little way?

The CHAIRMAN. Yes.

Senator FRANKEN. In Indiana, you took Medicaid expansion, didn't you?

Dr. ADAMS. Sir, we got a waiver to actually expand our Healthy Indiana plan utilizing funds that were made available through the Affordable Care Act by a waiver.

Senator FRANKEN. Exactly. I mean, funds were made available through the Affordable Care Act. You got a waiver, which was part of the structure of the Affordable Care Act. When—you can't have it both ways.

Dr. ADAMS. But the administration's plans for healthcare reform that have been put out here so far—each of them—and I know because I'm in touch with the Governor of Indiana—would still allow us to continue our Healthy Indiana——

The CHAIRMAN. We're well over time, and I have to go to a markup with——

Senator FRANKEN. I know, but every plan offered by the administration and by the Republicans—CBO has scored every one of them for, in many cases, tens of millions of Americans—fewer having insurance, and you know that. You have to know that.

Dr. ADAMS. I know we need to focus on wellness, and I look forward to working with all of you all to focus on wellness because——

Senator FRANKEN. That was not responsive to what I just asked you.

The CHAIRMAN. Okay. Thank you, Senator Franken.

Dr. Adams, thank you for being here for the hearing and for your suggestions and for your service to our country.

Senator Murray, do you have other things you'd like to say?

Senator MURRAY. Well, Mr. Chairman, I do want to just say that if you don't have access to insurance because the insurance market has collapsed, that's no healthcare coverage for a lot of people. That is why we are deeply concerned on this side.

But, Dr. Adams, I do want to thank you for your hearing testimony today. We want to work with you on healthy outcomes, lower healthcare costs for families. We are concerned about and deeply opposed to the proposal because it will increase costs, and when it increases costs, then people don't have access. I'm very deeply concerned about this administration's long-time activity to actively undermine the healthcare of our communities, and we will continue to focus on that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Thank you for being here. The Committee will stand adjourned.

[Whereupon, at 11:27 a.m., the hearing was adjourned.]

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