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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2020 BUDGET

HEARING

BEFORE THE

COMMITTEE ON THE BUDGET HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, D.C., MARCH 26, 2019

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2020 BUDGET

TUESDAY, MARCH 26, 2019

HOUSE OF REPRESENTATIVES,
COMMITTEE ON THE BUDGET,
Washington, D.C.

The Committee met, pursuant to notice, at 10:05 a.m., in Room 210, Cannon House Office Building, Hon. John A. Yarmuth [Chairman of the Committee] presiding.

Present: Representatives Yarmuth, Moulton, Jeffries, Higgins, Khanna, Doggett, Schakowsky, Morelle, Horsford, Scott, Jackson Lee, Jayapal, Omar, Sires, Peters; Womack, Woodall, Smith, Stewart, Roy, Meuser, Timmons, Hern, and Burchett.

Chairman YARMUTH. The—this hearing on the—thank you to the Ranking Member—this hearing on the HHS fiscal year 2020 budget—I would like to welcome Deputy Secretary Eric Hargan, and thank you for joining us.

I yield myself now five minutes for my opening statement.

Today we will discuss the President's 2020 budget for the Department of Health and Human Services and its impact on American families.

There are many concerning parts of the Administration's proposal, but the budget for HHS is particularly troubling because the line between massive funding cuts and severe consequences for American families, between policy changes and life or death outcomes, is so direct.

The Trump budget cuts more than $12.1 billion from HHS' discretionary budget; $4.5 billion from NIH, which includes research on the prevention, treatment, and care of diabetes, cancer, heart disease, Alzheimer's, and nearly every other disease or disorder facing Americans. It embraces austerity level spending caps, and the resulting cuts to health care investments, even though these caps have been repeatedly rejected by Congress on a bipartisan basis.

The budget also cuts $1.4 trillion from mandatory health care spending, including Medicare and Medicaid, which are the only sources of health care coverage for tens of millions of Americans.

The budget repeals the Affordable Care Act and replaces it with an inferior plan that would leave millions of families without meaningful insurance, while failing to continue guaranteed protections for people with pre-existing conditions. It ends the Medicaid expansion under the ACA, terminating health coverage for millions more.

In my home state of Kentucky, with total population of just over four million, nearly half-a-million people gained health care cov-

erage thanks to the ACA's Medicaid expansion. All this before the Administration's abhorrent decision last night to ask the 5th Circuit to completely invalidate the Affordable Care Act, making it crystal clear to the American public that this President has zero interest in protecting their health care in any form.

The budget also converts base Medicaid funding into a block grant or per-capita cap. This will force states to eliminate or drastically reduce services for low-income children, people with disabilities, and seniors, or, in the alternative, to raise billions of dollars to cover the cost—the loss of federal resources, which we all know states don't have.

In addition, the budget requires all states to implement work requirements for Medicaid enrollees, putting yet another barrier between Americans and quality health care. In Arkansas—wonderful home of my ranking member—which implemented the first work requirement in the country last year, more than 16,000 people have already lost their health insurance with no evidence that they found new employment. Expanding this policy nationwide would undoubtedly result in hundreds of thousands, if not millions, of Americans losing their health care coverage.

Deputy Secretary Hargan, it is clear that this budget jeopardizes the health care security of millions of Americans and their families. So it is hard for me and my Democratic colleagues to understand how that meets HHS' mission to "enhance the health and well-being of all Americans." Given the severity of the funding cuts and the extreme nature of the policy changes, this seems much more like an irresponsible way of offsetting our Republican colleagues' deficit-financed tax cuts for millionaires and big corporations than a true budget you or Secretary Azar would have crafted for your agency to succeed. I hope to discuss that further today.

There are some other areas of the budget that don't add up either, where the message doesn't match the math.

For example, the budget includes a $291 million investment in HIV/AIDS, but cuts the National Institute of Allergy and Infectious Diseases, which is responsible for most HIV/AIDS research at the National Institutes of Health, by $769 million.

The budget provides an additional $50 million for pediatric cancer research—sounds good—but cuts funding for the National Cancer Institute by $897 million.

The budget requests $1.5 billion for state opioid response grants—again, something I think we all favor—but it cuts Medicaid, the source of coverage for four in 10 adults with opioid addiction, by $1.5 trillion.

When you compare these small funding increases to the large cuts they are paired with, it is not hard to see them for what they are: token investments designed to get a good headline. If there is another explanation, Deputy Secretary, we would welcome it.

I know my Democratic colleagues have other questions about the choices made in this budget and the resulting consequences, about promises made by the President that are broken in this document. We want to know more.

So once again, thank you, Deputy Secretary Hargan, for being here today. We look forward to your testimony.

[The prepared statement of John A. Yarmuth follows:]

Chairman Yarmuth
House Committee on the Budget
Department of Health and Human Services
Fiscal Year 2020 Budget Hearing
Opening Statement
March 26, 2019

This hearing will come to order. I would like to welcome Deputy Secretary Eric Hargan -- thank you for joining us.

Today, we will discuss the President's 2020 budget for the Department of Health and Human Services and its impact on American families.

There are many concerning parts of the Administration's proposal, but the budget for HHS is particularly troubling because the line between massive funding cuts and severe consequences for American families…between policy changes and life or death outcomes, is so direct.

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The budget also cuts $1.4 trillion from mandatory health care spending, including Medicare and Medicaid, which are the only sources of health care coverage for tens of millions of Americans.

It repeals the Affordable Care Act and replaces it with an inferior plan that would leave millions of families without meaningful insurance, while failing to continue guaranteed protections for people with pre-existing conditions.

It ends the Medicaid expansion under ACA, terminating health coverage for millions more. In my home state of Kentucky, with total population of just over 4 million, nearly half of a million people gained health care coverage thanks to the ACA's Medicaid expansion. All this before the Administration's abhorrent decision last night to ask the 5th Circuit to completely invalidate the Affordable Care Act, making it crystal clear to the American public that this President has zero interest in protecting their health care in any form.

The budget also converts base Medicaid funding into a block grant or per-capita cap. This will force states to eliminate or drastically reduce services for low-

income children, people with disabilities, and seniors -- or raise billions of dollars to cover the loss of federal resources, which we all know states don't have.

In addition, the budget requires all states to implement work requirements for Medicaid enrollees, putting yet another barrier between Americans and quality health care. In Arkansas, which implemented the first work requirement in the country last year, more than 16,000 people have already lost their health insurance with no evidence that they found new employment. Expanding this policy nationwide would undoubtedly result in hundreds of thousands, if not millions, of Americans losing their health care coverage.

Deputy Secretary Hargan, it is clear that this budget jeopardizes the health care security of millions of Americans and their families. So it is hard for me and my Democratic colleagues to understand how that meets HHS' mission to "enhance the health and well-being of all Americans." Given the severity of the funding cuts and the extreme nature of the policy changes, this seems much more like an irresponsible way of offsetting our Republican colleagues' deficit-financed tax cuts for millionaires and big corporations than a true budget you or Secretary Azar would have crafted for your agency to succeed. I hope to discuss that further today.

There are some other areas of the budget that don't add up either– where the message doesn't match the math. For example, the budget includes a $291 million investment in HIV/AIDS, but cuts the National Institute of Allergy and Infectious Diseases, which is responsible for most HIV/AIDS research at the National Institutes of Health, by $769 million. The budget provides an additional $50 million for pediatric cancer research, but cuts funding for the National Cancer Institute by $897 million. The budget requests $1.5 billion for State Opioid Response Grants, but it cuts Medicaid – the source of coverage for 4 in 10 adults with opioid addiction – by $1.5 trillion. When you compare these small funding increases to the huge cuts they are paired with, it's not hard to see them for what they are -- token investments designed to get a good headline. If there is another explanation Deputy Secretary Hargan we would welcome it.

I know my Democratic colleagues have other questions about the choices made in this budget and the resulting consequences…about promises made by the President that are broken in this document. We want to know more.

So once again, thank you Deputy Secretary Hargan for being here today. We look forward to your testimony.

Chairman YARMUTH. I now welcome, and I recognize the Ranking Member for five minutes for his opening statement.

Mr. WOMACK. Apologies for running just a little bit late. But thank you, Mr. Chairman, and thank you, Deputy Secretary Hargan, for joining us.

Today we are here to examine the President's budget request for the Department of Health and Human Services for fiscal year 2020. This is an important conversation. Your agency is responsible for administering programs on which millions of Americans rely, including Medicare; Medicaid; Temporary Assistance for Needy Families, or TANF; Head Start.

Further, your agency is at the forefront of combating some of our country's biggest health crises, including the opioid epidemic which claims the lives of 115 Americans every day. Now, let's put that in context. Assuming we are here for two hours this morning, 10 people—10 people—will die because of this epidemic.

The growth in spending has been caused by several factors that require our attention in Congress. Health care spending is growing faster than any other sector of the economy. In 2017, the U.S. spent $3.5 trillion in health care. By 2007 [sic] health care spending is projected to reach nearly $6 trillion, just under 20 percent of GDP, according to a recent report of the Centers for Medicare and Medicaid Services' actuary.

The cost of care is increasing. According to Bureau of Labor Statistics, in 2018 the price of hospital services increased by 3.7 percent, the price of medical care by 2 percent, both of which were higher than the rate of inflation.

The second contributing factor? Americans are living longer. Thanks to advancements in modern medicine, the average life expectancy has increased by more than nine years since Medicare was created in 1965. It is projected to continue increasing. That is good news, but it does have an impact on growing health care spending.

Finally, the ratio of retirees to workers is shrinking, with an average of 10,000 Baby Boomers a day leaving the workforce. Unfortunately, the laws governing how our health care programs work do not reflect the dynamics we face today. As a result, there is increasing pressure on programs like Medicare, which today provides care to about 15 percent of our population.

As an example, Medicare Part A, which covers inpatient hospital care, skilled nursing facilities, Hospice, and lab tests, is expected to be insolvent by 2026, threatening the health benefits many expect to receive in the future—2026. That is just eight years away.

Congress and the Administration together have a shared responsibility to address these challenges and put our health care spending back on a sustainable path. That requires taking a hard look at what is working and what is not. It requires the courage to make tough choices that preserve and strengthen programs for Americans today and in the future.

The President's budget takes important steps to do just that, investing in the long-term health of the American people, while also advancing proposals that will help rein in health care spending.

For example, the President's budget continues historic funding to fight the opioid epidemic by expanding access to prevention, treat-

ment, support services, and research. This includes efforts to prevent improper or abusive prescription practices that have dangerously and unnecessarily exposed patients to opioids.

It also aims to dramatically decrease the number of people affected by HIV, with the goal of reducing new infections by 90 percent within a decade.

At the same time, the budget includes several common-sense reforms that have been proposed by Republicans and Democrats to make Medicare work better for patients by cutting waste, fraud, and abuse, increasing competition, and lowering drug prices and out-of-pocket costs.

All told, these efforts achieve roughly a trillion of savings in mandatory spending. That is important progress. But with $22 trillion in debt, and annual deficits nearly a trillion, there is much more work to do.

As I have said before, mandatory spending accounts for 70 percent of all federal spending, and the glide path we are on takes it to 78 percent by 2029. Until we make structural reforms to mandatory spending like Medicare, discretionary spending—including funds for defense and border security—we will continue to feel the squeeze, and Congress will continue to have the same battles year after year over what programs to fund, and how to handle our debt.

I am fearful that my colleagues on the other side of the aisle may double-down on this approach, proposing ideas that will make our nation's grim fiscal reality even worse. We have already seen a proposal that would radically disrupt our health care system, adding trillions of dollars to our national debt, while eliminating patients' choice and raising taxes. And there is no plan to pay for it.

We have a responsibility to put forward serious solutions, not catchy slogans, to improve our health care system and rein in spending.

I look forward to hearing more from the deputy secretary this morning as we work through these questions in Congress.

Mr. WOMACK. And with that, Mr. Chairman, I am proud to be here, and I yield back my time.

[The prepared statement of Steve Womack follows:]

Ranking Member Steve Womack (R-AR) Opening Statement

(As Prepared for Delivery)

Thank you, Chairman Yarmuth, and thank you, Deputy Secretary Hargan, for joining us.

Today, we're here to examine the President's budget request for the Department of Health and Human Services for fiscal year 2020.

This is an important conversation. Your agency is responsible for administering programs on which millions of Americans rely – including Medicare, Medicaid, Temporary Assistance for Needy Families, or TANF, and Head Start. Further, your agency is at the forefront of combatting some of our country's biggest health crises, including the opioid epidemic, which claims the lives of 115 Americans each day.

Your agency also faces several budgetary challenges that must be addressed.

Health care spending is growing faster than any other sector of the economy. In 2017, the U.S. spent $3.5 trillion on health care. By 2027 health care spending is projected to reach nearly $6 trillion – just under 20 percent of America's GDP – according to a recent report from the Centers for Medicare and Medicaid Services' Actuary.

This growth in spending has been caused by several factors that require our attention in Congress.

First, the cost of care is increasing. According to the Bureau of Labor Statistics, in 2018, the price of hospital services increased by 3.7 percent and the price of medical care increased by 2 percent – both of which were higher than the rate of inflation that same year.

Second, Americans are living longer. Thanks to advancements in modern medicine, average life expectancy has increased by more than 9 years since Medicare was created in 1965 and is projected to continue increasing. That's good news – but it does have an impact on growing health care spending.

Finally, the ratio of retirees to workers is shrinking with an average of 10,000 baby boomers leaving the workforce every day.

Unfortunately, the laws governing how our health care programs work do not reflect the dynamics we're facing today.

As a result, there is increasing pressure on programs like Medicare, which today provides care to approximately 15 percent of our population.

For example, Medicare Part A – which covers inpatient hospital care, skilled nursing facilities, hospice, and lab tests – is expected to be insolvent by 2026, threatening the health benefits many people expect to receive in the future.

2026. That is only eight years away.

Congress and the administration, together, have a shared responsibility to address these challenges and put our health care spending back on a sustainable path.

That requires taking a hard look at what's working and what's not. It requires the courage to make tough choices that preserve and strengthen programs for Americans today and in the future.

The President's budget takes important steps to do just that, investing in the long-term health of the American people while also advancing proposals that will help rein in health care spending.

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All told, these efforts achieve roughly $1 trillion of savings in mandatory spending. That's important progress. But with $22 trillion in debt and annual deficits nearly $1 trillion, there is much more work to do.

As I've said before, mandatory spending accounts for 70 percent of all federal spending today and will rise to 78 percent by 2029.

Until we make structural reforms to mandatory spending programs like Medicare, discretionary spending – including funds for defense and border security – will continue to be squeezed out, and Congress will continue to have the same battles year after year over what programs to fund and how to handle our debt.

I'm fearful that my colleagues on the other side of the aisle may double down on this approach, proposing ideas that will make our nation's grim fiscal reality even worse.

We have already seen a proposal that would radically disrupt our health care system, adding trillions of dollars to our national debt while eliminating patients' choice and raising taxes – and there's no plan to pay for it.

We have a responsibility to put forward serious solutions – not catchy slogans – to improve our health care system and rein in spending.

I look forward to hearing more from Deputy Secretary Hargan as we work through these questions in Congress.

With that, Mr. Chairman, thank you again, and I yield back.

Chairman YARMUTH. I thank the Ranking Member. And in the interest of time, if other members have opening statements, you may submit those statements in writing for the record.

Deputy Secretary Hargan, the Committee has received your written statement, and it will be made part of the formal hearing record. You will have five minutes to deliver your oral remarks, and you may begin when you are ready.

STATEMENT OF THE HON. ERIC D. HARGAN, DEPUTY SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. HARGAN. Thank you. Chairman Yarmuth and Ranking Member Womack, thank you for inviting me here to discuss the President's budget for HHS for fiscal year 2020.

It is an honor to be here today, and it is an honor to serve as deputy secretary of HHS. The men and women of HHS delivered remarkable results since the release of our last budget, including record new and generic drug approvals at FDA, the beginnings of a sea change in drug pricing behavior, opening up new affordable personalized insurance options, and initial signs that the trend in drug overdose deaths is beginning to flatten and decline.

The budget proposes $87.1 billion in FY 2020 discretionary spending for HHS, while making important reforms to help our discretionary and mandatory programs work more effectively and efficiently. While this budget delivers on our mission, it is important to realize that HHS had the largest discretionary budget of any non-defense department in 2018, which means that staying within the cap set forth by Congress has required difficult choices about the investments we make. Today I will highlight some budget proposals around four priorities Secretary Azar has identified for the Department: increasing the affordability of individual health insurance; bringing down drug prices; transforming our health care system into one that pays for value; and combating the opioid crisis.

First, the budget proposes reforms to help deliver Americans truly patient-centered, affordable health care. It would empower states to create personalized health care options that put the American patient in control and ensure he or she is treated like a human being, not a number. That means giving more responsibility back to states, and increasing options for patients, while promoting fiscal responsibility and maintaining protections for people with pre-existing conditions.

Second, the budget supports access to affordable prescription drugs through the four pillars of the President's drug pricing blueprint: more competition, improved negotiation, better incentives around list prices, and lower out-of-pocket costs. The budget will boost competition through fostering efficient approvals of generic drugs and biosimilars, ending anti-competitive practices, delaying or restricting these drugs' market entry, and reforming incentives to increase their adoption. The budget proposes that historic modernization of Medicare Part D to lower seniors' out-of-pocket costs, improve incentives for Part D plans that negotiate on their behalf, and save money for the program.

Third, President Trump is focused on the broader goal of delivering Americans better care at a lower cost. This means ensuring our federal health programs are driving value for patients, and liv-

ing up to the promises that we have made to our seniors. The budget proposes a value-based payment system for hospital out-patient departments and ambulatory surgical centers; expands site neutrality and payments; reduces burdens on providers; and addresses overpayments to post-acute care facilities. These reforms will mean lower cost for seniors and a stronger, more sustainable Medicare program. The budget, in total, will extend the life of the Medicare trust fund by eight years.

As you all know, the Administration has worked with Congress to make historic investments to address our country's opioid crisis, a crisis that, years ago, hit the town I grew up in, and it struck my own family.

The budget fully supports HHS's five-point strategy to improve access to prevention, treatment, and recovery services; to better target the availability of overdose-reversing drugs; to strengthen our understanding of the crisis through better data; to support research on pain and addiction; and to improve pain management practices.

The budget provides us four—provides $4.8 billion towards these efforts. This investment builds on appropriations Congress made in 2018, and ensures that the Substance Abuse and Mental Health Services Administration will continue all its opioid activities at the same funding level as fiscal year 2019. That includes the $1 billion state opioid response program, which we have focused on access to medication assisted treatment, behavioral support, and recovery services. The budget proposes to provide a full year of Medicaid benefits for pregnant women diagnosed with an opioid use disorder, and takes steps to reduce inappropriate prescribing within federal health care programs.

Finally, the budget invests in other important public health priorities, including fighting infectious disease at home and abroad. In particular, it proposes $291 million in new funding for the first year of President Trump's plan to use the effective treatment and prevention tools we have today to end the HIV epidemic in America by 2030.

This budget will advance American health care and help deliver on the promises we have made to the American people. I look forward to working with this Committee on our shared priorities this year, and I look forward to the Committee's questions today.

[The prepared statement of Eric D. Hargan follows:]

Deputy Secretary Hargan Written FY 2020 Budget Testimony

The mission of the U.S. Department of Health and Human Services (HHS) is to enhance and protect the health and well-being of all Americans by providing for effective health and human services and by fostering sound, sustained advances in the sciences underlying medicine, public health, and social services. This work is organized into five strategic goals, and is unified by a vision of our healthcare, human services, and public health systems working better for the Americans we serve. By undertaking these efforts in partnerships with states, territories, tribal governments, local communities, and the private sector, we will succeed at putting Americans' health first.

This past year saw HHS, the Department of Labor, and the Department of Treasury open up new affordable health coverage options, at the same time the Affordable Care Act (ACA) exchanges were stabilized, with the national average benchmark premium on HealthCare.gov dropping for the first time ever. According to a report by the Council of Economic Advisers, actions taken by the Administration, along with the elimination of the individual mandate penalty, are estimated to provide a net benefit to Americans of $453 billion over the next decade.

Congress worked with the Administration to deliver new resources for fighting the opioid crisis, allowing HHS to make more than $2 billion in opioid-related grants to states, territories, tribes, and local communities in 2018. Prescriptions for medication-assisted treatment options and naloxone are up, while legal opioid prescribing is down. HHS also worked to bring down prescription drug prices, including by setting another record for most generic drug approvals by FDA in a fiscal year and working with Congress to ensure pharmacists can inform Americans about the lowest-cost prescription drug options.

The President's Fiscal Year (FY) 2020 Budget supports HHS's continued work on these important goals by prioritizing key investments that help advance the Administration's commitments to improve American health care, address the opioid crisis, lower the cost of drugs, and streamline federal programs, while reforming the Department's programs to better serve the American people.

The Budget proposes $87.1 billion in discretionary budget authority and $1.2 trillion in mandatory funding for HHS. It reflects HHS's commitment to making the federal government more efficient and effective by focusing spending in areas with the highest impact.

HHS's Fiscal Year 2020 Budget reflects decisions not just to be prudent with taxpayer dollars, but also to stay within the budget caps Congress created in the Budget Control Act. With the largest non-defense discretionary appropriation of any cabinet agency in 2019, HHS must make large reductions in spending in order to stay within Congress's caps, set a prudent fiscal course, and provide for other national priorities. This budget demonstrates that HHS can prioritize its important work within these constraints, and proposes measures to reform HHS programs while putting Americans' health first.

REFORM, STRENGTHEN, AND MODERNIZE THE NATION'S HEALTH CARE SYSTEM

Reforming the Individual Market for Insurance

The Budget proposes bold reforms to empower states and consumers to improve American healthcare. These reforms return the management of health care to the states, which are more capable of tailoring programs to their unique markets, increasing options for patients and

providers, and promoting financial stability and responsibility, while protecting people with pre-existing conditions and high health care costs.

The Budget includes proposals to make it easier to open and use Health Savings Accounts and reform the medical liability system to allow providers to focus on patients instead of lawsuits.

Lowering the Cost of Prescription Drugs
Putting America's health first includes improving access to safe, effective, and affordable prescription drugs. The Budget proposes to expand the Administration's work to lower prescription drug prices and reduce beneficiary out-of-pocket costs. The Administration has proposed and, in many cases, made significant strides to implement bold regulatory reforms to increase competition, improve negotiation, create incentives to lower list prices, reduce out-of- pocket costs, improve transparency, and address foreign free-riding. Congress has already taken bipartisan action to end pharmacy gag clauses, so patients can work with pharmacists to lower their out-of-pocket costs. The Budget proposes to:

- Stop regulatory tactics used by brand manufacturers to impede generic competition;
- Ensure federal and state programs get their fair share of rebates, and enact penalties to prevent the growth of prescription drug prices beyond inflation;
- Improve the Medicare Part D program to lower seniors' out-of-pocket costs, create an out-of-pocket cap for the first time, and end the incentives that reward list price increases;
- Improve transparency and accuracy of payments under Medicare Part B, including imposing payment penalties to discourage pay-for-delay agreements; and
- Build on America's successful generic market with a robust biosimilars agenda, by improving the efficient approval of safe and effective biosimilars, ending anti-competitive practices that delay or restrict biosimilar market entry, and harnessing payment and cost-sharing incentives to increase biosimilar adoption.

Reforming Medicare and Medicaid
Medicare and Medicaid represent important promises made to older and vulnerable Americans, promises that President Trump and his administration take seriously. The Budget supports reforms to make these programs work better for the people they serve and deliver better value for the investments we make. This includes a plan to modernize Medicare Part D to lower drug costs for the Medicare program and for Medicare beneficiaries, as well as proposals to drive Medicare toward a value-based payment system that puts patients in control. The Budget also provides additional flexibility to states for their Medicaid program, putting Medicaid on a path to fiscal stability by restructuring its financing, reducing waste, and focusing the program on the low-income populations Medicaid was originally intended to serve: the elderly, people with disabilities, children, and pregnant women.

Paying for Value
The Administration is focused on ensuring federal health programs produce better care at the lowest possible cost for the American people. We believe that consumers, working with providers, are in the best position to determine value. The Budget supports an expansion of value-based payments in Medicare with this strategy in mind. That expansion, along with implementation of a package of other reforms, will improve quality, promote competition, reduce the federal burden on providers and patients, and focus payments on value instead of volume or site of service. Two of these reforms are: (1) a value-based purchasing program for hospital outpatient departments and ambulatory surgical centers; and (2) a consolidated

hospital quality program in Medicare to reduce duplicative requirements and create a focus on driving improvements in patients' health outcomes. Advancing value in Medicare along with the other reforms in the Budget will extend the life of the Medicare Trust Fund by eight years, while also helping to drive value and innovation throughout America's entire health system. Furthermore, in December the administration released a report entitled Reforming America's Healthcare System Through Choice and Competition, which contains a series of recommendations to improve the health care system by better engaging consumers and unleashing competition across providers.

PROTECT THE HEALTH OF AMERICANS WHERE THEY LIVE, LEARN, WORK, AND PLAY

Combating the Opioid Crisis

The Administration has made historic investments to address opioid misuse, abuse, and overdose, but significant work must still be done to fully turn the tide of this public health crisis. The Budget supports HHS's five-part strategy to:

- Improve access to prevention, treatment, and recovery services, including the full range of medication-assisted treatments;
- Better target the availability of overdose-reversing drugs;
- Strengthen our understanding of the crisis through better public health data and reporting;
- Provide support for cutting edge research on pain and addiction; and
- Improve pain management practices.

The Budget provides $4.8 billion to combat the opioid overdose epidemic. The Substance Abuse and Mental Health Services Administration (SAMHSA) will continue all opioid activities at the same funding level as FY 2019, including the successful State Opioid Response Program and grants, which had a special focus on increasing access to medication-assisted treatment—the gold standard for treating opioid addiction. At this level, the Budget also provides new funding for grants to accredited medical schools and teaching hospitals to develop substance use disorder treatment curricula.

In FY 2020, the Health Resources and Services Administration (HRSA) will continue to make investments to address substance use disorder, including opioid use disorder, through the Rural Communities Opioid Response Program, the National Health Service Corps, behavioral health workforce programs, and the Health Centers Program.

Medicare and Medicaid policies and funding will also play a critical role in combating the opioid crisis. The Budget proposes allowing states to provide full Medicaid benefits for one-year postpartum for pregnant women diagnosed with a substance use disorder. The Budget also proposes to set minimum standards for Drug Utilization Review programs, allowing for better oversight of opioid dispensing in Medicaid. Additionally, it proposes a collaboration between the Centers for Medicare & Medicaid Services and the Drug Enforcement Administration to stop providers from inappropriate opioid prescribing.

The Ending HIV Epidemic Initiative

Recent advances in HIV prevention and treatment create the opportunity to not only control the spread of HIV, but to end this epidemic in America. By accelerating proven public health

strategies, HHS will aim to reduce new infections by 90 percent within ten years, ending the epidemic in America. The Budget invests $291 million in FY 2020 for the first phase of this initiative, which will target areas with the highest infection rates with the goal of reducing the number of new diagnoses by 75 percent in five years.

This effort focuses on investing in existing, proven activities and strategies and putting new public health resources on the ground. The initiative includes a new $140 million investment in the Centers for Disease Control and Prevention (CDC) to test and diagnose new cases, rapidly link newly infected individuals to treatment, connect at-risk individuals to Pre-exposure prophylaxis (PrEP), expand HIV surveillance, and directly support states and localities in the fight against HIV.

Clients receiving medical care through the Ryan White HIV/AIDS Program (RWHAP) were virally suppressed at a record level of 85.9 percent in 2017. The Budget includes $70 million in new funds for RWHAP within HRSA to increase direct health care and support services, further increasing viral suppression among patients in the target areas. The Budget includes $50 million in HRSA for expanded PrEP services, outreach, and care coordination in community health centers. Additionally, the Budget also prioritizes the reauthorization of RWHAP to ensure federal funds are allocated to address the changing landscape of HIV across the United States.

For the Indian Health Service (IHS), the Budget includes $25 million in new funds to screen for HIV and prevent and treat Hepatitis C, a significant burden among persons living with HIV/AIDS. The Budget also includes $6 million for the National Institutes of Health's regional Centers for AIDS Research to refine implementation strategies to assure effectiveness of prevention and treatment interventions.

In addition to this effort, the Budget funds other activities that address HIV/AIDS including $54 million for the Minority HIV/AIDS Fund within the Office of the Secretary and $116 million for the Minority AIDS program in SAMHSA. These funds allow HHS to target funding to minority communities and individuals disproportionately impacted by HIV infection.

Prioritizing Biodefense and Preparedness

The Administration prioritizes the nation's safety, including its ability to respond to acts of bioterrorism, natural disasters, and emerging infectious diseases. HHS is at the forefront of the nation's defense against public health threats. The Budget provides approximately $2.7 billion to the Public Health and Social Services Emergency Fund within the Office of the Secretary to strengthen HHS's biodefense and emergency preparedness capacity. The Budget also proposes a new transfer authority that will allow HHS to enhance its ability to respond more quickly to public health threats. Additionally, the Budget supports the government-wide implementation of the President's National Biodefense Strategy.

The Budget supports advanced research and development of medical countermeasures against chemical, biological, radiological, nuclear, and infectious disease threats, including pandemic influenza. The Budget also funds late-stage development and procurement of medical countermeasures for the Strategic National Stockpile and emergency public health and medical assistance to state and local governments, protecting America against threats such as anthrax, botulism, Ebola, and chemical, radiological, and nuclear agents.

STRENGTHEN THE ECONOMIC AND SOCIAL WELL-BEING OF AMERICANS ACROSS THE LIFESPAN

Promoting Upward Mobility

The Budget promotes independence and personal responsibility, supporting the proven notion that work empowers parents and lifts families out of poverty. To ensure Temporary Assistance for Needy Families (TANF) enables participants to work, the Budget includes a proposal to ensure states will invest in creating opportunities for low-income families, and to simplify and improve the work participation rate states must meet under TANF. The Budget also proposes to create Opportunity and Economic Mobility Demonstrations, allowing states to streamline certain welfare programs and tailor them to meet the specific needs of their populations.

The Budget supports Medicaid reforms to empower individuals to reach self-sufficiency and financial independence, including a proposal to permit states to include asset tests in identifying an individual's economic need, allowing more targeted determinations than are possible with the use of a Modified Adjusted Gross Income standard alone.

Improving Outcomes in Child Welfare

The Budget supports implementation of the Family First Prevention Services Act of 2018 and includes policies to further improve child welfare outcomes and prevent child maltreatment. The Budget also expands the Regional Partnership Grants program, which addresses the considerable impact of substance use, including opioids use, on child welfare.

Strengthening the Indian Health Service

Reflecting HHS's commitment to the health and well-being of American Indians and Alaska Natives, the Budget provides $5.9 billion for IHS, which is an additional $392 million above the FY 2019 Continuing Resolution. The increase supports direct health care services across Indian Country, including hospitals and health clinics, Purchased/Referred Care, dental health, mental health and alcohol and substance abuse services. The Budget invests in new programs to improve patient care, quality, and oversight. The Budget fully funds staffing for new and replacement facilities, new tribes, and Contract Support Costs, ensuring tribes have the necessary resources to successfully manage self-governance programs.

FOSTER SOUND, SUSTAINED ADVANCES IN THE SCIENCES

Promoting Research and Prevention

NIH is the leading biomedical research agency in the world, and its funding supports scientific breakthroughs that save lives. The Budget supports strategic investments in biomedical research and activities with significant national impact.

NIH launched the Helping to End Addiction Long-term (HEAL) initiative in April 2018 to advance research on pain and addiction. Toward this goal, NIH announced funding opportunities for the historic HEALing Communities Study, which will select several communities to measure the impact of investing in the integration of evidence-based prevention, treatment, and recovery across multiple health and justice settings. The Budget provides $500 million to continue the HEAL initiative in FY 2020.

The Budget supports a targeted investment in the National Cancer Institute to accelerate pediatric cancer research. Cancer is the leading cause of death from disease among children in the United States. Approximately 16,000 children are diagnosed with cancer in the United States each year. While progress in treating some childhood cancers has been made, the science and treatment of

childhood cancers remains challenging. Through this initiative, NIH will enhance drug discovery, better understand the biology of all pediatric cancers, and create a national data resource for pediatric cancer research. This initiative will develop safer and more effective treatments, and provide a path for changing the course of cancer in children.

The new National Institute for Research on Safety and Quality (NIRSQ) proposed in the Budget will continue key research activities currently led by the Agency for Healthcare Research and Quality. These activities will support researchers by developing the knowledge, tools, and data needed to improve the health care system.

Addressing Emerging Public Health Challenges
CDC is the nation's leading public health agency, and the Budget supports its work putting science into action.

Approximately 700 women die each year in the United States as a result of pregnancy or delivery complications or the aggravation of an unrelated condition by the physiologic effects of pregnancy. Findings from Maternal Mortality Review Committees indicate that more than half of these deaths are preventable. The Budget supports data analysis on maternal deaths and efforts to identify prevention opportunities.

The United States must address emerging public health threats, both at home and abroad, to protect the health of its citizens. The Budget invests $10 million to support CDC's response to Acute Flaccid Myelitis (AFM), a rare but serious condition that affects the nervous system and weakens muscles and reflexes. With this funding, CDC will work closely with national experts, healthcare providers, and state and local health departments to thoroughly investigate AFM.

The Budget also provides $100 million for CDC's global health security activities. Moving forward, CDC will implement a regional hub office model and primarily focus their global health security capacity building activities on areas where they have seen the most success: lab and diagnostic capacity, surveillance systems, training of disease detectives, and establishing strong emergency operation centers. In addition, CDC will continue on-going efforts to identify health emergencies, track dangerous diseases, and rapidly respond to outbreaks and other public health threats around the world, including continuing work on Ebola response.

The Budget also strengthens the health security of our nation by continuing CDC's support to state and local government partners in implementing programs, establishing guidelines, and conducting research to tackle public health challenges and build preparedness.

Innovations in the Food and Drug Administration
FDA plays a major role in protecting public health by assuring the safety of the nation's food supply and regulating medical products and tobacco. The Budget provides $6.1 billion for FDA, which is an additional $643 million above the FY 2019 Continuing Resolution. The Budget includes resources to promote competition and foster innovation, such as modernizing generic drug review and creating a new medical data enterprise. The Budget advances digital health technology to reduce the time and cost of market entry, supports FDA opioid activities at international mail facilities to increase inspections of suspicious packages, strengthens the outsourcing facility sector to ensure quality compounded drugs, and pilots a pathogen inactivation technology to ensure the blood supply continues to be safe. FDA will continue to modernize the food safety system in FY 2020.

PROMOTE EFFECTIVE AND EFFICIENT MANAGEMENT AND STEWARDSHIP

Almost one quarter of total federal outlays are made by HHS. The Department employs more than 78,000 permanent and temporary employees and administers more grant dollars than all other federal agencies combined. Efficiencies in HHS management have a tremendous impact on federal spending as a whole.

Advancing Fiscal Stewardship

HHS recognizes its immense responsibility to manage taxpayer dollars wisely. HHS ensures the integrity of all its financial transactions by leveraging financial management expertise, implementing strong business processes, and effectively managing risk.

In an effort to operate Medicare and Medicaid efficiently and effectively, both to rein in wasteful spending and to better serve beneficiaries, HHS is implementing actions such as enhanced provider screening, prior authorization, and sophisticated predictive analytics technology, to reduce improper payments in Medicare and Medicaid without increasing burden on providers or delaying Americans' access to care or to critical medications. HHS continues to work with law enforcement partners to target fraud and abuse in health care, and the Budget increases investment in health care fraud and abuse activities. The Budget includes a series of proposals to strengthen Medicare and Medicaid oversight, including increasing prior authorization,enhancing Part D plans' ability to address fraud, and strengthening the Department's ability to recoup overpayments made to states on behalf of ineligible Medicaid beneficiaries.

Implementing ReImagine HHS

HHS eagerly took up the call in the Administration's Government-wide Reform Plan to more efficiently and effectively serve the American people. HHS developed a plan –"ReImagine HHS"– organized around a number of initiatives.

ReImagine HHS is identifying a variety of ways to reduce federal spending and improve the functioning of HHS's programs through more efficient operations. For example, the Buy Smarter initiative streamlines HHS's procurement process by using new and emerging technologies.

Conclusion

Americans deserve health care, human services, and public health programs that work for them and make good use of taxpayer dollars. The men and women of HHS are committed, innovative, hardworking public servants who work each day to improve the lives of all Americans. President Trump's FY 2020 Budget will help advance us toward that goal, accomplish the Department's vital mission, and put Americans' health first.

Chairman YARMUTH. Very good. I thank you for your testimony. The Ranking Member and I will defer our questions until the end.

So with that I recognize the gentleman from New York, Mr. Higgins, for five minutes.

Mr. HIGGINS. Thank you, Mr. Chairman. And thank you for being here, Mr. Hargan.

Firstly, I just wanted to point out that the National Cancer Institute was seeking a $400 million increase in funding over this year for next year. This was intended to bring promising new cancer treatments, particularly in the area of immunotherapy, to market.

As you may know, that drug discovery is a process that takes some 10 or 15 years. So when funding is delayed, promising new treatments are delayed, and those promising new treatments are denied for people that are in desperate need of new, effective therapies.

So the President's budget proposes to cut $900 million from the National Cancer Institute. What is the rationale behind that cut, which is enormous, based on anybody's view of it?

Mr. HARGAN. When we work within the caps that—on the budget, which were set forth by President Obama and this Congress years ago, we face a tough budgetary environment this year.

We fully support medical research and the NIH. We know that this is very important to the American people, and particularly the National Cancer Institute is important to ongoing research in oncology and cancer area.

Within that we are also proposing, as I am sure you have seen, increases for pediatric cancer. So we have attempted to——

Mr. HIGGINS. What is that amount?

Mr. HARGAN.——focus on——

Mr. HIGGINS. Is that $50 million?

Mr. HARGAN.——on pediatric cancer?

Mr. HIGGINS. Is that initiative $50 million dollars more for pediatric?

Mr. HARGAN. Yes.

Mr. HIGGINS. Okay.

Mr. HARGAN. So we are proposing new money for pediatric cancer.

Mr. HIGGINS. So it is still a cut of $850 million, generally, to the National Cancer Institute. Does that concern you, as a——

Mr. HARGAN. Within the discretionary budget that we have, we had its—the NIH is the largest component of our discretionary side of our budget. And we have attempted to be evenhanded in how we approached the—approached it. We have a lot of different initiatives within the Department, and we wanted to make sure that it—we were as evenhanded as we could, and as thoughtful as we could when we were confronting——

Mr. HIGGINS. Well, here is what I would say to you, that government funding is—has been involved in about 97 percent of the basic science and research toward the goal of bringing promising new cancer treatments to market. In fact, the last 100 major products, from Herceptin for metastatic breasts cancer, and many of the vaccines for immunotherapy are a direct result of government involvement in the financing of clinical trials that test both efficacy and safety.

And a cut of this amount, even when you take into account the increased funding for pediatric cancer, is still $850 million. That will have a devastating impact on what NCI is able to fund to the various cancer institutes throughout the country, including in Buffalo, New York, the nation's first cancer center, Roswell Park. So that is of concern.

Secondly, on the issue of Alzheimer's, Alzheimer's is a horrible disease. It inflicts pain not only on the afflicted, but those who love and care for the afflicted. Some 3.5 million new cases will be diagnosed this year. And the primary treatment is a drug called Aricept. And it was developed probably two decades ago. And in 60 percent of cases, it may delay the onset of Alzheimer's by maybe six months. This problem is growing, and we don't seem to have a handle on it.

I would ask you what are the Administration's initiatives, as it relates to developing new treatments for Alzheimer's, beyond the Aricept era of those drugs?

Mr. HARGAN. We definitely see the impact of Alzheimer's on our—directly on our—the beneficiaries of our programs. Obviously, a disease like that falls straight into many elements of the Medicare program that we administer. So we—and we take the issue of medical research very seriously across the Department to develop new therapies, new modalities to treat it.

It has proven a difficult disease to solve, but we are committed to standing behind our researchers that are working on that, both at NIH and then in the grantee community that is served with the money that is given generously by Congress to NIH.

Chairman YARMUTH. Okay, the gentleman's time has expired. I now recognize the gentleman from Missouri, Mr. Smith, for five minutes.

Mr. SMITH. Thank you, Mr. Chairman. Thank you, Deputy Secretary Hargan, for being here.

Labor HHS has been one of the most difficult funding bills to get through Congress. In fact, the fiscal year 2019 Labor/HHS being passed by the Republican House, the Republican Senate, and then signed by President Trump was the first time that a Labor/HHS bill had passed in over 20 years. And I think it is very noteworthy that the last time that a Labor/HHS bill was passed and funded was in 1996, the prior time that the Republicans were in power.

And so, I find it to be very ironic that my colleagues on the other side may throw arrows at you, and may criticize your budget, but yet they have failed to ever, in the last 20 years, to pass their own Labor/HHS budget. It is easy to point blame, but it is their turn to govern. And let's see if they govern this Congress in being able to pass a budget, and whether they will be able to appropriate a Labor/HHS.

I do want to say, Secretary, where did you grow up?

Mr. HARGAN. I was actually born in Cape Girardeau, Missouri.

Mr. SMITH. What a wonderful city.

[Laughter.]

Mr. HARGAN. Absolutely.

Mr. SMITH. It is home of Rush Limbaugh, as well.

[Laughter.]

Mr. SMITH. So two great people from southeast Missouri. And it is the great congressional district that I get to represent.

So we definitely are very interested of your rural upbringing. How has that affected how you have helped mold this budget?

Mr. HARGAN. Well, I didn't just grow up in a rural area in deep southern Illinois after being born in southeast Missouri, but my mother was actually an x-ray technician in a small hospital outside the town of 800 that I grew up in. She was an x-ray tech there for 58 years. So, yes, my late mother was there from 1953 to 2011.

So this is—the area—the issue of rural health is something that is extremely close to my heart. Having grown up underfoot in a hospital like that, you see the real challenges that are faced by rural hospitals and rural providers close up, and really, for my entire life.

I was very gratified that Secretary Azar last year instituted a rural health task force that brings together a lot of the elements of the Department to focus on rural health, particularly. In many cases, agencies deal specifically with their parts of the rural health landscape, and being able to unify that and focus on it when we have a lot of shared issues across the different agencies, I think, is going to result in some good effects that we are going to be able to have. And also, allowing more flexibilities around the use of telehealth and other sort of technological areas that I think are going to be important to solving rural health issues as we go forward.

We are going to need a lot of imagination to deal with the issues that are coming forward, a lot of good thinking about what is going—about how we solve the problems with rural health.

Mr. SMITH. We have nine critical-access hospitals in southeast Missouri, nine qualified health centers that serve almost 130,000 patients in 51 different sites. So when you are looking at a geographic area of 20,000 square miles, access to quality, affordable health care in rural America is big. So, I appreciate the Administration's effort on that. I appreciate your background.

Earlier I stated the fiscal year 2019 appropriations and budget passing for the first time in 20 years. Mr. Hargan, what benefits did you see from the certainty of fully funding HHS?

Mr. HARGAN. Yes, well, it was tremendous. As you say, the first time in 22 years that we have had a budget pass for the Department. So it creates a lot of confidence on our part to be able to plan for the future.

We were able to work through a lot of the issues to stand out the new initiatives—say the Ending HIV Epidemic in America initiative that the President announced in the State of the Union Address. It allows us to focus on—rather than focus on funding issues, we really focused on new initiatives to help the American people, to allow us to promote new ideas that we are going to—that we are standing out right now.

Mr. SMITH. I do want to state real quickly that proposal on the investment for eliminating HIV in the President's State of the Union is something that I applaud. And also investment in pediatric cancer research.

So thank you for being here, thank you for representing the Show Me State very well. Even though you were just born in Cape Girardeau, we adopt you. So——

[Laughter.]

Mr. HARGAN. I appreciate it. Thank you. Thank you, Congressman.

Chairman YARMUTH. The gentleman's time has expired. The love fest for Missouri will continue at some point.

The Chair now recognizes the gentleman from Texas, Mr. Doggett, for five minutes.

Mr. DOGGETT. Thank you very much for being with us, Mr. Hargan. But as to health, how is Secretary Azar? Is he ill this morning?

Mr. HARGAN. I don't have any knowledge of——

Mr. DOGGETT. Well, I know he has offered all week to be here. This is the second week he has been offered an opportunity to come. And it is almost as if the Administration has a policy of being fearful of sending its cabinet members to be questioned, indeed, on the tax bill. We couldn't get anyone at any level of the Trump Administration to come and answer questions and be held accountable about the hypocrisy in the bill.

So I do find it troubling that he has not come to respond on some of these issues, and all the more so because of what happened yesterday. And that is the decision of the Administration down in my home state of Texas to, once again, throw in the towel with our indicted Attorney General, and not only to go after pre-existing conditions, which you have been doing, but to say that you favor, as our Republican colleagues did 60 or 70 times, the total repeal of the Affordable Care Act. And I don't see anything in your budget that would provide comparable care for the tens of millions of people that will lose out if you and the Texas Attorney General are successful in destroying the Affordable Care Act, which our Republican colleagues tried so often but were unable to do anything about.

Let me ask you, since I am sure we are not going to agree on that, about one issue that I would hope we could agree on, that you referred to in your testimony, though I don't see it anywhere in the fine print, and that is this whole question of prescription drug costs, and whether we can save taxpayers and seniors anything on that.

Candidate Trump made it very clear that he could save hundreds of billions of dollars on prescription drugs, and it seems to me that this budget really abandons that. It goes around the edges. It does not deal with what candidate Trump said on January 11th of 2017, among other times, that we are the largest buyer of drugs in the world, and yet we don't bid properly. And he said we could save hundreds of billions of dollars, and of course, he is right. The estimates are up to half-a-trillion dollars in annual—excuse me, in 10-year savings that could be had by negotiating drug prices.

I don't see anything in this proposal that calls for the negotiation of drug prices, and I would just ask you if the Administration is abandoning candidate Trump's promise that we bid, as he talked about it, that we negotiate drug prices in order to protect seniors and to protect taxpayers.

Mr. HARGAN. We welcome all of this, we welcome this issue. The President is very dedicated to lowering drug prices for Americans——

Mr. DOGGETT. So far he hasn't been too successful. But I am—he has reiterated his desire, and I hope there could be some bipartisan action on this.

Mr. HARGAN. We have the first lowering of drug price inflation in 46 years.

Mr. DOGGETT. Well, he didn't run on a promise that he would keep prices from going up quite as much as they had before. He said he was going to do something to lower them and save us hundreds of billions of dollars. And there is nothing in this budget to do that.

Mr. HARGAN. We have seen the actions that have been taken that resulted in companies lowering drug costs for cholesterol medicine, for diabetes medicine——

Mr. DOGGETT. They've lowered it where they had competition to meet. And I agree with you that competition is a good way to deal with this problem. But unless there is a negotiation, as the President himself pointed out when he was a candidate, you don't get where we need to be.

And in that regard, I will move from prescriptions directly into one specific prescription and another issue you mentioned, which is the opioid crisis.

We know that the price of Naloxone from one provider went up about 700 percent at the same time our first responders all over the country were being told to stock it. Chris Christie, who headed the President's opioid commission, and more recently the Office of National Drug Control Policy, Jim Carroll, in testimony to the Oversight Committee here within the last month, have agreed that what we need to do is at least, if we can't get comprehensive negotiation through Medicare, we ought to at least negotiate down the price of Naloxone, which can help respond to the fact that we are seeing so many Americans every day—an average of 115 every day—die of overdose.

Do you agree with Mr. Carroll and Chris Christie and his commission, that we ought to be negotiating on the prices for these overdose drugs?

Mr. HARGAN. We believe that the most popular form of Naloxone, which is Narcan, the nasal spray, is highly affordable, that there are other forms of Naloxone that have higher prices. But we believe that it is widely available to all states and first responders.

Mr. DOGGETT. While I don't agree with you, I thank you for your candor. You don't really think there is a problem on Naloxone that needs to be negotiated.

Mr. HARGAN. We believe that it is highly affordable for——

Mr. DOGGETT. Thank you very much.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from Utah, Mr. Stewart, for five minutes.

Mr. STEWART. Thank you, Mr. Chairman.

Deputy Secretary, thanks for being here. You have a difficult job, but it is important work. And I think you take a very serious approach to that. I want to thank you for that.

And the proposal that you have before us that you are here to defend today, I would like to point out before I get to my main point and my question, many parts of it are bipartisan. I was interested to see a New York Times, which is hardly a bastion of con-

servative thought—even the New York Times in the last day had an editorial scolding the Democrats for disparaging it and putting aside some of the proposals that you and the President have put forward, saying that many of them make sense, that many of them should have bipartisan support, and they are just practical reforms that will drive down costs. And I could go into that, but again, that is not where I want to spend my time.

But I will conclude by saying this. We will hear again and again and again—we are going to be told the Administration wants to cut $845 billion from Medicare, and $1.5 trillion from Obamacare. But again, it is not true. It is just simply not true. About a third of that $845 billion is being shifted out of Medicare, but it is being shifted into other programs. The money is still going to be spent, it is just being spent more efficiently.

And again, I appreciate your being here to defend that, and I hope you do so vigorously, because these are defensible positions that you and the Administration have taken.

Now, if I could get to my point, and that is, like you, I grew up in a small town. In fact, I have you beat on this. You grew up in Mounds, which has 800 people. That was a big city to me. I grew up in a town of 295. It had two bars. I don't understand how that quite adds up.

But in my district—I represent Salt Lake City, but also very rural parts of Utah, some incredibly beautiful places—Zion National Park and Bryce's and Canyonlands—but these are rural, difficult places to get to here in the country. About a third of my district lives very rural. They drive up to an hour, just—not to see a specialist—just to see a family doctor.

So talk to me a little bit about tele-health. I mean we think it is incredibly important to providing our rural communities with better health care. We know you are interested in this. Take a few minutes and tell us how we are going to help our rural communities, especially in the West.

Mr. HARGAN. Sure. We think that it is one thing that has got to be one of the keys. We have to get more specialty care. We have to have more access to more sophisticated care to be provided at the rural locations. And with—between that and the development of a health care workforce that can get the information once we are able to use tele-health to provide information to a rural setting, I think we will be able to see there to be just much more and better provision of health care in rural areas.

So we have allowed there to be much more flexibility in CMS for the use of tele-health, and we are looking forward to kind of building out on that, and——

Mr. STEWART. Elaborate on that, if you would, the flexibility and, you know, practical application, what that means to a family.

Mr. HARGAN. So a practical application would be that—how do you—if you have somebody who is going to be prescribing to you, can you use a—can you use tele-health to be able to—for a patient in one location to be able to have a screen in front of them, to be able to talk to a doctor. A doctor can then analyze something, make a prescription, then the prescription can be sent by tele-health, and then sent bar-coded to a pharmacy, and they can dispense it there, so that you can actually do prescriptions remotely.

You can actually provide—with the sophistication of the cameras and the technology we have now, you can have a lot of things that are done, a lot of visits, virtual visits that are done by doctors that can provide really good and sophisticated care and diagnoses to a patient which can then be used locally to provide care.

Mr. STEWART. So, Mr. Hargan, I would be curious, and I don't know the answer to this.

One of the benefits—again, my district and others—is to make it more accessible. It can be difficult, especially for someone on a fixed income, someone who has some limited capabilities, to travel an hour to see a doctor. That is a great thing. Get that—you just indicated that that was possible.

I am curious whether this is also more efficient. Do we actually save money by some of these processes, where the doctor is able to see the patient more quickly and more effectively?

Mr. HARGAN. We have been doing research on that. We look forward to sort of further developing that with Congress about what the cost impacts are going to be. But we definitely want to have them move from higher-cost settings like hospitals into being able to take care of themselves at home.

I personally have sponsored this thing called the Patient Empowering Technology Summit that—we are looking to advocate for more tele-health, more wearable technologies, and things where patients can have technology for themselves in their own homes, in their own settings, that allow them to have better, more sophisticated care for themselves at home or in local settings like community health centers.

Mr. STEWART. And thank you. I am out of time, but I appreciate your answers.

Chairman YARMUTH. Thank you. The gentleman's time is expired. I now recognize the gentlelady from Illinois, Ms. Schakowsky, for five minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman, and thank you, Deputy Secretary. I want to talk to you about Title X, which is the only federal program dedicated to contraceptive health care and family planning services. The program has operated successfully for about half a century, and serves 4.1 million low-income individuals, which is why I think its funding actually should be increased. Right now it is—in the budget it is $280 million. I think $400 million would be better.

But my concern right now is the way that a—an executive order was issued, and a regulation that would dramatically change Title X and the organizations that are possible recipients of Title X funding, providing a tremendous service.

I wonder if you could describe in—perhaps more specifically what we see, many of us, including providers, as a domestic gag rule preventing physicians and providers from giving the full story of the full range of health care services, including even recommending or referring for abortion services.

Mr. HARGAN. The final rule is not a gag rule. It is—it does not prohibit. In fact, it affirmatively permits counseling, non-directive counseling, about abortion. So it is—in this way it is different than the Reagan Administration's Title X rule that was upheld in the Supreme Court.

What we are trying to do is to make sure that the Title X, the statute we have to obey, says none of the funds appropriated under this title shall be used in programs where abortion is a method of family planning. This rule is intended to safeguard the requirements in the law that require us not to fund abortions or to—in the program.

Ms. SCHAKOWSKY. Well, you know that under current law, under the Hyde amendment, no dollars can be spent for abortion services. But what we are concerned about—and correct me if I am wrong—that organizations like Planned Parenthood, who provide many preventative services, the single largest organization to receive Title X funding, believes that their programs would have to dramatically change, not just a matter of providing abortions, but my understanding is that counseling about abortions, leaving it as a potential option, or for—with other money, not federal dollars, providing abortion.

Are you saying that Planned Parenthood is misinformed, and that they will continue to receive funding from the federal government under Title X?

Mr. HARGAN. I don't know the details of Planned Parenthood's internal finances or how they arrange their centers. I know as long as they comply with the law, that they will be entitled to apply for the funds under Title X, as long as they comply with the rules and regulations——

Ms. SCHAKOWSKY. Well, how would you define them, complying with the law? That is what I want to get at, because many of us feel that the—preventing qualified providers who—the Planned Parenthood itself sees about five million people a year, often for screening for cancer, STDs, for basic health care, that they would be prevented from getting Title X, which is very important.

Mr. HARGAN. Well, the final rule is there to help provide high-quality, comprehensive family——

Ms. SCHAKOWSKY. No, no, no. I want to know, regarding abortion, how this affects organizations like Planned Parenthood.

Mr. HARGAN. I would have to refer you to them for the impacts that they think the rule would have for that particular——

Ms. SCHAKOWSKY. No, except that you—aren't you the person that is speaking on behalf of the Administration on a dramatic change?

In your view, do you think these changes in Title X will lessen the number of people who get served by Title X?

Mr. HARGAN. I don't believe that—we have lots of federally-qualified health centers located all over the country, 1,400 health centers——

Ms. SCHAKOWSKY. Other than what? You said we have many other.

Mr. HARGAN. Other providers.

Ms. SCHAKOWSKY. Than Planned Parenthood?

Mr. HARGAN. And Planned Parenthood can comply with the rule. They are—they can come and provide these services. And we are not intending to box out any particular provider. We just have to make sure that the law is implemented, and this regulation is intended to implement the intent of that law.

So if they intend to apply for this, it is not directed to prevent them from applying for these things, just that they have to comply with the law. So any provider can apply for this, as long as they fit within the regulatory framework and the statutory framework.

Chairman YARMUTH. The gentlelady's——

Ms. SCHAKOWSKY. Their concerns are warranted, and I yield back.

Chairman YARMUTH. The gentlelady's time has expired. I now recognize the gentleman from Pennsylvania, Mr. Meuser, for five minutes.

Mr. MEUSER. Thank you, Mr. Chairman, and thank you to Deputy Secretary Hargan, very much, for being here with us this morning.

The President's budget seems to me to be very focused on making health care more affordable. In fact, better for beneficiaries. For instance, the goal is to make prescription drugs far more affordable than over the past.

It also provides much more responsibility to the states, and there is no question—I would say 50 out of 50 states—appreciate that.

It also addresses—in, really, an unprecedented manner, and I hear this from drug awareness groups in my—throughout my district—very strong fixes and support to fight the deadly opioid and drug epidemic that many districts and communities face.

So there is a lot of positives. It also has programs such as Medicare Advantage, or enhances them by—Medicare Advantage has a—has reduced both premiums and deductibles, and I have heard this from many constituents, and the data proves that to be the case. So there is as number of positives.

What I would like to ask is my district, on the opioid and drug epidemic issue, like many communities throughout the country, have some big problems. Can you outline what the Department's budget request allocates to address this crisis?

Mr. HARGAN. I am happy to. As I have mentioned, you know, I come from a community that has been afflicted by the opioid epidemic for decades. In fact, in my own family. The President has signaled this as, you know, the foremost public health crisis of our time, and the budget invests $4.8 billion, an increase over last year, in a difficult environment, of over—of $123 million. This is to—this shows the seriousness with which we have to take this. It is the driver of a three-year decline in American life expectancy.

And the efforts that the Administration has been taking has resulted in what we hope to be a flattening and a decline for the first time in years of the opioid overdose deaths that we are seeing. So we are driving both research into non-addictive pain killers, the greater access to medication-assisted treatment, more money for states and opioid response grants that we have been standing out over the last couple of years to really build out the capacity of the states and localities to deal with this, and for families to get access to the treatment and the recovery services that they need and deserve.

Mr. MEUSER. Thank you. You addressed somewhat the issue of rural areas and the support that this budget provides. You did mention something about workforce development. Could you expand upon that?

Mr. HARGAN. So we have a number of proposals, one of which within the Indian Health Service, which addresses a lot of rural areas throughout the United States, where we are trying to focus on community—the community health aid program. The budget advocates for this, which is providing a training for—to build out a corps of community health aids who can be on the ground in rural areas. And also, Indian Health Service is one of our foremost agencies identified by us in fighting the opioid epidemic, which disproportionately affects tribal members.

So—and we can get lessons learned from a lot of these things, in terms of workforce development.

Mr. MEUSER. Great. Can you describe a few of the Medicaid reforms that are in this budget?

Mr. HARGAN. Yes. So the Medicaid reforms, as you have mentioned, are really dedicated to providing flexibilities for states. So we have put forward a block grant program of $1.2 trillion over 10 years that really is intended to refocus the Medicaid program on the populations it was originally intended to serve: pregnant women, children, the disabled, the elderly. So we are really focusing on the most vulnerable populations, and giving states flexibility to deal with their particular populations that they uniquely have the knowledge on the ground of how to deal with them.

So we have—it is—so we have actually stood out more programs, more flexibilities on that side, and $1.2 trillion on a new program to address these issues and provide flexibilities for the states.

Mr. MEUSER. Thank you. I just got a couple of seconds here. I will just ask quickly. Prescription drugs, are there one or two examples of what you are doing effectively to reduce prescription drug costs?

Mr. HARGAN. Yeah. We have seen companies reduce in cholesterol medicines, in insulin for diabetics, and in hepatitis C drugs, where companies actually announced lowering drug costs for patients in those areas, and these are widely-used drugs. Millions of people use cholesterol drugs, as well as those dealing with diabetes.

Mr. MEUSER. Thank you.

Thank you, Mr. Chairman.

Chairman YARMUTH. Sure. The gentleman's time has expired. I now recognize the gentleman from Nevada, Mr. Horsford, for five minutes.

Mr. HORSFORD. Thank you, Mr. Chairman, and thank you for holding this hearing to allow us to discuss the President's Health and Human Services 2020 budget proposal. I would like to start off with Medicaid.

Today more than 640,000 Nevadans rely on Medicaid, which provides health coverage to children, pregnant women, parents, seniors, and individuals with disabilities.

President Trump promised during his 2016 campaign that he would not cut Medicaid funding. In fact, on May 7th, 2015 then-candidate Trump tweeted—and I quote—"I was the first and only potential GOP candidate to state there will be no cuts to Social Security, Medicare, and Medicaid."

Deputy Secretary, can you tell me and my constituents back in Nevada why the President is now breaking his promise and proposing to cut Medicaid by $1.5 trillion over the next 10 years?

Mr. HARGAN. The budget does not propose to cut. It cuts and adds in $1.2 trillion, as I mentioned, in new grants that allow flexibilities for states to respond. So, whereas——

Mr. HORSFORD. And those new cuts——

Mr. HARGAN. Whereas——

Mr. HORSFORD. Those new programs are being paid for through cuts to the existing Medicaid program, correct?

Mr. HARGAN. So there—it shifts—the budget shifts the money from being paid as it currently is to more flexibilities on a different line. So it might appear to say it cuts Medicaid by a certain amount, but actually the money is mostly shifted into a more flexible budget line.

So we are standing up the market-based health care grants to the states, which is going to allow them to focus the program more flexibly. So——

Mr. HORSFORD. Yes. As a former state legislator, having worked on budget issues, we understand what those block grants to the states would actually mean. For states like Nevada, that have population growth, it is not going to actually allow us to keep up with our health care needs.

Let me turn to the HIV eradication. President Trump, in his State of the Union speech said it is his goal to end the U.S. HIV epidemic. And while that is a very commendable goal, I question the approach. Some of my colleagues have talked about the $1.2 billion cuts to global health programs, but we can't ignore the cuts the Trump Administration is making to domestic health care programs that help address HIV.

You see, Medicaid is the single largest source of coverage for all Americans with HIV, and this plan looks to gut the program. This will be detrimental in Nevada, which has the seventh-highest population of individuals with HIV in the nation. Evidence shows that reducing federal funds through a per capita or block grant would limit Nevada's ability to respond to public health crisis such as the HIV epidemic or the opioid epidemic. Without Medicaid coverage, 8,900 people living with HIV in Nevada will likely go without any care.

So Deputy Secretary, how does the Administration plan to make up for the loss of care for HIV patients?

Mr. HARGAN. We have proposed to end the HIV epidemic in America by 2030. This budget proposes $291 million targeted to the areas that account for 50 percent of new diagnoses. We are dedicated to ending this scourge for all Americans, and we followed the advice of our public health specialists, our researchers, that——

Mr. HORSFORD. You are not answering my question.

Mr. HARGAN.——we think between——

Mr. HORSFORD. Reclaiming my time, can you answer the question? How does your plan specifically seek to end the eradication of HIV, when you are making these dramatic cuts?

Mr. HARGAN. We are going to be standing out, through the community health clinics, more access to PrEP, which will allow us to suppress the virus on the front end, prophylactically, and then also maintain funding for the Ryan White CARE Act, with—which allows us to—which is where we get the ART on the—for people who are infected.

So between PrEP and ART, and through community health clinics, and through the state and local-based elements of the Ryan White CARE Act, we believe that we will be able to, through those and——

Mr. HORSFORD. I will look forward to getting more information, since it is not very clear.

I want to just mention on the issue of tele-health—I know the budget does factor in $44 million of additional money to tele-health grants. I just visited a number of rural health care centers in my district last week with FCC Commissioner Starks.

However, based on the need that I heard from those providers, $44 million, while an increase, still seems rather inadequate, based on the information that I received from those health care providers. So I would ask the Administration to really look at that, based on the fact that it is an area where we may share some agreement. Thank you.

Mr. HARGAN. Thank you, Congressman.

Chairman YARMUTH. The gentleman's time has expired. I now recognize the gentleman from South Carolina, Mr. Timmons, for five minutes.

Mr. TIMMONS. Thank you, Mr. Chairman. Thank you, Deputy Secretary, for taking the time to come before our committee today.

We are hearing a lot from my colleagues across the aisle about the changes in spending. The spending priorities that have been proposed are different than last year, and these cuts that we keep hearing about—I understand some of their concerns. But I want to talk to you about a different kind of cut.

We have $22 trillion in debt right now. We passed a $1 trillion deficit budget. What happens when our credit limit runs out? It is not a question of if, it is a question of when. So whether it is five, 10, 20 years from now, or next year, I want you to give me the scenario of a 20 percent across-the-board cut to your budget.

Mr. HARGAN. Well, as you have seen, we are trying to preserve the viability of these programs. In fact, in the budget we are extending the life of the Medicare trust fund by eight years, just simply by lowering the rate of growth in the program from 7.8 percent to 6.9 percent, and by taking some of the elements out of the Medicare trust fund that may not really belong there, like graduate medical education or uncompensated care—by moving those out into the general fund, we are extending the life of the Medicare trust fund by years, which helps us keep our promises to American seniors.

Just by enacting some common-sense reforms to these programs, we are going to extend the life and the promises that we have made.

Mr. TIMMONS. Let's get more specific, though. So next year you get 25 percent less dollars. You—just specifically, what would you have to do?

Mr. HARGAN. You know, I would say that if we have hypothetical scenarios, we work through a lot of these different elements in 25 percent to—a scenario would be a huge cut this year.

We have proposed a 12 percent cut in our discretionary lines within the budget. It would require a lot of thoughtful work on our budget people's behalves to make sure that we can balance out the

necessary—there is a focus, like, for example, this year, opioids, pediatric cancer, where we are trying to focus on these areas. But it would require a lot of difficult decisions.

Mr. TIMMONS. Would Americans see a reduced quality of health care?

Mr. HARGAN. With a 25 percent cut, it depends on where we would, hopefully, be able to—we would be able to work to make sure that there were no lowering in overall care for Americans. We would do our best.

Mr. TIMMONS. You would do your best, but 25 percent less money, it would be catastrophic.

Mr. HARGAN. It would be a blow to have to endure larger and larger cuts as time went on.

Mr. TIMMONS. So the Budget Committee of the United States Congress should take very serious steps to make sure that that doesn't happen.

Mr. HARGAN. Yeah, I think that we have laid out some commonsense reforms in this budget that would enable us to take action in time to prevent—to make moderate changes now that would prevent worse decisions taking place later on down the line.

Mr. TIMMONS. Thank you.

Thank you, Mr. Chairman.

Chairman YARMUTH. I thank the gentleman. I now recognize the gentleman from Virginia, Mr. Scott, for five minutes.

Mr. SCOTT. Thank you.

Mr. Hargan, if an—does your budget anticipate funding agencies that discriminate based on religion?

Mr. HARGAN. We enforce all the civil rights laws, and all the constitutional safeguards that are given to us in trust.

Mr. SCOTT. Okay. So if an agency said that they are going to discriminate in hiring based on religion, and then turned around and—say if it is an adoption agency only considers certain religions for adoption, would you—would that disqualify them from federal funding? Or would you support that discrimination in hiring and providing the service?

Mr. HARGAN. We can balance the needs of grantees and their religious expression with—that is one of the constitutional guardrails——

Mr. SCOTT. Is that a yes or a no?

Mr. HARGAN.——that we are given to enforce.

Mr. SCOTT. Would that agency be disqualified by virtue of the fact that they intend to discriminate in hiring with the federal money, only hiring, say, Christians, other religions need not apply; and then only considering for adoption services Christian families, other religions need not apply? Would they be disqualified from federal funding?

Mr. HARGAN. So I assume you are dealing with the Miracle Hill——

Mr. SCOTT. I am not—I am just asking a general question.

Mr. HARGAN. We have to protect both religious expression——

Mr. SCOTT. Is that a yes, you would fund such an agency?

Mr. HARGAN. We have to protect all the constitutional rights——

Mr. SCOTT. Is that a yes, you would fund such an agency?

Let me ask it another way. Is it yes, you have funded such an agency?

Mr. HARGAN. South Carolina approached us with a request for an exception for—to allow them to place more children with foster care and loving homes——

Mr. SCOTT. Is that a yes? Wait, wait, wait a minute. Wait. An agency intends to discriminate based on religion in hiring, and then based on religion they are going to disqualify families from participating in adoption services.

Mr. HARGAN. No, no family is disqualified for participating in adoption services. Any time that an organization like Miracle Hill——

Mr. SCOTT. They——

Mr. HARGAN. It—they are referred back to the state, and—the state or another agency. So anyone who wants to participate in that as a foster parent can apply to the state, they can apply to another agency——

Mr. SCOTT. But not that agency. That agency is going to discriminate. Is that right?

Mr. HARGAN. The agency is allowed to——

Mr. SCOTT. To discriminate.

Mr. HARGAN.——to express——

Mr. SCOTT. And you will—and they can use federal funds doing that?

Mr. HARGAN. The agency is allowed to express its religious——

Mr. SCOTT. I am just trying to get a straight answer. I mean this is a very straightforward question.

Mr. HARGAN. No one is prevented from participating in that foster care program.

Mr. SCOTT. They are—but the agency can disqualify them—they are not going to consider any non-Christian adoptive parents, is that right? And you are going to give them federal money?

Mr. HARGAN. The state agency——

Mr. SCOTT. Excuse me. You gave them federal money?

Mr. HARGAN. The state agency will not turn away anyone who wants to apply to——

Mr. SCOTT. Answer—this is——

Mr. HARGAN.——be a foster——

Mr. SCOTT. Did you fund—are they spending federal money and discriminating? Yes or no.

Mr. HARGAN. We give money to the state——

Mr. SCOTT. Yes, okay.

Mr. HARGAN. We give money to the state, and the state gives it to the agency——

Mr. SCOTT. Yes, okay. I think we have gotten the point. You have funded an agency that has the express intention—I do not know if they are doing it or not—but discriminating in hiring with federal money, and disqualifying, that agency, parents who are not the right religion from participating, and they are using federal money.

Mr. HARGAN. I could not as a Catholic participate as a foster family with that organization.

Mr. SCOTT. And you gave them federal money?

Mr. HARGAN. I could not participate.

Mr. SCOTT. You gave them federal money. Let me get to another one, talking about block grants. Is it true that a community services block grant that reduces poverty, did they get zeroed out?

Mr. BURCHETT. I believe that we have not allocated money for that program.

Mr. SCOTT. And Social Services' block grant, supportive services for families, did they get zeroed out?

Mr. HARGAN. Like other programs where we have sort of low results for the program——

Mr. SCOTT. Is that a yes?

Mr. HARGAN.——we zero them out.

Mr. SCOTT. And you are going to a block grant with – in terms - after the Affordable Care Act. Your plan anticipates ending the Affordable Care Act and replacing it with a block grant, and the block grant will increase annually with inflation; is that right?

Mr. HARGAN. Yes, we have the whole provision set out.

Mr. SCOTT. Okay. And the inflation, is that regular inflation or is medical inflation?

Mr. HARGAN. I would have to get back to you. I believe it is regular inflation.

Mr. SCOTT. And so what is the difference between regular inflation and medical inflation?

Mr. HARGAN. There are lots of different calculations for different kinds of——

Mr. SCOTT. Medical inflation is a lot higher than regular inflation. So every year you would be falling behind. The purchasing power of that block grant would be eroding every year based on the difference in inflation; is that right?

Mr. HARGAN. If the inflation rate that year were higher than regular inflation.

Mr. SCOTT. Oh, come on. The inflation rate for medical inflation has been higher than regular inflation. When was the last time it was not higher?

Mr. HARGAN. I do not know. We would have to get back to you.

Mr. SCOTT. Okay.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from Oklahoma, Mr. Hern, for five minutes.

Mr. HERN. Thank you, Chairman, Ranking Member Womack.

Deputy Secretary Hargan, I want to thank you for your work you do in promoting and enhancing the health and well-being of the American people. I appreciate your work and this Administration's commitment to lowering the cost of prescription drugs, protecting the unborn, combating the opioid crisis, and many other ideals.

This Administration's equal commitment to health and fiscal responsibility is commendable.

First, I would like to express my support for the Department of Health and Human Services' final rule separating abortion from family planning. Until now, the Title X program accounted for hearing 60 percent of Planned Parenthood expenditures from all agencies reported between 2013 and 2015.

During this time frame, Planned Parenthood received $170 million of taxpayer money through the Title X program, an average of $56 million annually.

While previous regulations violated longstanding conscience laws and required all Title X recipients to refer for abortion, the final rule ensures that none of the funds appropriated for Title X may be used in programs where abortion is a method of family planning.

The elimination of the egregious abortion referral mandate appropriately protects the conscience rights of health care providers. Abortion is not family planning, and I am grateful for this Administration's acknowledgement of the fact.

So really briefly, I would like to know what else this department is doing to ensure that they are allowing our great medical care providers to protect the religious freedoms and consciences while on the job.

Mr. HARGAN. Thank you, Congressman.

We have set out in our Office of Civil Rights a Division for Conscience and Religious Expression to be able to protect, to be able to investigate potential violations by our conscience rule, that is, to protect people's conscience rights and their religious rights when they are providing medical care.

There are a number of statutes that have been put in place over years, some stretching back decades into the 1970s that protect Americans who are in the health care sector, that protect both their conscience and their religious expression rights.

So under this Administration, we now have staff that are going to be dedicated to making sure that those rights are not violated.

Mr. HERN. Thank you, Mr. Secretary.

I would also like to ask you about the medical device tax. This fundamentally flawed public policy was put into place in an effort to pay for the unaffordable health care act. This punitive tax punishes businesses in a specific industry for innovation. It is the epitome of the war on business and is already having a major negative impact on the competitiveness of vital, world-leading, American industry.

According to data from the U.S. Department of Commerce, the U.S. medical technology industry saw its job ranks fall by nearly 29,000 while the medical device tax was in effect. In a 2017 study by the American Action Forum, assessed that this rate of job losses would likely return if the tax goes back into effect.

Those workers earn an average of $58,000 annually, well above the national average for manufacturing.

First, do you support the repeal of the medical device tax?

Mr. HARGAN. Yes, I and we do.

Mr. HERN. And what is your department doing, working with Congress, urging them to—let me just rephrase it this way.

What is your department urging Congress to do to keep the health care industry competitive?

Mr. HARGAN. Yes. We are supporting innovation on all fronts, not just through medical research that we are doing on NIH, but we are also going to try to enact a series of regulatory reforms.

For example, I am chairing something called the Regulatory Sprint which is going to hopefully help de-burden a lot of areas around coordinated care, that is going to allow there to be more innovation in this area.

We think that innovation is really in many ways a solution to some of the health care problems that we have, and it is a way in which we can kind of solve some of the problem, whether cost, and also help American industry. If we can support innovation in this country, we are really going to support the position of the entire United States.

It is the largest sector of the American economy, and whatever we can do to help enhance innovation in this country, it is going to help not just the Americans as patients, but also American industry as well in the health care sector.

Mr. HERN. Thank you, Mr. Secretary.

Mr. Chairman, I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I do not know what is going on with the mikes here. Still working out the kinks.

I recognize the gentlelady from Texas, Ms. Jackson Lee, for five minutes.

Ms. JACKSON LEE. Mr. Chairman and Ranking Member, thank you so very much.

And to the Deputy Secretary, thank you for your service to the Nation.

I am going to ask very quick questions, and I would appreciate, as best you can, answers that would move as quickly as possible because my time is limited.

Let me start out by saying in 2012 there were 45.6 million people that were uninsured. As the Affordable Care Act began to do its work, 2018, 28.3 million, 8.8 percent uninsured.

I think every life, every child is valuable and should have access to health care. Do you believe that, yes or no?

Mr. HARGAN. Yes.

Ms. JACKSON LEE. Thank you very much.

Let me, with that in mind, let me begin methodical questions. It is my understanding that the President's budget includes $1.5 trillion in Medicaid cuts over 10 years. Part of the work of Medicaid is cutting HIV transmission. Part of its work is dealing with prescriptions. The Part D plans must cover all HIV drugs.

But the Administration now is limiting the coverage of drugs, when we are seeing a surge of HIV. Is that giving a death knell to people who are suffering from HIV?

What mindset would cause you to engage in cuts in people who are fighting for their lives?

Mr. HARGAN. As you know, the President is dedicated to ending the HIV epidemic in American by 2030.

Ms. JACKSON LEE. By his works, not his words, by his deeds.

Mr. HARGAN. We are putting $291 million more, million new dollars, into fighting HIV. Both are expanding access to prep and as well as ART. So the main forms by which people fight this terrible scourge, we are enabling people to have actually more access to——

Ms. JACKSON LEE. I am interested in your answer about the fact that HIV transmissions and drugs that are going to be excluded are going to be lost. That opportunity is going to be lost. Do you admit that?

Mr. HARGAN. We hope that access to effective HIV therapies is not just not lost, but it's going to be enhanced.

Ms. JACKSON LEE. But we are hoping that.

Let me move on to indicate that you are cutting $130 billion from Medicaid over 10 years. What is your estimate of the people who will lose Medicaid coverage?

Mr. HARGAN. Well, we believe that what we are doing in this budget is, first of all, as I indicated earlier, while there are cuts in the budget, there is also $1.2 trillion in grants that are going to go to states to enable them to focus

Ms. JACKSON LEE. In block grants.

Mr. HARGAN.——to focus on the most vulnerable.

Ms. JACKSON LEE. And that is a challenge.

Do you know how many people in your new work formula will lose Medicaid because of the mandatory work requirement? And these people are unable to work.

Do you know how many people will lose it because of that?

Mr. HARGAN. We believe that we are going to look for the effects of the community engagement requirements that we have in states right now. We are hopeful with the strong economy that we have right now and that has been enabled by President Trump's reforms——

Ms. JACKSON LEE. Forgive me for reclaiming my time or restoring my time. I know you are believing in hope. I want you to see the picture of devastation.

Let me also say coming from Texas, we were the poster child for the uninsured. Now the Administration is going in to implode, blow up, and destroy the Affordable Care Act with his position on the *Texas v. Azar* decision.

Were you involved in that decision making?

Mr. HARGAN. Litigation strategy is with the Department of Justice.

Ms. JACKSON LEE. Do you agree with throwing out the Affordable Care Act that has been a lifeline to many people?

Mr. HARGAN. President Trump wants to make sure that people with preexisting conditions and all the——

Ms. JACKSON LEE. That will be impossible if he blows up the Affordable Care Act. What is his substitute right now? Does he have bill that is going through the House and Senate that he is going to pass and sign?

Mr. HARGAN. We have spelled out in the budget a——

Ms. JACKSON LEE. You have no legislation that will deal with that.

So let me deal with the unaccompanied children. How many unaccompanied children does HHS anticipate needing services for in 2020? How much are you asking for?

Mr. HARGAN. We are asking for an expansion of our ability to transfer to 20 percent and then a $2 billion contingent fund that will enable us to deal with influxes and surges into this——

Ms. JACKSON LEE. And do you have an accounting? I have asked almost every administration representative that comes before my Committees, plural. What is the number that you have right now?

Mr. HARGAN. It is between 11 and 12,000.

Ms. JACKSON LEE. And that 11 to 12,000 has been a steadfast number of holding and incarcerating children. Aren't you part of the process of getting connected to their family members?

Mr. HARGAN. We want to make sure that process takes place as quickly as possible.

Ms. JACKSON LEE. Then can I ask you to ask the President to cease and desist incarcerating these children?

I wrote the legislation. So let me just say I understand. We in the judiciary tried to find alternative places for children as opposed to the detention conditions, but now it has become an industry, and you are asking for another $2 billion.

Mr. HARGAN. We want to make sure that the children's welfare and safety is at the center of everything we do at HHS.

Ms. JACKSON LEE. I will be back in touch with you.

Let me quickly ask. Head Start, you are lowering the Head Start funding. With the Head Start funding you are going to be able to serve one-third less eligible children, and we know that it is only reaching less than one-third of eligible children, and you are proposing to reduce it.

How are you going to help the children that need to be in Head Start with reducing the budget?

Mr. HARGAN. We are actually focusing our efforts on making sure we preserve programs that have demonstrable effects like Head Start and the child care programs. We are putting forward actually new proposals on child care, I think $1 billion more into a child care fund.

Ms. JACKSON LEE. Mr. Hargan, you are losing slots, and the parents are begging. I would beg that to be revisited as we will revisit it in terms of all these questions that I asked.

These are desperate situations, desperate times, and they need the help of the federal government as it relates to health care, HIV/AIDS, and, of course, Head Start, and many others. So I beg of you to be a voice of reason for this Administration.

I yield back.

Chairman YARMUTH. The gentlelady's time is expired.

I now recognize the gentleman from Tennessee, Mr. Burchett for five minutes.

Mr. BURCHETT. Thank you, Mr. Chairman.

And thank you for being here, Ranking Member. Thank you, sir.

I will not beleaguer questions that have already been asked. Being number 436 out of 435, I am going to wing it on a couple of things that I was curious about.

On these deductions or supposed cuts to Medicare-Medicaid, but you say that, in fact, you are going to basically—correct me if I am wrong—you are going to take the bureaucracy out of it and send it to the states and allow them to share in the responsibility of providing this care and maybe the aspect of a local control is best.

Is that primarily what I understand you saying, sir?

Mr. HARGAN. Yes, it is.

Mr. BURCHETT. Okay. I wanted to get that straight.

Two other issues I was concerned about. The pediatric cancer investment, I salute you for that. That along with the HIV investment, I guess my biggest concern is I have seen up here both parties do it. So it is not like it is any big secret, but it seems that in funding bills we reward and we punish, and you see funding for research for things possibly spread out among members who may be more cordial with others than some are, than some that aren't.

And I am wondering, and I guess my biggest concern is for things like pediatric cancer, you know, we have got St. Jude's in Memphis, which is on the other end of the state, but they clearly do the Lord's work. I'm wondering if you all are looking at areas where there could be duplication.

Because in that funding, it seems a lot of times it has very little to do, at least in my layman's view, of the ones that are actually delivering the goods, but it is going to the more prestigious areas and it may be that more prominent members represent those districts. And I am concerned of duplication.

I would just like to get to the bottom of it, get to the cures, take care of these sick folks, and quit with all of the politics. I don't care if they do it in Dan Crenshaw's district or Tim Burchett's district, but if they're solving the problem, that is where the money needs to go, and I hope you all are addressing that duplication that I see a lot in research.

Because it seems to me that, you know, we just keep reinventing the wheel on some of these things, and if we could consolidate and maybe have some collaboration within these institutions that we could solve some of these problems.

If you would, just comment on that.

Mr. HARGAN. I think that is probably the central case that we are trying to deal with here. Pediatric cancer has been very fragmented and siloed in a number of different places that we think has sort of dragged at the ability to make as much progress in this area as we would like.

So us being able to kind of gather information on the data, get it together into a single place, and determine where we are seeing better results within pediatric cancer is kind of central to the problem that we have articulated to ourselves.

So the President's initiative on pediatric cancer, a lot of it is going to be addressed precisely with what you are talking about, which is the fragmentation and siloing of pediatric cancer research in the past.

Mr. BURCHETT. You used the term "silo." I understand what that means, but could you explain that to Mr. Crenshaw because I am not sure that he understands exactly what that means.

Mr. HARGAN. Yes, there is often a development straight up in a particular area. They do not talk to each other, right?

Mr. BURCHETT. Honestly, I do not know what "siloed" means. So if you can just explain it to me.

[Laughter.]

Mr. BURCHETT. That was me saying that, you know, trying to look a little smoother, but you did not catch onto that, but go ahead.

Mr. HARGAN. I guess coming from a farm, I did use a rural term. So, yes, so siloing, we often find that people do not talk to each other within this area. They do not share data collaboratively within this area, and it is just the development of these longstanding ways of doing business that we hope to be able to overcome.

Mr. BURCHETT. Okay.

Mr. HARGAN. To bring the information together, stop the fragmentation, stop the non-sharing of data, and prepare a single data

resource that is available more broadly that will allow us to kind of make some steps forward in this area.

Mr. BURCHETT. Thank you, brother.

I yield the rest of my time, Mr. Chairman. Thank you for your indulgence.

Chairman YARMUTH. Well, I thank you, sir.

The chair now recognizes the gentleman from California, Mr. Peters, for five minutes.

Mr. PETERS. Thank you, Mr. Chairman.

And thank you, Deputy Secretary Hargan, for coming to join us today.

One of the challenges in health care is keeping premiums down, and I think you would agree that one of the ways we do that is to make sure we get young people into the pool. Would you agree with that?

Mr. HARGAN. There are lots of ways to address those issues with the pool.

Mr. PETERS. I just it was one of the ways, is to get younger——

Mr. HARGAN. It is possible one of the ways is to bring lower cost people into the pool.

Mr. PETERS. Right. And you know, we did have a mechanism in the Affordable Care Act which was enacted before I got here. So I have no pride of authorship. The individual mandate was intended to get people to come in, and now after you are 26 and you come off your parents' insurance, assuming you have it from them, there is no real incentive to get you to get in the pool.

And I notice that one of the things that the proposed budget would do would be to cut advertising by 90 percent and in-person consumer assistance by more than 80 percent, close to $150 million.

Don't you think it would be useful to help get the word out that insurance is available in terms of as one mechanism at least to get young people who are healthy into the pool and keep insurance premiums down?

Mr. HARGAN. We have seen torts as the ACA enrollment has developed. We have seen less and less use of navigators, for example; that they were not really connecting people at some point.

We had one result where we had spent $200,000, and there was a single person enrolled by a navigator in one area. That is an area where it seems like there was some waste going on.

Mr. PETERS. I certainly think we should root out the waste. I will just tell you that California's experience has been at variance with that.

According to Covered California, Mr. Chairman, without objection, I would ask that the Covered California summary of marketing matters be added to the record.

Chairman YARMUTH. Without objection.

[The information follows:]

Marketing Matters: How Marketing and Outreach Builds Stable Marketplaces and Pays Off for the Federal Government

By Peter V. Lee, Vishaal Pegany, James Scullary and Colleen Stevens

Introduction

With the Affordable Care Act woven into the fabric of America's health care system, one important question that remains before policymakers at the state and federal levels is what can be done to stabilize the individual health insurance market and lower premiums for consumers.

This issue brief is a summary version of Covered California's extensive analysis — "Marketing Matters: Lessons from California to Promote Stability and Lower Costs in the National and State Individual Insurance Markets" (http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17) — which shows marketing and outreach are proven ways to increase enrollment, lower premiums, save consumers' money and stabilize the individual insurance market.

The report finds that not only are marketing and outreach critical investments to promote enrollment, but they appear to have a large return on investment since bringing more healthy people into the risk pool further lowers premiums, saving money for everyone.

Simply put, investing in marketing and outreach pays off.

Marketing Spending Makes a Difference for the Federally-facilitated Marketplace

Over the last two years, the federal government has increased its marketing and outreach investments to support enrollment in the individual markets served by the Federally-facilitated Marketplace (FFM). During this period, the annual spending for marketing and outreach

Highlights:

- Covered California's extensive marketing and outreach efforts helped create of the best take-up rates and lowest risk scores in the nation. This bigger and healthier enrollment translates to 20 percent lower premium costs — representing on-exchange premium savings of $2.6 billion for 2015 and 2016.
- Covered California's marketing and outreach investments likely lowered premiums by 6 to 8 percent for 2015 and 2016. Significant marketing lowers premiums by boosting enrollment of healthy consumers.
- In 2018, Covered California plans to spend more than $111 million on marketing and outreach. It estimates that every marketing dollar likely yields more than a three-to-one return on investment.
- If the federal government invested in marketing and outreach at a level similar to Covered California, it would amount to $480 million for 2018. This could lead the Federally-facilitated Marketplace to enroll 2.1 million more consumers between 2018 and 2020 while lowering premiums by 3.2 percent. The premium savings mean consumers overall save $6 billion over the three-year period. Covered California estimates this would likely yield a more than 500 percent return on investment.
- If the federal government goes ahead with its planned 72 percent reduction in marketing and outreach spending ($47 million total spend), there will likely be one million fewer Americans getting insurance, a less healthy risk pool and premiums that will be more than 2.5 percent higher in 2019.

increased by 40 percent — from $111 million for the 2016 enrollment year to $167 million for the 2017 enrollment year. In a departure from gradual year-over-year increases, the Centers for Medicare and Medicaid Services (CMS) recently announced that it would significantly reduce its marketing spending for 2018 by 90 percent for advertising and by 42 percent for Navigator grants. This would reduce the total marketing and outreach spending for the FFM by 72 percent to $47 million.

Evidence from California suggests if instead of cutting marketing and outreach spending, CMS increased its spending to a level similar to Covered California, which invests 1.4 percent of premiums collected on marketing and outreach, it would amount to $480 million, this would result in an increase in enrollment and a healthier risk mix, leading to lower costs for consumers. This increased investment could be funded without taxpayer funds because CMS is projected to collect $1.2 billion in plan assessment revenues that are intended to support marketplace functions, including marketing and outreach. (https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf).

The *Marketing Matters* report finds that this level of investment would likely yield a return on investment from 300 percent to 500 percent (see Table 1. Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018-2020). The evidence suggests that over a three year period, with the $480 million investment increasing annually based on the consumer price index, premiums would decrease by more than 3 percent and 2.1 million Americans could gain insurance, of which 1.3 million would be subsidy-eligible.

The report also finds that reducing marketing spending, as announced by CMS in August, will likely result in lower enrollment, a less-healthy risk mix, higher premiums and less plan participation. The potential one-year impact of the proposed 72 percent reduction in marketing and outreach spending would mean one million fewer Americans with health insurance and premiums in 2019 that are from 2.6 percent to 5.3 percent higher.

Why Selling Insurance is Challenging

Marketing is one of the most important elements for creating and continuing any successful business. Investments are critical to convincing consumers to buy all types of products and services. The individual health insurance market is no different. Indeed, selling health insurance can be harder than selling other products because there are human biases against spending money today for potential benefits tomorrow.

Behavioral science shows that selling health insurance is uniquely difficult. While sick people are motivated to buy coverage, humans have several innate biases that require healthier people to be encouraged, nudged and reminded about the value of having health insurance.

While some have questioned whether marketing is necessary — pointing to the lack of outreach in the employer, Medicare and Medicaid markets — the individual market is fundamentally different from other sources of coverage.

Many employers automatically enroll their employees in coverage and renew their coverage each year, older consumers are more aware of needing Medicare, face penalties for not signing up and Medicare Advantage plans spend billions of dollars on marketing and agent commissions, and it is easier to enroll in Medicaid because there is little or no-cost to the consumer.

Marketing Matters: How Marketing and Outreach Builds Stable Marketplaces and Pays Off for the Federal Government

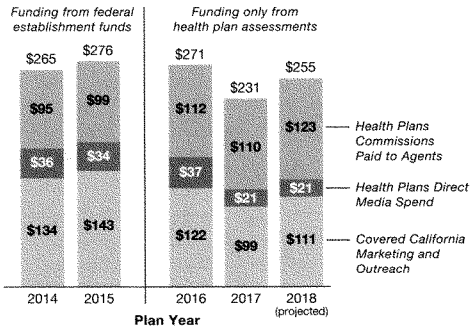
Selling health insurance in the individual market — even with the majority of consumers receiving financial help - is more challenging. The evidence from behavioral economics, social psychology and cognitive neuroscience suggests that there are several innate biases that deter people from spending discretionary income on something intangible that they perceive they may never need.

Overcoming those biases requires deep insights and sophisticated marketing — especially to enroll young and healthy consumers. The investment helps ensure the insurance risk pool is of sufficient size and has a well-balanced risk mix.

California's Pay-Off from Aggressive Marketing and Outreach

Marketing is not just a one-year investment. Marketing is a multi-year effort that pays off over time. While most state-based marketplaces have generally cut back on their marketing investments since the exhaustion of their federal establishment funds, Covered California has continued its aggressive marketing and outreach spending.

Figure 1
California On-Exchange Total Marketing and Outreach Investments, 2014-2018 (millions)[1]



Our research shows that even with high name recognition and awareness of Covered California and the Affordable Care Act, a significant number of consumers eligible for financial help are not aware that the benefit is available to them. At the same time, we now have four years of experience and know that in California, about 40 percent of those enrolled in the marketplace leave each year — leaving for employer-based and other sources of coverage. Recent research found that almost three-quarters of uninsured Californians who are eligible for subsidies did not realize they could receive financial help in the form of subsidies or assumed they are not eligible. Marketing and outreach is essential to retain existing insured consumers and reach out to the newly uninsured and enroll them in coverage.

In this environment, Covered California continues to maintain an aggressive marketing and outreach campaign, and has budgeted $111 million for the upcoming 2018 coverage year. These investments complement spending by health plans on marketing and agent commissions to promote enrollment. (See Figure 1: California On-Exchange Total Marketing and Outreach Investments, 2014-2018 [millions]). The total investment for marketing and outreach of $299 million from health plans and Covered California is a significant investment and comes on the heels of similar spending over the past four years. However, Covered California's spending is relatively small as a portion of premium (reflecting about 1.4 percent of on-exchange premium and 0.9 percent of total individual market premium) and it is a critical component to achieving the good enrollment and better risk that lowers premiums.

California's Positive Return on Investment from Marketing and Outreach Spending

Research and Covered California's experience suggest that this robust marketing investment is money well spent with a large return on investment. It is difficult to establish empirically the precise effects of marketing and the specific benefits of each incremental dollar invested, but there are two critical pieces of evidence that Covered California's aggressive efforts have been paying off.

First, Covered California has achieved a take-up rate among those who are subsidy-eligible that is nearly 25 percent higher than the average for FFM states (see Figure 2. Comparing California and Federal Marketplace Take-Up Rates: 2014-2016). As of 2016, Covered California enrolled about 79 percent of subsidy-eligible consumers compared to the average for FFM states (64 percent).

Second, as documented and reported by CMS, Covered California's enrollment reflects a substantially healthier mix of enrollees.[3] The CMS-calculated risk scores of California's individual market enrollees are about 20 percent lower than the national average (see Figure 3. Comparison of FFM, SBM and Covered California Risk Scores).

This 20 percent lower risk score means that California's $6.5 billion in on-exchange premiums collected in 2016 is roughly $1.3 billion lower than it would have been if the average risk of individual market enrollees in California were the same as the FFM average. Conservatively attributing only one-third of the $2.6 billion in premium savings for 2015 and 2016 to the state's relatively more robust marketing and outreach efforts, California has earned a more than three-to-one return on marketing investment. California's efforts in these areas have also contributed to California having one of the most stable markets in the nation — with the same eleven plans that were part of our marketplace in 2014 participating in 2018 and a four-year average rate increase of 8.5 percent.

Figure 2
Comparing California and Federal Marketplace Take-up Rates: 2014-2016[2]

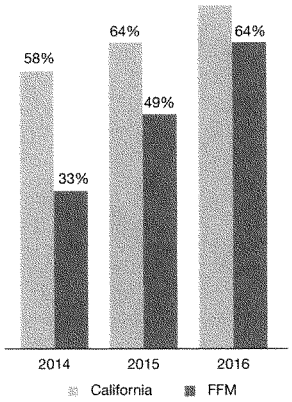
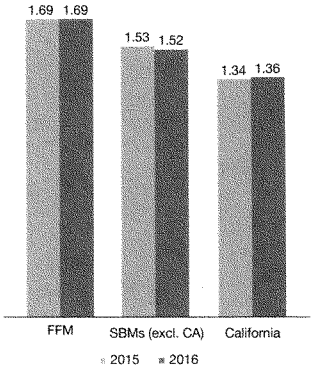


Figure 3
Comparison of FFM, SBM and Covered California Risk Scores



Investing to Save Money: Potential Impacts of Federal Marketing Investments

Further study is warranted to explore the specific returns for different levels of incremental investment, but the available data provides parameters for modeling the potential return on investment and impact on coverage and premiums based on different spending paths by the federal government.

If the FFM invested in marketing and outreach at the same percentage of premium as does Covered California, it would represent a $480 million investment, which is ten times what CMS is currently proposing. Covered California's experience shows that there would likely be an immediate increase in the number of consumers who sign up for coverage and a healthier risk pool, which would in turn lower premiums for all who were already insured.[4]

In contrast, if the FFM reduces it marketing and outreach spending as proposed, Covered California's experience shows that there would likely be an immediate decrease in the number of consumers who sign up for coverage and a worse risk pool, which in turn will increase premiums for all of those who keep their coverage and the federal government.

Potential Increased Enrollment and Lower Premiums from More Federal Marketing Spending

If the FFM were to invest $480 million for plan year 2018 and continue this marketing and outreach investment over three years — increasing the marketing spend at the rate of the consumer price index (CPI) — the total marketing spending of $1.5 billion over three years would represent only 1 percent of total FFM on-exchange gross premiums collected from 2018 to 2020 (see Table 1. Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018-2020).

The potential impacts of this enhanced investment include:

- 2.1 million more Americans would enroll in or keep their health insurance over this three-year period. More than 1.3 million subsidy-eligible Americans would enroll, increasing take-up of subsidy eligible consumers by 20 percent, from 58 percent in 2017 to 70 percent in 2020. At the same time, more than three-quarters of a million Americans would sign up without a subsidy.
- Premiums over the three years could be on average 3.2 percent lower than they would be because of the expanded consumer pool and healthier profiles of the additional enrollees.
- Over that three year period there would be a phased enrollment growth of 20 percent from what would be anticipated if the federal government continued its 2017 investments, and the enhanced federal marketing investment would likely have a better than 500 percent return on investment, based only on looking at lower premiums for those who would have had insurance under a baseline (not the enhanced marketing scenario).
- Unsubsidized individuals who were already insured would be paying lower premium — saving them more than $2.1 billion over the three years.

Table 1
Potential Impacts of Enhanced Marketing and Outreach for FFM States — 2018–2020[5]

	2018			3 Year Total (2018-2020)	
	Baseline (Projected at 2017 level)	**Enhanced** (Hypothetical)	**Difference** (Impact)	**Potential 3 Year Impact Due to Enhanced Marketing**	
Marketing Spend					
Baseline	$165 million	$165 million	—	—	$531 million
Enhanced	—	$315 million	—	—	$968 million
Total	$165 million	$480 million	$315 million	—	$1.5 billion
Enrollment					
				End of Period Enrollment	Difference from Baseline
On-Exchange Subsidized	6,622,133	7,284,347	662,213	7,946,560	1,324,427
On- and Off-Exchange Unsubsidized	3,773,076	4,150,384	377,308	4,527,691	754,615
Total	10,395,209	11,434,730	1,039,521	12,474,251	2,079,042
Premiums (Individual)					
Per Member Per Year	$5,374	$5,252	– $122	Average Premium Decrease (2018–2020)	
Percent Change	– 2.3%			– 3.2%	
Total Premiums (Aggregate)					
Core Group				Total Cumulative Premiums (3 Years)	Difference from Baseline
On-Exchange Subsidized	$35.6 billion	$34.8 billion	-$809 million	$110.7 billion	– $3.8 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$19.8 billion	– $461 million	$63 billion	– $2.1 billion
Subtotal	$55.9 billion	$54.6 billion	– $1.3 billion	$173.7 billion	– $5.9 billion
Marketing-Induced Group					
On-Exchange Subsidized	—	$3.5 billion	$3.5 billion	$16.8 billion	$16.8 billion
On- and Off-Exchange Unsubsidized	—	$2 billion	$2 billion	$9.6 billion	$9.6 billion
Subtotal	—	$5.5 billion	$5.5 billion	$26.4 billion	$26.4 billion
TOTAL					
On-Exchange Subsidized	$35.6 billion	$38.3 billion	$2.7 billion	$127.5 billion	$13.1 billion
On- and Off-Exchange Unsubsidized	$20.3 billion	$21.8 billion	$1.5 billion	$72.6 billion	$7.4 billion
Subtotal	$55.9 billion	$60.1 billion	$4.2 billion	$200.1 billion	$20.5 billion
Potential Return on Investment of Enhanced Marketing (return is lowered premiums for original group)					
Potential ROI	303%			508%	

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent less costly to insure.

Potential Decreased Enrollment and Higher Premiums Resulting from Lower Federal Marketing Spending

In light of the recent announcement by CMS to reduce planned marketing and outreach to $47 million, Covered California also analyzed the potential impact of reduced marketing and outreach spending. The analysis examines possible impacts on enrollment and the financial impacts to those remaining insured in the individual market when fewer consumers enroll or maintain their coverage because of reduced marketing spending. Based on a scenario in which enrollment declines by ten percent in 2018, which is likely a conservative estimate, the reduced enrollment, worse risk mix and higher premiums would impact some consumers immediately and likely lead to higher costs and less market stability in 2019 (see Table 2. Potential Impacts of Reduced Marketing and Outreach for FFM States — 2018).

The potential impacts of the proposed reduced marketing investment include:

- One million fewer Americans enrolled in health insurance. This would include 660,000 subsidy-eligible consumers, which would reduce take-up of subsidy eligible consumers by 10 percent, from 58 percent in 2017 to 52 percent in 2018.
- Premiums for the 2019 plan year would be on average 2.6 percent more than they would be because of the smaller consumer pool and less healthy risk profile of the remaining group, translating to $1.3 billion higher premiums in 2019 for the remaining 9.4 million insured consumers in the individual market. Of this group, unsubsidized consumers would pay $465 million more in premiums.

If the same reduced spending were to lead to a decline in enrollment by 20 percent, which is easily in the range of the possible, this would lead to 2.1 million fewer insured Americans, of whom 1.3 million would have been subsidy-eligible. Under this scenario, the number of insured consumers in the individual market would shrink from 10.4 million to 8.3 million and would be less healthy overall. Premiums would likely increase by 5.3 percent, meaning insured consumers remaining in the individual market would pay $2.4 billion in higher premiums — of which $850 million is borne by unsubsidized consumers.

Table 2
Potential Impacts of Reduced Marketing and Outreach for FFM States — 2018[6]

	2018		
	Baseline (Projected with 2017 Marketing Spend)	**Reduced** (Projected Based on Announced Spending)	**Difference** (Impact)
Marketing Spend			
Baseline	$165 million	$47 million	—
Enhanced	—	—	—
Total	$165 million	$47 million	– $118 million
Enrollment			
On-Exchange Subsidized	6,622,133	5,959,920	– 662,213
On- and Off-Exchange Unsubsidized	3,773,076	3,395,768	– 377,308
Total	10,395,209	9,355,688	– 1,039,521
Premiums (Individual): Impact on Premium for 2019 Based on Health Status Change Only			
Per Member Per Year	$5,374	$5,252	– $122
Percent Change	—	2.6%	2.6%
Total Premiums (Aggregate)			
Remaining Insured After Reduced Enrollment (Premium Difference is Estimated Impact on 2019 Premiums Based on Health Status Change Only)			
On-Exchange Subsidized	$32 billion	$32.8 billion	$821 million
On- and Off-Exchange Unsubsidized	$18.2 billion	$18.7 billion	$468 million
Total	$50.3 billion	$51.6 billion	$1.3 billion
Reduced Enrollment Group (Premium Difference is Gross Reduction in Premium for 2018 Based on Non-Coverage)			
On-Exchange Subsidized	$3.6 billion	—	– $3.6 billion
On- and Off-Exchange Unsubsidized	$2 billion	—	– $2 billion
Total	$5.6 billion	—	– $5.6 billion

Assumption: Enhanced marketing leads to 20 percent increase in enrollment of consumers who are 25 percent loss costly to insure.

Conclusion

The evidence is compelling — marketing and outreach investments are an effective and efficient mechanism for improving take-up rates, lowering premiums, saving consumers money and stabilizing individual markets.

While the specific mix of strategies and tactics that work well in one state or geographic region may not be as effective in another area, *Marketing Matters* highlights California's successful approach and is offered to inform other marketplaces as they evaluate their marketing and outreach strategies moving forward.

About Covered California

Covered California is an independent part of the state government whose job is to make the health insurance marketplace work for California's consumers. It is overseen by a five-member board appointed by the governor and the Legislature. For more information about Covered California, please visit CoveredCA.com.

[1] Health plan agent paid commissions are estimated based on enrollment data and best available information on commission rates, but may not reflect actual spend. 2018 figures are projected using Covered California's proposed 2017-18 budget and direct media spend is assumed to be the same as 2017. Direct media spend by plans was allocated in proportion to enrollment, 68 percent to on-exchange enrollment and 32 percent to off-exchange enrollment. To enable common benchmarks based on a share of on-exchange premium, Covered California attributed health plans' direct media spending proportionally based on 68 percent of individual market enrollment being on-exchange and 32 percent off-exchange.

[2] Covered California analysis of Kaiser Family Foundation estimates of subsidy-eligible population (2015 and 2016) and CMS/ASPE effectuated enrollment snapshots (December 2014, March 2015 and March 2016).

[3] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf.

[4] The estimates provided in this modeling are based on validated assumptions about how much additional marketing leads to increased take-up and take-up of healthier enrollees. Because of the lack of rigorous empirical basis for estimating these two factors, the modeling provides illustrative examples of what could occur under reasonable assumptions for these effects. In developing this modeling, Covered California used the CMS reported budget (https://www.cms.gov/About-CMS/Agency-Information/PerformanceBudget/Downloads/FY2018-CJ-Final.pdf) for health plan assessments of $1.2 billion as the basis for calculating what a 1.4 percent of premium spend would equate to for the FFM. This calculation is used to determine potential 2018 spending, even though the same total marketing spend of $480 million would likely be a far lower percentage of premium due to the increased enrollment and subsequent increase in gross premiums and plan assessments that would result. The research methodology considered a range of increases in take-up based on the enhanced marketing spending. The range of potential increases in enrollment was from 5 percent to 25 percent. Similarly, the model considered a range of differences in the health status of the incremental enrollment — ranging from 10 percent healthier and less costly to 40 percent healthier and less costly. Based on California's enrollment and risk mix experience, as well as its return on investment, the model considered the most likely impact of the enhanced investments resulted in a 20 percent enrollment increase from 2017 to 2020 (with net enrollment reflecting a year-over-year increase of 10 percent in 2018 and 4.5 percent in 2019 and 2020), and that those incrementally enrolled individuals would be 25 percent healthier and less costly. Under these two assumptions, Covered California's marketing and outreach investments would have been responsible for the enrollment of more than 350,000 Californians, and lowered premiums by more than 4 percent compared to what they would have been without the enhanced marketing — which is consistent with the return on investment analysis for Covered California's marketing investments which found a potential 300 to 350 percent return on investment if only one-third of Covered California's healthier risk mix were attributed to marketing. For additional details on the modeling and assumptions, see http://hbex.coveredca.com/data-research/Methodology_for_Potential_Impacts.pdf.

[5] The baseline spending for 2018 modeled the assumption that the FFM total marketing and outreach spending was the same level as the $165 million spent for 2017. Although CMS recently announced it will spend $47 million on marketing and outreach for 2018, the scenario models spending continuing at the same rate as 2017. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM. The $480 million marketing and outreach spend for 2018 under enhanced marketing was calculated by applying California's benchmark spending of 1.4 percent of premium to the FFM's projected $34.3 billion in total gross premiums. For purpose of identifying the available budget for marketing activities, the FFM total gross premiums is derived by dividing CMS' reported $1.2 billion in plan assessment revenue for 2018 by the 3.5 percent user fee on plans. For 2019 and 2020, the model grows the marketing and outreach spending by 4 percent (instead of medical inflation) for each year thereafter.

[6] The baseline spending for 2018 is FFM total marketing and outreach spending of $165 million for 2017. The reduced marketing spend for 2018 is based on the recent CMS announcement that proposes $47 million in marketing and outreach spending. Baseline enrollment for 2018 uses 2017 effectuated enrollment for the FFM.

Mr. PETERS. They will spend about $111 million on marketing outreach for just one state, although we are 40 million people, and they believe that the amount that they have spent has kept premiums down by 6 to 8 percent, and that if the federal government would go ahead with its 72 percent reduction in marketing, there will likely be one fewer Americans getting insurance, a less healthy risk pool, and premiums will be 2.5 percent higher now than they were in 2019.

They also say that the premium savings from expenditures on advertising would yield more than a 500 percent return on investment for the federal government. We know that getting folks in, and if there is no mechanism to do this through a requirement like the individual mandate, all we've got is advertising, and it has worked well in California.

I just do not understand the logic of bringing us to this point.

Mr. HARGAN. When we previously had reduced some of the advertising and navigator money, we saw, really, very little effect on enrollment, and we have seen that the private plans had themselves advertised for their own product and that we were seeing a lot of brokers and agents that had appeared privately to guide people into the plan.

So we did not really see a lack of enrollment; that there had been kind of a period where those navigators and the advertisement that had been done had been useful in the early stages when people were less familiar with the ACA, but now we have seen that really being transitioned into the plans themselves, the brokers and agents guiding people.

Mr. PETERS. Again, that is at variance with California which has had the most successful uptake rates in the country. I guess I would suggest we learn a lesson.

I wanted also just to comment generally on someone mentioned the New York Times editorial on Medicaid cuts, that we should work together.

I want you to know that I am someone who was not here when the Affordable Care Act was passed. I believe it is a tremendous undertaking to remake the entire health care system in the United States. It is going to need tweaks.

But it is hard for us to talk, on one hand, to you about these changes when, on the other hand, the President's Justice Department is out there trying to sabotage the whole thing. It puts us in a very defensive position.

And I know this was not something that was up to you. I appreciate your work on the Affordable Care Act, on making it right and making it work for people, but if the Administration is trying to cut out the whole thing, it makes it very, very difficult for us to feel like we are in a cooperative mood or feel that we can trust it.

And I ask that you take that back to the Administration.

Finally, I want to just point out that your budget would cut funding by $4.5 billion on NIH, the National Science Foundation by 13 percent. This is a devastating blow to biomedical research, particularly devastating in San Diego where the life sciences industry is a major driver of economic growth, home to more than 1,000 biotech companies, 80 independent research and university-affiliated research institutions.

According to NIH, investments in research focus on a particular area stimulate increased private investment in the same area. A $1 increase in basic public research stimulates $8.38 of industry investment after eight years. A $1 increase in public clinical research stimulates an additional $2.35 of industry R&D investments after three years.

Have you estimated the devastating impact that these cuts would have on our economy?

Mr. HARGAN. Well, we are fully behind the medical research mission of NIH, and we know that the things that are done by the staff at NIH and by our grantee network is very important for the health of the American people.

Mr. PETERS. Well, I would suggest that this is extremely counterproductive, and I think it should be opposed.

Mr. Chairman, I yield back.

Chairman YARMUTH. Thanks. The gentleman's time has expired.

I now recognize the gentleman from Texas, Mr. Crenshaw, for five minutes.

Mr. CRENSHAW. Thank you, Mr. Chairman.

And thank you, Deputy Secretary, for being here on this very important subject as we have a hearing about what is almost a third of our budget.

Under HHS, tell us again how much of that budget do you manage, mandatory and discretionary?

Mr. HARGAN. Yes. It is about a $1.3 trillion budget, about a quarter, a little over a quarter of the federal budget.

Mr. CRENSHAW. It is an enormous amount, and we don't have an infinite amount of resources. So any time we budget, this is always about choices.

And I want us to recognize the fact that as politicians, we often get elected by promising action, by promising more. We take advantage of the human preference for more things, especially if somebody else might pay for those things and we don't have to.

It is a cultural trend that is going on in this country, and it affects everything. It is an unsustainable cultural trend, this idea that someone else should take action so that you do not have to.

And it is also this idea that the states are completely incapable of managing their own systems of government.

This unsustainable cultural trend also leads to completely unsustainable policies, and Medicare is one of those. Medicare is completely unsustainable, and that greatly affects a generation like mine. I just turned 35, and I have really little hope that I will see Medicare in my lifetime.

But there is a good chance that you will have to raise my taxes considerably to pay for this unsustainable program, and it frustrates me that on the Republican side we often have to be the adults in the room and say, "Hold on. We cannot promise all of these things."

So on Medicare specifically I want to talk about some of those things that are driving those costs. What are some of the main elements driving the unsustainability of Medicare?

And what are you doing to fix that?

Mr. HARGAN. Well, some of the things were really things that were put into Medicare Trust Fund that really did not belong

there, things like uncompensated care, things like graduate medical education. Simply moving those out into the general fund means that Medicare Trust Fund is the sort of the reckoning that is delayed by a number of years.

Also, just lowering the amount spent from 7.8 percent growth to 6.9 percent has a tremendous effect overall.

Then we also address some of the issues where some of the payment rules have kind of gotten to making things more neutral between sites of care.

Mr. CRENSHAW. Okay. And how does this affect the consumer of Medicare, our senior citizens relying on it? Will they see these changes?

Mr. HARGAN. They will not see these changes. These changes are not to beneficiaries. They are not going to increase out-of-pocket costs to seniors. They are not going to affect the beneficiaries' access to any one of these things.

Mr. CRENSHAW. Thank you for that. That is a very important point. Thank you.

I also had an interesting note from a group of nurses in my district. They said, "We do not need Medicare for All. We need primary care for all." It is an interesting look at things.

Are you familiar with direct primary care?

Mr. HARGAN. Yes.

Mr. CRENSHAW. What is the Administration doing to foster more direct primary care, this market-based solution to gain more access for people for primary care?

Mr. HARGAN. So one of the things that we are doing is by allowing more money to be put into health savings accounts and allowing people to manage their care more through either health reimbursement accounts, health savings accounts.

So if they are able to do this, they are able to be able to access direct primary care, we are able to provide more flexibilities in the budget at the state level, but also at the patient level, that is going to allow people to be able to have access to direct primary care.

Mr. CRENSHAW. Excellent. It is amazing what can be accomplished in our markets if we let people take back their own money and use it for things like direct primary care.

I also want to ask you about the pay for delay regarding generics and biosimilars and what the Administration is doing on that front.

Mr. HARGAN. Yes. So we are proposing a whole suite of reforms in this area. So in the case of pay for delay, we intend to actually reduce payment for drugs where a company has engaged in gaming of the system, like pay for delay, where they pay another company to keep a competing drug off the market.

Mr. CRENSHAW. Okay. The last question I want to ask you about is graduate medical education. You have made some reforms to that. In Texas, we are unfairly discriminated against compared to other states when it comes to GME. We have less spots according to our size and on our needs.

Does this help states like Texas? Does this equalize it across the board?

It is unclear what these reforms will do.

Mr. HARGAN. So by consolidating some of the fragmented programs that we have right now, we are going to be able to put them

into a single overall graduate medical education program, and we hope that is going to allow for a more rational approach to GME. It could include things like allowing places that are under-resourced to be resourced.

Mr. CRENSHAW. Thank you.

Thank you, Mr. Chairman.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentlelady from Washington, Ms. Jayapal, for five minutes.

Ms. JAYAPAL. Thank you, Mr. Chairman.

And thank you so much for being here.

Just to my colleague across the aisle, when you talk about adults in the room, perhaps I wish you were here last year when we were talking about the GOP tax cut, and we clearly said at the time that this was a three-step dance, that the Republicans were going to cut taxes for the rich; that that would then explode the deficit, and in fact, it has, estimates of $1.9 trillion; and then that would lead to demanding big cuts to the things that Americans really care about like Medicaid and Medicare.

And I think, Mr. Chairman, that we are right at that place here. And I hope that I will have a chance to talk about my Medicare for All bill that really takes on a broken health insurance marketplace. I believe we will on Budget Committee, and I look forward to telling my Republican colleagues about exactly what that looks like.

Mr. Hargan, I wanted to start with questions about HIV and Medicaid. There are over 955,000 individuals living with diagnosed HIV, and it continues to be a significant health concern in the United States, but thanks to the gains of our scientific and public health community that we have seen in improved screening and treatments, over 90 percent of individuals with HIV survive for more than three years after the diagnosis.

In his State of the Union address, President Trump announced a new initiative to end HIV transmissions by the end of the decade, and the President's budget provides $291 million to support that initiative.

However, it is very important for the American people to understand it includes $1.5 trillion in Medicaid cuts over the next 10 years, and Medicaid is the largest source of insurance coverage for people living with HIV.

And that is because as of 2017, 32 states expanded Medicaid coverage to include individuals with HIV who were previously excluded. And so now more than 40 percent of people with HIV who are receiving treatment are covered by Medicaid.

How is the goal of ending HIV transmissions achievable when the Administration is simultaneously proposing to cut roughly a quarter of the Medicaid budget?

Mr. HARGAN. So while we had moved a reduction in one line, we actually plussed up $1.2 trillion in flexible grant money for states in Medicaid. So the shift is really from one type of program to another, to allow there to be more flexibility for the states in Medicaid and allow them to concentrate on the traditional vulnerable Medicaid populations: the elderly, the pregnant women, children, the disabled.

So we are really moving the money from——

Ms. JAYAPAL. But you are talking about converting Medicaid into a block grant or a per capita cap and then requiring states to implement so-called work requirements, all of which would strip Medicaid as we know it. That is essentially what you are talking about.

Let me move on to public health in the United States, comprised of federal agencies, state health agencies, tribal and territorial departments, and more than 2,500 local health departments. These are systems that protect us not only from emerging health threats, but also serve our everyday needs, like immunization, food safety, and delivery of health services.

And that is why the CDC, our Nation's health protection agency, dedicates 85 percent of its domestic funding to state and local public health departments. And yet, the President's budget proposes cutting the CDC's budget, that is, the Center for Disease Control, by nearly 20 percent.

What is your justification for cutting this major source of funding for local and state public health agencies, and an agency that is central to the prevention and transmission of disease in the United States?

Mr. HARGAN. Well, we had just proposed in terms of CDC funding there is really only a net decrease of 1 percent from FY2019. So our net decrease in funding for it is really just about 1 percent for CDC.

In a difficult environment, we really did preserve public health funding for CDC among our agencies.

Ms. JAYAPAL. Maybe my numbers are wrong. So it is not a cut of nearly 20 percent?

Mr. HARGAN. No. We had moved from $12.1 billion in fiscal year 2019 to $12.0 billion in 2020.

Ms. JAYAPAL. Well, that is good. If that is true, that is great, and I apologize for getting that wrong. I hope that we actually see an increase in CDC funding, which would be even better.

Actually, I do not have time. I wanted to just put on the radar the public charge rule that we are deeply concerned about and that would strip care for a number of people across the country who might be seeking care that is legitimately provided through state programs and introduce for the record a letter signed by 111 members of Congress around the public charge rule.

Mr. Chairman, I ask unanimous consent to introduce that letter.

Chairman YARMUTH. Without objection.

[The information follows:]

Congress of the United States
Washington, DC 20515

May 7, 2018

The Honorable Kirstjen M. Nielsen
Secretary
Department of Homeland Security
300 7th Street, SW
Washington, D.C. 20024

The Honorable Mick Mulvaney
Director
Office of Management and Budget
725 17th Street, NW
Washington, D.C. 20503

Dear Secretary Nielsen and Director Mulvaney,

As Members of Congress, we write to express our collective concern regarding the draft rule from the Department of Homeland Security that would allow immigration officers to weigh the use of public benefits by immigrants and their family members in the determination of applications for visas or green cards. Such a rule would essentially force families, including those with U.S. citizen children, to choose between getting the help they need to prosper – from crucial programs that provide medical care, food assistance, housing assistance, and early childhood education – and reuniting with those they love. These are not the ideals of our country, and we urge the Department to reconsider this ill-advised proposal.

The proposal of such rule is a back-door attempt to circumvent Congress and unilaterally restrict family reunification. Expanding the definition of "public charge" under this rule would in essence create a new authority to bar immigrants from obtaining legal entry or permanent resident status in the country by virtue of caring for their family through the use of social services that they are legally entitled to use while under their current status. This proposed rule is not about preventing immigrants from taking advantage of benefits to which they do not have legal access – current law already prevents the vast majority of immigrants from accessing most Federal means-tested public benefits. It is about leveraging public health and education to deny immigration benefits and keep families apart. This clearly presents a conflict in which immigrant parents, for example, may hesitate to take their U.S. citizen children to the doctor because it would be counted against them in their immigration case. It is unconscionable to think that the U.S. government would jeopardize the health and wellbeing of American children and our nation in order to restrict legal immigration.

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The work of government is to support our communities and allow them to thrive. Restricting access to vital services for many families not only harms the restricted families, but also the communities in which they belong. This rule would force families to choose between putting food on the table for their children and being granted legal status. In doing so, the government would be putting families at risk for simply feeding their kids, directly harming American children and damaging the communities in which they live. We urge the Department to reconsider this rule as it is harmful to America and its people.

We look forward to your timely response.

Sincerely,

Adriano Espaillat
Member of Congress

Zoe Lofgren
Member of Congress

Raúl M. Grijalva
Member of Congress

Michelle Lujan Grisham
Member of Congress

Judy Chu
Member of Congress

Cedric L. Richmond
Member of Congress

Yvette D. Clarke
Member of Congress

Luis V. Gutiérrez
Member of Congress

Jerrold Nadler
Member of Congress

Jimmy Panetta
Member of Congress

Dina Titus
Member of Congress

Juan Vargas
Member of Congress

Grace F. Napolitano
Member of Congress

Alcee L. Hastings
Member of Congress

Barbara Lee
Member of Congress

Nydia M. Velázquez
Member of Congress

Gwen Moore
Member of Congress

Albio Sires
Member of Congress

J. Luis Correa
Member of Congress

Al Green
Member of Congress

Gene Green
Member of Congress

Mark DeSaulnier
Member of Congress

Keith Ellison
Member of Congress

Nanette Diaz Barragán
Member of Congress

John Lewis
Member of Congress

Pramila Jayapal
Member of Congress

Bennie G. Thompson
Member of Congress

Mark Takano
Member of Congress

Betty McCollum
Member of Congress

James P. McGovern
Member of Congress

Ro Khanna
Member of Congress

Adam Smith
Member of Congress

Eleanor Holmes Norton
Member of Congress

Elijah E. Cummings
Member of Congress

Henry C. "Hank" Johnson, Jr.
Member of Congress

John A. Yarmuth
Member of Congress

Jan Schakowsky
Member of Congress

Jimmy Gomez
Member of Congress

André Carson
Member of Congress

Anthony G. Brown
Member of Congress

Bonnie Watson Coleman
Member of Congress

Brenda L. Lawrence
Member of Congress

Grace Meng
Member of Congress

Rick Larsen
Member of Congress

Ruben J. Kihuen
Member of Congress

Joseph Crowley
Member of Congress

Linda T. Sánchez
Member of Congress

Debbie Wasserman Schultz
Member of Congress

Frank Pallone, Jr.
Member of Congress

Kathleen M. Rice
Member of Congress

Peter Welch
Member of Congress

Rosa L. DeLauro
Member of Congress

José E. Serrano
Member of Congress

Suzanne Bonamici
Member of Congress

Sander Levin
Member of Congress

Beto O'Rourke
Member of Congress

Robert C. "Bobby" Scott
Member of Congress

Michael E. Capuano
Member of Congress

Diana DeGette
Member of Congress

Joaquin Castro
Member of Congress

Timothy J. Walz
Member of Congress

Carolyn B. Maloney
Member of Congress

Darren Soto
Member of Congress

David E. Price
Member of Congress

Carol Shea-Porter
Member of Congress

Lucille Roybal-Allard
Member of Congress

Mark Pocan
Member of Congress

Val Butler Demings
Member of Congress

Tulsi Gabbard
Member of Congress

Jamie Raskin
Member of Congress

Frederica S. Wilson
Member of Congress

Eddie Bernice Johnson
Member of Congress

David N. Cicilline
Member of Congress

Donald Norcross
Member of Congress

Chellie Pingree
Member of Congress

Doris Matsui
Member of Congress

Jared Huffman
Member of Congress

Mike Quigley
Member of Congress

Susan A. Davis
Member of Congress

Eliot L. Engel
Member of Congress

Brad Sherman
Member of Congress

William R. Keating
Member of Congress

Donald S. Beyer Jr.
Member of Congress

Mike Thompson
Member of Congress

Jerry McNerney
Member of Congress

Lloyd Doggett
Member of Congress

Ms. JAYAPAL. Thank you.

Thank you, Mr. Hargan. I will follow up with you on the CDC thing because I do not usually get those things wrong, but if I did, I apologize.

Thank you.

Chairman YARMUTH. Thank you. The gentlelady's time has expired.

I now recognize the gentleman from Georgia, Mr. Woodall, for five minutes.

Mr. WOODALL. Thank you, Mr. Chairman.

I would like to endorse what my friend Ms. Jayapal said. She rarely gets things wrong. So I hope you will share it us, too, when you find out what that is.

Ms. JAYAPAL. I will do that.

Mr. WOODALL. CDC sits in my backyard, and so I tend to associate myself with the numbers Mr. Hargan has in front of him, and we are also proud of that mission, but it was not always that way. CDC was woefully underfunded in the 1980s and 1990s, and only when we realized what we had missed out on did we finally redouble those efforts. So I appreciate your focus on that.

Mr. Hargan, I want to talk about some things that I think went right and some things that could go even better. I know you have already gotten an earful about things folks don't like and they don't think we are moving in the right direction on. I want to move in the right direction.

You have done some work on pressure ulcers as it results to hospital discharges. That is something that is near and dear to me personally, but it is also near and dear to me as a budget hawk because we throw away a lot of money on preventable hospital-acquired illnesses.

When the Appropriations Committee last cycle asked HHS to go back and look at pressure ulcers to see if we were doing all that we could do, you came back with a new model that was based on a ten-factor scale and used pressure ulcers as one of those to say we can do better than the 58 percent increase in pressure ulcer discharges and do better down the road.

We have got a lot of great groups. One is in my district, Molnlycke, that has an amazing technology that we can do more, not do more with less, but do more and prevent more bad outcomes, and thus, we end up spending less.

The entire Pressure Ulcer Association is working along those lines, and you all have I would say moved with the efficiency one would expect from a government agency. You can take that as you see fit, but there is some good work that is happening there. There is more good work that can be done, but I want to thank you for that.

I also want to put on your radar screen, and I know you have been busy preparing for this hearing, the General Assembly in Georgia yesterday passed a bill that will give our governor permission to ask for two waivers, one is an Affordable Care Act waiver. Another is a Medicaid waiver.

I listened to Mr. Peters as he challenged your numbers, talking about all of the good work that California does. I have no doubt that California is doing good work, and I have no doubt that the

failures that you observed in the case of a $200,000 program only signing up one individual; I have no doubt about the accuracy of that either.

We can do better in Georgia. No offense to the federal laws and statutes, regulations that are on the books. We just have more experience in rural Georgia than you do. We have more experience in metropolitan Atlanta than you do, and so when those waiver proposals come forward, I just want to encourage you to look favorably upon those.

There are limited resources. Can you tell me a little bit about the resources dedicated to approving those waivers?

And either or not we'll be able, I know so many are coming across your desk. Will we be able to proceed on those expeditiously?

Mr. HARGAN. I would say that, you know, we very much look forward to if Governor Kemp bringing the proposal forward to us. We would very much look forward to engaging with him.

We know that states and localities know a lot more about their unique needs than we do here in Washington. So we know that they are going to be in the best position to know the unique needs of their populations there, and we applaud states for bringing creative proposals forward to us.

So we are going to look forward to engaging with him if he brings it forward after the passage of the bill.

Mr. WOODALL. I do not see my timer. Oh, there I am up on the wall. Let me re-ask that specifically.

When we get to the appropriations cycle, folks will take money out of administrative accounts and put them into things that feel better, like NIH funding, like CDC funding, and so on.

Are we at risk, underfunding the administrative account at HHS, of not seeing those applications acted on as quickly as we would all like to see them acted on?

Mr. HARGAN. I think that the Administrator at CMS is going to focus what she needs to focus on having a swift analysis and resolution on whatever we have, whatever is brought forward by Governor Kemp or anyone else creatively in the 1115 space.

Mr. WOODALL. I do not know if you have been down to the CDC recently. It is always a good excuse to go to Atlanta. Security is one of the things that troubles me. We spend a lot of money on science, but we do not spend as much money on security.

You're in a difficult space. Health is the focus, but bad security leads to bad health outcomes from time to time. Is that an issue that rises to your C Suite level?

Mr. HARGAN. Particularly cybersecurity is an issue that we take very seriously. We deal a lot with data, with science, with new ideas, with new science and intellectual property, and so cybersecurity is a big issue both for Americans, to make sure that their health data is kept secure for researchers.

So we have actually stood up a Health Sector Cybersecurity Coordination Center at HHS that is going to help facilitate maintaining security over a lot of the information that Americans entrust to their doctors, to the health care system, and to HHS.

Mr. WOODALL. Mr. Chairman, as I look at the pictures on the wall, I see that only Mr. Panetta was brave enough to leave Congress and go and serve in the Administration afterwards. So thank

you, Mr. Hargan, for what you are doing. Clearly, it is not something that we choose to do.

I yield back.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from New York, Mr. Jeffries, for five minutes.

Mr. JEFFRIES. Thank you, Mr. Chairman, for your leadership.

And thank you, Deputy Secretary Hargan, for your presence here today.

Medicaid provides health coverage to 7.2 million low income seniors who are also enrolled in Medicare; is that correct?

Mr. HARGAN. Medicare, yes. Medicare serves tens of millions of people.

Mr. JEFFRIES. The answer would be Medicaid provides health coverage to 7.2 million low income seniors, correct?

Mr. HARGAN. I will take your number as being accurate.

Mr. JEFFRIES. Roughly 60 percent of all nursing home residents receive Medicaid coverage; is that correct?

Mr. HARGAN. I will take, again, your number as being accurate.

Mr. JEFFRIES. Do you think that nursing home care is an important part of our health care fabric here in the United States of America?

Mr. HARGAN. Yes, all different kinds of post-acute care settings are important. Skilled nursing facilities, long-term care facilities, home health, we seek to make sure that whatever setting Americans want and choose what is best for their care is enabled.

Mr. JEFFRIES. So nursing home care is important, correct?

Mr. HARGAN. Nursing home care can be important for the right senior.

Mr. JEFFRIES. Close to half of all long-term care services for the elderly are paid for by Medicaid. True?

Mr. HARGAN. Yes, it is an important component for individual nursing home payment.

Mr. JEFFRIES. Medicaid also covers premiums, deductibles, and cost sharing for Medicare beneficiaries; is that correct?

Mr. HARGAN. In certain settings, yes.

Mr. JEFFRIES. Medicaid provides coverage to 27 million children under the age of 18 in the United States of America. True?

Mr. HARGAN. Again, I will take your numbers to be accurate.

Mr. JEFFRIES. More than 700,000 children in Medicaid expansion states gained coverage between 2013 and 2015; is that correct?

Mr. HARGAN. I will take your numbers as accurate.

Mr. JEFFRIES. And research shows that children with Medicaid coverage have better health care outcomes as adults. Is that true?

Mr. HARGAN. Could you repeat the question?

Mr. JEFFRIES. Research shows that children with Medicaid coverage have better health outcomes as adults than those without Medicaid coverage, correct?

Mr. HARGAN. I am not familiar with that research.

Mr. JEFFRIES. Okay. But the totality of the import of what Medicaid provides, I think, is well established, and you have agreed in several different areas that Medicaid is covering a substantial number of Americans from children all the way to low income seniors and those who are receiving care in nursing homes.

So for the life of me I am struggling to try to figure out why this Administration proposes essentially to slash $1.5 trillion in Medicaid and create a smoke and mirrors block grant program that will devastate, devastate the ability of these recipients who rely on Medicaid to receive care.

Now, the President during the campaign promised that he would not touch Medicaid; is that correct?

Mr. HARGAN. The President is fully committed to supporting the Medicaid program.

Mr. JEFFRIES. Why is the President breaking his promise not just with respect to Medicaid, but also Social Security and Medicare by submitting a budget that would cut approximately $2 trillion?

Mr. HARGAN. The budget proposes a shift into a $1.2 trillion new program to allow states to flexibly deal with the most vulnerable populations that Medicaid was intended to address: the elderly, disabled, pregnant women, children.

So we are fully committed to that, and that is a $1.2 trillion new program that we are advocating for in this budget.

Mr. JEFFRIES. And you propose creating this $1.2 trillion new program because you want to address alleged waste, fraud, and abuse in the current Medicaid program; is that right?

Mr. HARGAN. We want to make sure that states have the flexibility in the new program to address the unique needs of their populations and focus the program on the traditionally vulnerable, fragile populations that Medicaid was intended to address from its very beginning.

Mr. JEFFRIES. Okay. So at minimum, even if we assume that this new $1.2 trillion block grant program is going to actually reach the people who are currently being served by Medicaid, which there is reason to doubt, you are cutting at least $300 billion from Medicaid.

Can you give me a single example of the type of waste, fraud, and abuse that you are trying to address that would justify billions of dollars in cuts, not millions, not tens of millions, not thousands, billions of dollars in cuts?

Can you give me some understanding of the waste, fraud, and abuse that you are addressing?

Mr. HARGAN. Actually over 10 years, Medicaid spending goes up under this budget plan. So we are not addressing actually a lowering in the budget of Medicaid spending, but actually increasing it.

Mr. JEFFRIES. Can you give me a single example of the waste, fraud, and abuse that justifies cutting billions of dollars from children, low income seniors, and those receiving nursing home care?

Mr. HARGAN. Our Inspector General and our Centers for Program Integrity are constantly working to identify areas where there are waste, fraud, and abuse that take place throughout our programs. We have entire——

Mr. JEFFRIES. Reclaiming my time. I assume that is a no.

I yield back. Thank you.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from Texas, Mr. Roy, for five minutes.

Mr. ROY. Thank you, Mr. Chairman.

I appreciate you coming here to testify today and taking the time to join us here.

Just as a threshold matter, the national debt to today is what? Do you know? Twenty-two trillion, over $22 trillion, does that sound about right?

Mr. HARGAN. That is my understanding.

Mr. ROY. I was recently PolitiFact'ed that I made a comment in a hearing that we were racking up $100 million of debt per hour, and I actually got a mostly true out PolitiFact, which basically means it is the Book of Luke in the eyes of PolitiFact if I get a mostly true.

A hundred million dollars of debt per hour, right? So as a backdrop for the questions that we are going to ask here.

With respect to some of the Medicaid questions that were just asked, it was alleged that it is smoke and mirrors when we talk about block granting Medicaid. Are you familiar with some of the studies and some of the state organizations and think tanks, for example, the Texas Public Policy Foundation, which would suggest that they might be able to save upwards of $4 to $5 billion in Texas in administering Medicaid if they were able to get the money in the form of a block grant?

Is that where some of the kinds of savings you were talking about are?

Mr. HARGAN. I am not familiar with their particular study, but we have certainly seen lots of examples from our program integrity initiatives and otherwise where we see examples overall of waste in programs.

Mr. ROY. Well, I appreciate that.

And also with respect to Medicaid, we talk a whole lot the, quote, gains in coverage for Medicaid. Are you also familiar with some of the studies in think tanks, for example, the Illinois Policy Institute, which pointed out that there are literally thousands of people that are on waiting lists in Medicaid rolls because of the number of people that were jammed onto the Medicaid rolls after Obamacare and the expansion of Medicaid so that people for whom Medicaid was originally designed are on the outside looking in because of so much burden being placed on the Medicaid system?

Is that an accurate depiction at least in some areas of the country?

Mr. HARGAN. That is certainly something that we have heard.

Mr. ROY. Is it also true that we have had upwards of six million or more people who lost private coverage since Obamacare has been put in place in the private market?

Mr. HARGAN. I am not sure of the exact number, but we certainly had people who lost their plans in the wake of the passage of the Affordable Care Act.

Mr. ROY. Okay. I appreciate that.

And then one last question on Medicaid that I am just curious. With respect to Medicaid expansion, has anybody in the Administration, has the Secretary or anybody in the Administration, actively encouraged states that have not expanded to embrace a partial expansion or expansion now, for example, Texas, which has not expanded?

Mr. HARGAN. We only entertain things coming from the states as opposed to, say, encourage or discourage. Normally, we are responding in that program to initiatives coming from the states.

So, for example, in the Georgia case that was just cited, if the Georgia legislature passes that bill and the governor brings it to us, we are going to entertain that, within the statutory restrictions that we have in the program.

Mr. ROY. Okay. Thank you for that.

One last question on budgeting. Do you all ever engage in what some people might refer to as zero based budgeting or building up from the ground up, or do you basically budget off of last year's numbers and so forth when you work with OMB and others to get the budgeting process done?

Mr. HARGAN. We work with OMB on any number of different scenarios for the budget, but generally, we abide by the rules that they give us in order to base off of our budget line.

Mr. ROY. But you are not aware of that budget. This is not what you might refer to as a zero-based budget?

Mr. HARGAN. This is abiding by the caps agreement, which President Obama and the Congress passed years ago.

Mr. ROY. A couple of questions on the $2 billion line in the budget with four unaccompanied alien children. Do you know how many alien minor children that is meant to try to deal with over the next three years?

And am I correct it is $2 billion allotted for the next three years?

Mr. HARGAN. Yes, it is a $2 billion contingent fund for the next three years if the program needs it and exceeds the transfer authority, and in this case we have asked for 20 percent transfer authority to the UAC program.

Mr. ROY. Is this mandatory or discretionary spending?

Mr. HARGAN. I believe this was a mandatory. The $2 billion is on the mandatory side, I believe.

Mr. ROY. Okay. So I guess my question is: do you have any estimate on how many UACs were preparing for in coming up with that $2 billion number?

Mr. HARGAN. We have to look really within HHS. We deal with the children when they are brought to us.

Mr. ROY. Sure.

Mr. HARGAN. We can look at ins and outs. There are great differences year to year. That is why we had a contingent fund as opposed to asking for more increased money every year just because there are great fluctuations with the number of unaccompanied alien children coming over the border year to year, month to month, day to day.

Mr. ROY. Well, and to that point, right, in fiscal year 2018, CBP apprehended 50,000 unaccompanied alien minor children at the southwest border. Just between October and February, we saw 26,937, which means we are looking at a higher number.

We have seen a massive expansion over the last several months in February and March. We see the numbers that are coming across that we are having to deal with, my point being: is it fair to say that the burdens of what is happening at the border with our inability to secure the border is putting a strain on HHS' budg-

et because we are having to deal with this problem in failing to secure our border?

Mr. HARGAN. Fundamentally, this is traced back to a broken immigration system, and the fact that we have to deal with a tremendous number of children that we are going to care for, we are going to advocate and make sure that the child welfare and safety is the utmost and that we move them to an appropriate sponsor as quickly as we can out of these shelters, but it does mean that there are huge numbers of children being sent to us to take care of, and that does place a strain on our budget.

Mr. ROY. Thank you for that. Thanks for being here.

Chairman YARMUTH. The gentleman's time has expired.

And now I recognize the gentleman from California, Mr. Khanna, for five minutes.

Mr. KHANNA. Thank you, Mr. Chairman. Thank you for your leadership.

Thank you, Secretary Hargan, for being here.

Secretary Hargan, you worked for President Bush; is that correct?

Mr. HARGAN. I did.

Mr. KHANNA. And you were there during his tenure and when he was doubling NIH funding; is that correct?

Mr. HARGAN. Yes, I was.

Mr. KHANNA. You probably remember that President Bush ran saying that we need to double the NIH budget in five years. Do you remember that?

Mr. HARGAN. Yes, we were, I believe, continuing over a doubling that was taking place at NIH.

Mr. KHANNA. It is kind of you to give President Clinton credit. He started it, and then President Bush continued it.

Are you aware that when President Bush took over, the NIH budget was $17 billion, and when he left, the NIH budget was $28.6 billion?

Mr. HARGAN. I will defer to your numbers on the past numbers for NIH.

Mr. KHANNA. I was recently with Secretary Condoleezza Rice, and she said one of the biggest things we can be doing for this country is doubling funding for the NIH and National Science Foundation. Would you agree with her comments?

Mr. HARGAN. I believe that, as I said, medical research is core to part of the mission of HHS to enhance the health and well-being of the American people. We stand fully behind NIH and its medical research mission, both for it and for the grantees that it enables to do that important work.

Within the caps agreement and the budget that we have, we have to operate within the budgetary environment we have been given by the caps agreement that was entered into.

Mr. KHANNA. In your opinion though, when you look at President Bush's approach and the approach Condoleezza Rice is recommending, I mean, they also have to operate within hard budgets. They found the money to double NIH.

Do you think their approach was better for a competitiveness or the current President's approach?

They are two very different philosophies.

Mr. HARGAN. I have great respect for Ms. Rice, but we also have to operate within the legal environment that we have, the budgetary rules that are put in place. We can't violate those.

And we have to prepare our budgets realistically within the bounds that are set for us by the law. So in making those decisions, we have to abide by the agreements and the laws that we are given by the Congress.

Mr. KHANNA. But you know that in the context of the federal budget, $4.5 billion, do you think that is a significant percentage?

You just have to guess. I mean, it is probably less than .1 percent or .5 percent of our federal budget.

Mr. HARGAN. And we are attempting also within the NIH budget to preserve focus on a lot of the important focuses that we have within opioids, within pediatric cancer, within the HIV epidemic. To focus within those and to save those areas within NIH, apart from the overall budgetary environment that we are in, a tough budgetary environment dealing with the caps agreement.

Mr. KHANNA. Would it be fair to say that President Bush and Condoleezza Rice put a higher priority on the National Institutes of Health than this current President?

Mr. HARGAN. Well, President Bush was not operating in an environment where there were discretionary caps, and so there were sort of fewer restrictions on this, but we have to operate in an atmosphere of discretionary caps.

Mr. KHANNA. Would you say that if you were meeting President Bush and he asked you do you think President Trump has as much of a priority on the NIH, what would you say to him?

Mr. HARGAN. I would hope that President Bush would understand as we have just talked about, which is in an environment with no discretionary caps versus an environment with real discretionary caps, you have to operate in those areas.

There were hard decisions made in the budget under President Bush. I was in leadership at HHS at that time, and we had hard decisions to make, and we have hard decisions to make here, and hopefully we have made them as thoughtfully as we can for your consideration when you are working through the budget.

Mr. KHANNA. You stand by the $4.5 billion NIH funding cut and the $897 million cut for National Cancer Institute? Given your experience, your service in the Bush Administration, your views with Condoleezza Rice and her basic view that we ought to be doubling, and she understands the budget constraints, I am just trying to understand, and I mean this with respect.

Are you defending this because that is your job? You work for the President. He gets to set the direction, or do you really think that his vision is better than Bill Clinton's and George Bush's and Barack Obama's and every single President before him in modern time who wanted to increase funding for the NIH?

Mr. HARGAN. Well, I would say we have something around a $99 billion discretionary budget at HHS. NIH has been $38 billion of that. It is the largest single item of discretionary spending within our department.

We have many programs within that, within the caps agreement, within the cuts to discretionary funding and the caps that we have to abide by. We have to try to be as thoughtful as we can be in

that environment to make sure we comply with the law and the caps that were sent to us.

Mr. KHANNA. Thank you.

Chairman YARMUTH. The gentleman's time has expired.

I now recognize the gentleman from New York, Mr. Morelle, for five minutes.

Mr. MORELLE. Yes, thank you, Mr. Chairman, for hosting the hearing.

And thanks to the Deputy Secretary for joining us I was going to say this morning, just about this morning and afternoon.

Let me just editorialize for just a second. I am new to the Congress, and I note that in the budget there are a number of changes which have been discussed by my colleagues regarding Medicare payment policies. For a number of these changes, however, the budget does not indicate how much they would cost or save the government, and I am just struck by the footnotes that say estimates were not available at the time of budget publication.

And I just note that I find it unusual and strange that you could recommend policies without knowing exactly how they would affect federal spending on Medicare, both to the government and to beneficiaries.

But if I can, I just want to jump around in the limited time. Related to investments, I recognize as many members have talked about the impending challenges of Medicare and mandatory spending as the population ages, as costs will grow, and there is the need to clearly address this.

I would do it from the point of view of investments and looking at key investments and whether spending on those investments, do for instance, in the area of health care, what the AAA and everyone talks about, better outcomes, better experience for patients, and bending the cost curve.

One of the investments that we make typically is in graduate medical education. I represent the University of Rochester, which is an academic medical research facility. The budget restructures federal support for graduate medical education, cuts the funding by a total of $48 billion over a 10-year period by capping funding, and it grows at less than the rate of inflation.

The population is aging. There is a growing need for doctors in areas such as primary care and gerontology. How does this proposal improve the health care and the health needs of the workforce to meet the needs of that growing senior population?

Mr. HARGAN. The reforms that we are advocating for in the budget are intended to better focus the federal spending on health care professionals because we are consolidating GME programs that are currently fragmented into a single program.

By consolidating these disparate streams of funding, we believe that we are going to be able to address shortage areas, rural health, making sure that we have better trained professionals to build a stronger health care workforce that is more targeted to the needs that we have now. When we have these different funding streams consolidated, if these reforms are undertaken, we will be able to reorient these programs.

Mr. MORELLE. But it does, and I am sorry to interrupt, and I appreciate that, but there is a significant cut in dollars that accom-

panies it. It is not only the consolidation, which I might argue maybe there are some valid reasons to do that and it will give you more authority, but the $48 billion cut is a real one even as you combine the programs into a single program.

Mr. HARGAN. Yes. Again, we are operating within a tough budgetary environment. We do understand the needs to work—to make sure that the next generation of the health care workforce is in place. We are hoping that by doing these targeted reforms, we will be able to kind of sort of skate to where the puck is going to be in terms of graduate medical education.

Mr. MORELLE. Okay. Very good. Thank you. Let me jump now briefly in the few moments I have left. The budget calls for no increase in funding for Head Start, another investment I think is very important, particularly as we are trying to get to children in poverty, getting them to read at grade level.

You fund the program at the same level as that of 2019. Your own internal documents show funding will support 871,000 slots, down from 890 funded last year. Head Start currently reaches less than one-third of eligible children. Why would we reduce the slots in the 2020 budget?

Mr. HARGAN. Holding Head Start level in a tough funding environment like this is showing what a priority we place on this program. So we have actually attempted within a very tough budgetary environment, where we have been—where we have been—we have had to put cuts into some programs, trying to maintain levels——

Mr. MORELLE. Would this be a program—I am sorry to interrupt—but would this be a program you would increase if you were not in a tough budgetary cycle?

Mr. HARGAN. I think we have to abide by the restrictions on the discretionary funding that we have been given by past—by the existing law. But we have held it level, and that is attempting to make sure that we show the focus that we have on programs that we think work.

Mr. MORELLE. I do want to—and you do not need to respond to this—but just acknowledge that the budget also eliminates $250 million in preschool development grants, which help build state and local capacity, and many of my colleagues often talk about local and state governments being closer to the people.

But it reduces their capacity to provide preschool to low and moderate income households, and another troubling, in my view, cut to a significant investment to people who would be far more productive as citizens if we could give them that support. And I yield back my time, Mr. Chair.

Chairman YARMUTH. The gentleman yields back. I now recognize the gentleman from New Jersey, Mr. Sires, for five minutes.

Mr. SIRES. Thank you, Mr. Chairman. Mr. Hargan, thank you very much for being here.

You know, in New Jersey we have about 1.7 million people that take advantage of Medicaid. About 1.4 of those are Medicaid; the other is involved in the CHIP program. I see that the budget proposes to implement a work requirement for Medicaid recipients in all 50 states. Are you aware that when they implemented the work

requirement program in Arkansas, how many people lost their coverage?

Mr. HARGAN. We have seen, I think, the latest numbers of people show a sort of average churn in the Medicaid program. We have not yet seen—it is very early days in Arkansas's implementation of that community engagement requirement. So we have seen, so far, the numbers show an average number of people passing in and out of the program.

Mr. SIRES. Well, the numbers that I got is about 16,000 people lost their coverage in Arkansas when they implemented the work program. Are you——

Mr. HARGAN. Did you have a question?

Mr. SIRES. Yes. Following up on the question, I understand also that you are also cutting $130 billion—you anticipate $130 billion in savings—on the Medicaid program?

Mr. HARGAN. We have a number of different ways, places that we are showing savings in the Medicaid program.

Mr. SIRES. Well, how much of that do you think is from kicking people off the program by requiring them to work?

Mr. HARGAN. I do not know that there is—it is going to depend on how different programs are implemented in different states. This is ultimately a Medicaid issue, which means that it is a state-directed program. So each state is going to come in with a different way of dealing with the community engagement—with the community engagement requirement that they want to put into their own state.

Some of them, they are going to have different structures. They are going to have different ways in which the populations deal with the community engagement requirement. Ultimately, it is a state—it is a state set of requirements that they come to us and——

Mr. SIRES. But you are anticipating that if you ask a work requirement, there will be people losing their coverage?

Mr. HARGAN. That could happen because—but it is also—and certainly Arkansas has structured some of these things so that people have the requirement in there. If they do not obey the requirement, it is an issue for them maintaining Medicaid coverage.

There are also other requirements that states put into place. If people get work of a certain level, they leave the Medicaid program. If people move out of state, if they do not return their paperwork—there are other ways in which people lose Medicaid coverage as well.

Mr. SIRES. To me, this looks like this is a way of cutting the Medicaid programs by requiring people to work, knowing full well that you're going to lose coverage on people. So therefore, you are slashing.

Mr. HARGAN. Primarily, the community engagement requirement is intended to help people. It is——

Mr. SIRES. How can that help people when they——

Mr. HARGAN. We know that there are studies dealing with social isolation, dealing with the health—behavioral and mental health effects of people who do not engage with their community by states that come to us that have a thoughtfully structured way in which to encourage people to have community engagement, whether it is work or other forms of community engagement.

That is an area where we believe that people are going to be well affected, both in their health, and it can have also fiscal effects on the state as well, as well as having good effects on people for engaging in work to have money in their pocket, to have more engagement with their community.

If that is the way in which the program is structured, we think it can have a number of good effects, not just dealing with keeping the sustainability of the state Medicaid program moving forward from a fiscal point of view. It has other effects as well.

Mr. SIRES. So what are the bad effects? What are the bad effects? You have all these good effects that you are telling me. What are the bad effects that you anticipate?

Mr. HARGAN. Well, we are hoping that any state that comes in is going to avoid bad effects by structuring a community engagement requirement so that, say, in the case of Arkansas, that people who are primary caregivers for children, people who are medically frail, people who are full-time students, people who a doctor or medical professional says cannot work or should not work, are exempted from the program.

So hopefully, the restrictions on the community engagement requirement themselves will help obviate bad effects of the program, but also enable people who can engage in the community to encourage them to do so.

Mr. SIRES. Thank you, Mr. Chairman. My time is up.

Chairman YARMUTH. The gentleman's time is expired.

I now recognize the gentleman from Massachusetts, Mr. Moulton, for five minutes.

Mr. MOULTON. Mr. Hargan, thank you very much for joining us.

Does the President believe that individuals should be able to deduct healthcare insurance premiums from their taxes?

Mr. HARGAN. I believe that we have stood for a lot of different proposals in the budget regarding healthcare. It depends on the type of—the type of things. We have certainly advocated for greater expansion of health savings accounts that——

Mr. MOULTON. Well, if you do not what the President, your President, has proposed, he said during the 2016 presidential campaign that his reform—excuse me—his plan to reform healthcare included allowing individuals to deduct all of their insurance premiums from the income tax that they owe.

Historically, which Americans are most likely to benefit from these tax deductions? Wealthy Americans? Poor Americans? Middle class?

Mr. HARGAN. I would—for tax issues, I would have to refer you to possibly the Department of Treasury for——

Mr. MOULTON. Well, the answer is that wealthy people can take advantage of deductions.

The President's budget justification states, "All individuals receiving subsidized coverage should contribute a portion of their health insurance premium." So the President believes that individuals making $12,490 or families of four with a household income of $25,750 should pay more towards healthcare.

Does the President's budget propose wealthier Americans pay more for the cost of health insurance?

Mr. HARGAN. I believe that we are trying to reorient——

Mr. MOULTON. Actually, it is just quite a simple question, Mr. Hargan. Does the President's budget propose that wealthier Americans pay more of their costs for health insurance?

Mr. HARGAN. We are proposing greater expansions of health insurance options to all Americans. We are actually proposing areas like where we expand more options that cost less for Americans, for example short-term plans——

Mr. MOULTON. That is great. So I have given a chance to dodge the question. Now maybe you could just answer it. Is it yes or no?

Mr. HARGAN. So short-term—say short-term plans cost 50 to 80 percent less for Americans. By expanding options, all health insurance options——

Mr. MOULTON. The President is not asking wealthy Americans to pay more. But he is asking poor Americans to pay more for health insurance. My Republican colleagues often state during these hearings that there is a philosophical difference between Republicans and Democrats on spending.

And I agree. Apparently Democrats think that the poor should pay less, and Republicans think that the poor should pay more.

Mr. HARGAN. We are supportive of the ACA exchanges. We have been implementing them all along, and they provide a tremendous premium subsidy——

Mr. MOULTON. The President supports the Affordable—wait. The President supports——

Mr. HARGAN. The Administration has carried out the ACA exchanges and those——

Mr. MOULTON. So would you be willing to say that the President supports the Affordable Care Act?

Mr. HARGAN. We obey the law within the Administration. We have put forward——

Mr. MOULTON. Does the President support the Affordable Care Act? You said he supports the exchanges.

Mr. HARGAN. We have put forward alternatives to the ACA. But as long as——

Mr. MOULTON. But just does he support it or not?

Mr. HARGAN. But as long as it is the law of the land, we are going to provide premium support, a tremendous amount of premium support.

Mr. MOULTON. Well, that is hardening to hear—we certainly know that we have a President who loves to follow the law of the land.

Mr. Hargan, who famously said that the most terrifying words in the American language are, "I am from the Government and I am here to help"?

Mr. HARGAN. I am not sure who the actual originator of that quote is.

Mr. MOULTON. It may have been a speechwriter. But of course it is attributed to President Ronald Reagan. So even with his quest to limit the federal government, he signed into law the Low Income Home Energy Assistance Program during his first year in the White House, which specifically protects millions of low-income households each year from extreme heat and cold when high energy bills exceed their ability to pay.

So how much does President Trump propose for this program in fiscal year 2020?

Mr. HARGAN. Zero.

Mr. MOULTON. Okay. And his justification states that it is because there are 15 states that offer similar protection. So what about the people so unfortunate to live in the other 35 states?

Mr. HARGAN. Many states make it so that utilities cannot cut off service to people during periods of severe weather. Also, in 2010, the GAO found that that program was not high-performing, had lots of problems with waste and fraud. We believe that this is not a program that is a very high-performing program——

Mr. MOULTON. So it sounds like if it is not high-performing, the problem is not with the poor people who cannot afford to heat their homes, but the administrators of that program. And as the Administration, you are in charge of the administrators of that program.

So why not reform the program rather than forcing low-income people to freeze?

Mr. HARGAN. The program——

Mr. MOULTON. Sorry. My time is expired.

Chairman YARMUTH. I thank the gentleman.

I now recognize the gentlelady from Minnesota, Ms. Omar, for five minutes.

Ms. OMAR. I will just pick up, I think, where my colleague left off. I am from the state of Minnesota, and we are very much accustomed to having extreme cold weathers. And so I understand the need for us to worry about what happens when families are not able to heat their homes.

So the program that my colleague was talking about helps 6.3 million households. In Minnesota alone, there are 120,000 families that utilize this particular program. And so my question to you is: What do you propose happens to these families who now have health and safety problems because of the extreme cold weather?

Mr. HARGAN. Well, I am from Chicago, so I understand the issue about cold winters. When we have a program that does not have strong performance outcomes, and LIHEAP is one of those that has had this going all the way back to when I was at HHS under President Bush, and when the GAO tells us that it is at risk for fraud for improper payments and we look at——

Ms. OMAR. But sir, there is a difference between what my colleague is suggesting about us reforming and figuring out the best ways to utilize the dollars that we have, and saying zero dollars should go to assist people who live in conditions where it gets as low 12, 30 negative.

Mr. HARGAN. So all 50 states have protections for people who cannot pay their bills in periods of severe weather. So every state——

Ms. OMAR. Where would the resources come from if that protection exists? Yes, you need by legislation——

Mr. HARGAN. Every state protects people from their electricity, their heat, being cut off during periods of severe weather. And the LIHEAP program is really duplicating protections that are out there, $3.7 billion to duplicate protections that people have already who are disadvantaged.

Now, 15 states have alternative programs that really duplicate by providing payments and other things. But all 50 states protect people against having their——

Ms. OMAR. So let me get this clear. You have 15 states out of the 50 states that have programs where there are resources to help assist people. Other states just have a protection that might say, you might not be able to cut this off, or other things.

But we are deciding that there is no resources from the federal government that is going to help any of these people. Correct?

Mr. HARGAN. Well, we are—they are protected. So they are not going to lose their heat. They are not going to lose their cooling in hot weather.

Ms. OMAR. But protection and providing resources for them to do that are totally two different things. You know that, and you are trying to say otherwise. So we will just move on.

I wanted to, for the remainder of my time, talk about the child care budget within the budget that you proposed. The budget includes a one-time temporary funding of $1 billion to help address the cost of child care. It is unclear whether this approach will ultimately achieve the intended goal. Why are you only providing it on a one-time basis?

Mr. HARGAN. Well, this money, which is one-time mandatory funding which we put in place due to the caps proposal, it is intended to augment what we think of as being the most effective parts of our budget in social services, which is supporting child care and allowing states to build out capacity to provide new ways to provide child care. We also——

Ms. OMAR. And how will the funds be distributed? Is it going to be up to the states to determine what regulations they will use to meet the definitions of unnecessary?

Mr. HARGAN. Yes. So this is going to be provided as a grant to states, to help businesses and localities, to help them provide new ways of doing child care, and hopefully to reach underserved areas, rural communities, and communities that are underserved with child care.

Ms. OMAR. All right. Thank you. I yield back.

Chairman YARMUTH. The gentlelady's time is expired.

I now yield 10 minutes to the Ranking Member for his questions.

Mr. WOMACK. I thank the chairman, and again, Mr. Hargan, thank you for being here today. I will say at the outset I appreciate you being patient with my friend from Rocky Top, Mr. Burchett, who was trying to get a question answered and blaming it on Crenshaw's lack of knowledge of something when it was actually his own.

But what can you say about a guy that walks around in a Carhartt jacket when it is pretty moderate outside and a big hole in the right sleeve? But that is Tim. He is a great guy and fellow mayor. So I appreciate him, and he does a very good job on this Committee.

You were asked a few questions in the hearing by two or three different members on the other side of the aisle from me, questions about HIV initiative, yes or no questions, those type, treatment of foster care within the budget request—there were a handful of other questions that you were attempting to close on with your an-

swers, but because of their quest for yes or no answers, not given an opportunity to explain.

I will give you a chance here for a moment or two, if you would like, to finish, maybe, some of those thought processes on those subjects and any others that you would care to expound on regarding this part of the President's budget.

Mr. HARGAN. Right. Well, thank you for that. I mean, I think that some of the questions about the effects that Medicaid might have on people with HIV, as I had explained, we are actually replacing the cuts or reductions in one line with an increase on the other side, and flexibilities.

So we do not believe that a state would choose to disadvantage a particular population or places being served just simply because they are given more flexibilities in funding. So we are hopeful that to the extent that people are fearful that the states would cut Medicaid funding to HIV, we do not have any idea that that is what would happen.

And in the meantime, we are increasing funding for HIV $291 million. It is clearly one of the primary focuses of this department, to address that issue, to end that scourge for Americans. So we want to make sure that that focus is really clear on that.

With regard to the issue of Miracle Hill, there is no one who is going to be turned down as a foster parent who is otherwise suitable as a foster parent by the state of South Carolina. If an organization like Miracle Hill has a parent like me, for example, as a Catholic, who is not going to qualify for that program, they are going to refer me, and they are supposed to refer me, to another agency or to the state for me to apply and get inside the foster care program.

We have to. The American people have given HHS a budget of $1.3 trillion and tremendous amount of authority in some of the most intimate and personal parts of their lives. And in return, we have to obey the constitutional safeguards and the legal safeguards that the American people expect us to obey. Some of those are the Bill of Rights, the constitutional safeguards of people's religious expression. That has to be a cornerstone of everything that we are doing.

And so it is important to us that we can do both of these things. We can make sure that we both fund important social services and healthcare activities and also obey the constitution. We have to be able to do both at the same time.

Mr. WOMACK. It was said earlier, and I cannot remember which one of my colleagues made the comment, but about the prospect of healthy kids. Kids that have access to healthcare at an early age typically would be better performing physically from a health perspective later on in life.

I can sign onto that. I think that is a rational, reasonable approach. But I would also ask whether or not that same healthy child early on in life is going to be well served if in fact that later on in life, the costs associated with what we are doing today are piled on to that generation of children in the form of higher taxes in order just to meet the daily needs.

So $22 trillion in debt, I think you would agree, is a pretty substantial amount of money that we owe currently.

Mr. HARGAN. Yes.

Mr. WOMACK. And that trillion dollar deficit that is going to be added to that $22 trillion in debt is also a very significant amount of money.

Mr. HARGAN. Yes.

Mr. WOMACK. So in your business, when you are preparing a budget, you are having to take the—just like people at home. People watching this hearing today do this at home. They take their income and they take their expenses, they compare the two, and then they have to make what I call tough choices.

So you have to make tough choices. What are some of those tough choices?

Mr. HARGAN. So some of the tough choices that we have to make are situations where we are seeing that we are going to have to reduce the rate of growth in programs. Those are tough choices. We have to make choices between making sure that different sites of care are equally provided. Those are going to impose potential costs on providers, but not beneficiaries.

We have to maintain the focus that the seniors, the beneficiaries of our programs, are taken care of and that they do not have an increase in out-of-pocket cost. But at the same time we have to have reforms in these programs or they will not, as you rightly point out—will they be sustainable for the long run?

We have to make sure that they are and that the child today that we are going to endeavor to have the best healthcare possible for them, that these programs are around for them. And that is why we try to adopt a thoughtful approach in this budget that extends the life of the Medicare Trust Fund by eight years, and that it does with making thoughtful choices within a tough budget environment.

Mr. WOMACK. My colleague, Mr. Sires, brought up the state of Arkansas, my home state, and changes it has made to its Medicaid program regarding the work requirement. Are you familiar with a work requirement? What is that work requirement?

Mr. HARGAN. Yes. So this is a community engagement requirement that we have that we have allowed Arkansas to put into place. There are a number of elements of it. But Arkansas, while requiring people to engage in community engagement or work, also has a lot of safeguards on that program that we have built into place to make sure that really this is targeted towards people who can engage in work, who can engage in community engagement.

So that people who are caring for a minor child 17 or younger are exempted from that program; that we have people—anyone who is caring for an incapacitated person, people who have substance use disorder—those are all categories that are exempted from the community engagement requirement by Arkansas.

Mr. WOMACK. How many hours are they required to work?

Mr. HARGAN. I believe it is——

Mr. WOMACK. It is about 20 hours a week?

Mr. HARGAN. 20 hours a week. I think it is 20 hours a week.

Mr. WOMACK. 20?

Mr. HARGAN. Yes. I think it is 20 hours a week.

Mr. WOMACK. Do you think that is reasonable?

Mr. HARGAN. Well, I think that it is probably not a work week—a lot of people work a 40-hour work week. We are requiring—Arkansas is requiring 20 hours in this case.

Mr. WOMACK. In my area, in the 3rd District of Arkansas, the unemployment rate is significantly below 4 percent. In my home county, it is probably 2, 2.5 percent, which I would assert is very close to full employment. Lots of jobs. Lots of opportunities.

In the 16,000 or so people that have lost their Medicaid coverage, is it not true that because of the youth of the program, so to speak, the fact that it is not a mature program yet; we do not have a longitudinal study on its effects—but is it not possible that many of those 16,000 people have entered the workforce?

Mr. HARGAN. Yes.

Mr. WOMACK. Is it possible that many of those 16,000 now have acquired some form of health insurance through their employer?

Mr. HARGAN. Yes. I mean, we definitely know that this economy is the strongest that it has been in years. We are seeing unemployment rates that are the lowest they have been in 50 years, the lowest African American unemployment, Hispanic unemployment, female unemployment. We see very—those very high numbers.

We also know that besides employment issues, we also see that there are other reasons why people—they move out of the state. There are lots of reasons why people leave a Medicaid program. And we look forward to engaging with Arkansas on that and figuring out exactly why people might drop out of enrollment.

But it is nothing out of the ordinary. The percentages we are seeing in terms of what we call "churn" within Medicaid, people coming in and out of the program, has not yet—we have not yet seen a significant effect statistically in that from Arkansas.

Mr. WOMACK. Mr. Hargan, you have got a tough job in a constrained resource environment where we find ourselves consistently with trillion-dollar deficits and a $22 trillion debt. The country is going to have to look at its spending habits and the promises it has made and going to have to make some of those tough decisions.

And I applaud the fact that over in HHS they are looking at programs to reform for long-term sustainability because so many people rely on the programs, but at the same time with an eye toward the future in terms of our fiscal solvency.

With that, Mr. Chairman, I yield back my time.

Chairman YARMUTH. I thank the gentleman.

I now yield myself 10 minutes for my questions. Once again, Deputy Secretary, thank you for being here. Thank you for your responses.

You have, on a number of occasions throughout your testimony today, talked about the constraints of the budgetary caps under the Budget Control Act of 2011. Perfectly understandable. You also said, if I remember correctly, that you appreciated the spending levels in 2019 that you are working under now that was much more adequate for the programs that you are trying to manage.

Can I infer from those comments that you would be supportive of raising the budgetary caps for 2020 and 2021?

Mr. HARGAN. We do not formulate budget policy within HHS. We only work with the Office of Management and Budget, within the caps environment, to present to you what we hope is a thoughtful

budget that's compliant with the caps agreement. So I would refer any questions on overall budgetary policy to OMB.

Chairman YARMUTH. But you did say that you appreciated the spending levels in 2019. It made things easier for the department.

Mr. HARGAN. Well, I think we appreciated, for example, the opioids, the great support for the opioids initiative of the President, and that Congress had great support from the point of view of resources and authorities within the opioids initiative, the SUPPORT Act, all of which we very much appreciate.

Chairman YARMUTH. Well, if you were to have spending levels for 2020 and 2021 that resemble 2019 levels, would you still make the cuts that you are proposing to make in this budget?

Mr. HARGAN. Well, we would have to—whatever proposal was made by the Congress, we would have to work with OMB and throughout the rest of the Administration to come up with, hopefully, a wise budget for you, depending on the priorities that you all establish and that we have in the Administration.

Chairman YARMUTH. Thanks. Last night DOJ announced that the Administration believes the entire Affordable Care Act should be invalidated, adding—sending a message to the federal court in Texas where the case is under appeal. Were you or others at HHS consulted on this DOJ decision?

Mr. HARGAN. DOJ sets the litigation strategy for the federal government. We do not have independent litigating authority.

Chairman YARMUTH. No. But were you consulted as to, for instance, what kind of impact that ultimately might have if the courts totally invalidated the ACA?

Mr. HARGAN. Well, as things stand now, the judge has not issued a stay or enjoined the Affordable Care Act. So it will have no impact as it stands on our administration of the Affordable Care Act. But this Administration, the Trump Administration, stands ready to work with the Congress on policy solutions like those in our budget, and then power consumers in states to regain control over their healthcare and increase affordability and continue to protect individuals with preexisting conditions.

Chairman YARMUTH. I am going to spend most of the rest of my time on Medicaid. But I have one question on Medicare—well, two questions on Medicare.

Has anyone in the HHS ever considered increasing the Medicare withholding tax?

Mr. HARGAN. The which? Could you repeat that?

Chairman YARMUTH. Considered increasing the withholding tax that funds the Medicare Trust Fund?

Mr. HARGAN. I do not think that the budget sets forth an increase in the withholding tax.

Chairman YARMUTH. Has anybody ever discussed that, to your knowledge, in this Administration? We talk about adjustments to the program, but we always talk about it on the spending side. We never talk about it on the revenue side. I was just wondering whether, since it has been a very long time since that tax has been changed.

Mr. HARGAN. I do not believe that we have proposed that.

Chairman YARMUTH. All right. Thank you.

Mr. HARGAN. Any changes would the withholding tax.

Chairman YARMUTH. Thanks. We talked from time to time during the hearing about different things that affect the Medicare costs, prescription drugs being one, of course. Are there not things in the statute and rules that need to be changed because they drive up costs unnecessarily?

I am referring, for instance, to the Medicare three-day rule, that you have to spend three days in a hospital before you can get post-acute care paid for by Medicare. Every physician I have talked to thinks that is an absurd rule.

Mr. HARGAN. I think we are—we would love to work with you. You had mentioned drug pricing. We would love to work with the Congress on a lot of issues that have been stood out in the blueprint, and that we would very much welcome working with you and providing technical assistance to you all on drug pricing reform that brings the costs of prescription drugs down in this country.

Chairman YARMUTH. You talked a number of times, again now getting to Medicaid, about how you want to increase flexibility for the states. In recent years, a number of states with Republican administrations that had initially decided not to expand Medicaid—thinking about Arizona and thinking about Utah; there are several others, referendums and otherwise—and they made the decision, after watching what had happened over the first few years of the ACA, that it was to the benefit of their citizens to expand Medicaid.

How does your initiative comply with that degree of local control that those states exercised?

Mr. HARGAN. Well, states that—when we provide the flexibilities, we would hope that the states would welcome the amount of flexibilities that we would plan to provide them under this initiative, and that they would also welcome the fact that Medicaid is oriented towards those vulnerable populations that it is intended to cover; that we would have—we have other programs that are outside of Medicaid and that we are proposing that would cover different kinds of populations.

And we would allow more flexibilities across the board, more choice and more competition, among different payers and different plans, to allow Americans to purchase the kind of coverage that they want to have.

Chairman YARMUTH. But when you eliminate the ACA's Medicaid expansion, you have limited the amount of local control that those states have. You have done it in my state. In my state, we have roughly a half a million people out of a little over four million people covered under Medicaid expansion alone, another 800,000 covered by regular Medicaid.

So I am wondering what that says to those states who are trying to do the best thing for their citizens.

Mr. HARGAN. I think that—I think that hopefully they would see that individuals—that they are not necessarily required to cover the same people under the Medicaid expansion. But we do not have a lot of assumptions on how states would use the block grants.

We really are looking to provide more flexibilities for those. It would not—so given greater state flexibility with regard to eligibility requirements, benefits, the use of the block grant funds, we are hopeful that they are going to be able to cover their most vulnerable populations under Medicaid with the new flexibilities; and

really whichever state it is, Kentucky or Arkansas or otherwise, that they would be able to fashion this and really achieve the ultimate goal that Medicaid was originally set out to be, which is a state federal-directed program with flexibilities to allow the states to fashion it for their own populations.

Chairman YARMUTH. All right. Is there anything in the Medicaid law that defines it as a job program?

Mr. HARGAN. It is not a—it is not a—I don't know that it is defined as a job program.

Chairman YARMUTH. Well, we are fighting this in Kentucky because our governor is trying to impose work requirements and, actually, also premiums under a Section 115 waiver that basically was written by Seema Verma, the now-administrator of CMS, and it was approved by her. And how it has already been—that decision has already been overturned in court once, and it is back in court again.

And one of the things that we have been questioning continuously since the effort of the governor—by the way, the Section 115 waiver application specifically or explicitly says that if it is approved, 95,000 Kentuckians will lose coverage.

So I think that is a pretty good indication when somebody who is actually trying to get a waiver and impose a work requirement, or community engagement requirement, admits that almost 100,000 people will lose coverage. You extrapolate that across the entire country and it is going to have a considerable impact, presumably, on the healthcare of our country.

But I was wondering: Do you have any data to show—you said that you do not really know what happens, what the exact reason is for 16,000 in Arkansas losing their coverage. But when you have taken this path, do you have any experiential reasons for saying that this is not going to be devastating for people? Do you know, for instance, what percentage of people on Medicaid across the country are working already or would be otherwise exempt from these programs?

Mr. HARGAN. So when—we are really looking for the states to come to us with regard to their specific populations to determine the parameters of the community engagement requirement. So we would look to Kentucky. We would look to Arkansas and the other states when they are coming forward to us to see what works for their population in terms of the hours that they have, in terms of the other requirements of the program.

So in that sense, we do monitor what we are expecting from the states. We are certain they are going to send us information about how work is going to affect and whether it allows the transition off of the program ultimately and into the workforce, which I think many people, that's what they are trying to achieve here.

We are looking at it more broadly, as community engagement or as work. But I know that a lot of people, that is going to be the form that they take. And that is going to have both economic effects on them, on their community, on the workforce that is allowed to be there.

And then, at the end of the day, we think on their behavioral and their mental health as they engage with their community. And I have heard about it as I come across the country. I have heard

about it many, many times in Kentucky. It was one of the places where I met with a group of people with substance use disorder.

And one of them said to me, said that: "The thing about it was, before I was working, I was just a patient. I was a person who is an addict. And all I did was sit at home and look for the next meeting with my doctor, the next meeting with my counselor, the next meeting with my group. When I had work, at least for eight hours a day people are treating me as a coworker and a colleague, and I did not think about my addiction all the time."

That took him out of himself and meant that he was not always an addict And that was a huge improvement for him, for his own feeling about himself. And that has ramifications, and I think that as we see these things going forward, whether I have heard it from people with mental health issues, for people who have substance use disorders, for the disabled, that they all look to us and they say—I have heard it from each one of those groups, saying, "It is so important for us to have encouragement to work so that people see us not just as a disabled person, a person with a mental disorder or an addict, but as somebody who can contribute to them, who can be a coworker, a colleague, and a fellow American."

So I think it is an important—I think it could be a tremendous achievement.

Chairman YARMUTH. I do not want to abuse the power of the chair. But I would say I think that maybe makes the case for not having work requirements because what it indicates to me is that people basically do want to work, and if they can, they will. So you do not need to put this unnecessary burden on them.

But with that, I would say thank you so much, Deputy Secretary Hargan. I appreciate your testimony. And please be advised that members can submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record. Any members who wish to submit questions for the record may do so within seven days.

Once again, thank you. And with that, without objection, this hearing is adjourned.

[Whereupon, at 12:45 p.m., the Committee was adjourned.]

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CONGRESSWOMAN SHEILA JACKSON LEE OF TEXAS

STATEMENT
HEARING:
"U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES FISCAL YEAR 2020 BUDGET"

COMMITTEE ON THE BUDGET
210 CANNON
MARCH 26, 2019
10:00 A.M.

- Thank you Chairman Yarmuth and Ranking Member Womack for convening this hearing on the President's proposed FY2020 budget for the U.S. Department of Health and Human Services, and related agencies.

- Let me welcome our witness, HHS Deputy Secretary Eric Hargan.

- In short, Mr. Chairman, this phony numbers and fuzzy math HHS budget is Act III of the immorality play we predicted last year that the President would write.

- Act I was the cutting of taxes for the rich; Act II was the inevitable exploding of the deficit we predicted would result and our Republican friends denied would ever happen.

- The President's proposed budget projects FY2020 revenues of $3.645 trillion and outlays of $4.746 trillion, leaving a deficit of $1.101 trillion.

- Which brings us to Act III, in which Republicans claim to have newly rediscovered their horror over the deficits created by their fiscal irresponsibility and insist that the mess they created be cleaned up by slashing investments in the health and services programs relied upon by the 90-95 percent of Americans who were made worse off by the GOP TaxScam.

- This budget for HHS makes it very clear that the President's priorities are not with the "forgotten Americans" that he claims to represent.

- How else could he justify the following draconian cuts to life-saving and life-changing programs.

- The discretionary budget for HHS is cut by 12 percent - $12.1 billion – to $87.1 billion from the $99.2 billion enacted in 2019.

- Medicaid is cut by $1.5 trillion over ten years, breaking one of the President's signal campaign promises, and this budget calls for the complete repeal of Medicaid expansion, converting the program into a block grant or per-capita cap, and requiring all states to implement so-called work requirements.

- Breaking another key campaign pledge, the President's budget makes several changes to Medicare by shifting costs onto hospitals, post-acute care providers, and some beneficiaries, reducing federal spending by more than $500 billion.

- Breaking yet another of his campaign promises, that "everybody's going to be taken care of" – the President's budget replaces the Affordable Care Act (ACA) not with "something terrific" but with a state block grant that grows with the rate of inflation, meaning it would decline over time relative to need and leave millions of Americans without meaningful health insurance.

- This budget makes life harder, much harder, for people living with HIV/AIDS by cutting funding for the National Institute of Allergy and Infectious Diseases, which is responsible for most of the HIV/AIDS research at NIH, by 14% and cutting funding for programs to treat global HIV/AIDS by $1.7 billion, or 29%, below the 2019 enacted level.

- While the President's budget includes an additional $50 million investment in scientific research, drug discovery, clinical trials, and data sharing, for pediatric cancer, these gains are more than wiped out by the proposed cuts in funding for the National Cancer Institute of $897 million – more than any other Institute at NIH.

- The President's budget is short-sighted in another critical respect; by slashing funding for the Centers for Disease Control and Prevention by 19.1%, the budget puts the nation at risk because CDC protects the nation's health through population health surveillance, research, and work with partners across the globe to identify health, safety, and security threats.

- Almost 85 percent of CDC's domestic funding goes to state and local public health departments so these cuts would have serious impacts on public health agencies in every state.

Budget Slashes Programs Supporting Children and Families

- Mr. Chairman, because Temporary Assistance for Needy Families (TANF) block grant funding has remained flat at approximately $17 billion each year since 1996, the purchasing power of TANF benefits has eroded substantially in most states.

- Notwithstanding that TANF is severely underfunded, this cruel budget goes after the most vulnerable Americans by cutting 10% from the TANF base program.

- Additionally, the budget cuts $6 billion over ten years by eliminating the TANF contingency fund, preventing the government from ensuring struggling families can access the basic supports they need to get by during future economic downturns.

- The budget completely eliminates the Social Services Block Grant (SSBG), costing states $16.6 billion in funding over 10 years (roughly $1.7 billion per year).

- States use this funding to decide how best to improve and complement services like foster care, child protective services, day care, case management, and other services that protect vulnerable children and adults; in 2016, as many as 26 million Americans across all 50 states received services supported in whole or in part by SSBG.

- Head Start is level funded at $10.063 billion, which will only serve 871,000 children, a decrease from the estimated 891,142 slots funded in 2019 and enough to fund less than 31 percent of children aged 3–5 eligible to participate in a head start program.

- Mr. Chairman, it is cruel and heartless to eliminate funding, as this budget does, for Low-Income Home Energy Assistance Program (LIHEAP).

- Cutting this $3.7 billion program puts millions of families at risk when extreme temperatures hit, both in the summer and in the winter.

- This budget completely eliminates CSBG, a block grant program that allows states, territories, and tribes to reduce poverty by focusing on effective ways to address employment, education, housing, nutrition, and health.

- CSBG grants served roughly 17 million individuals from 7.3 million families and were funded at $725 million last year to meet our shared goals of lessening poverty and improving outcomes.

- Mr. Chairman, we are living through a period of increasing income and wealth inequality that gets worse each passing year and is exacerbated by the policies pursued by this Administration and favored by our Republican colleagues.

- Consider the implication of these facts.

- America's top 10 percent now average more than nine times as much income as the bottom 90 percent.

- Americans in the top 1 percent average over 40 times more income than the bottom 90 percent.

- The nation's top 0.1 percent are taking in over 198 times the income of the bottom 90 percent.

- In 2018, the three men at the top of the Forbes 400 list — Amazon founder Jeff Bezos, Microsoft founder Bill Gates, and investor Warren Buffett — held combined fortunes worth more than the total wealth of the poorest half of Americans.

- The median African American family, with just over $3,500, owns just 2 percent of the wealth of the nearly $147,000 the median White family owns.

- The median Latino family, with just over $6,500, owns just 4 percent of the wealth of the median White family.

- Put differently, the median White family has 41 times more wealth than the median Black family and 22 times more wealth than the median Latino family.

- Mr. Chairman, this budget would undermine the very programs relied upon by poor, working, and middle-class families and our nation's most vulnerable citizens: children, senior, the disabled, and the homeless.

- Under the President's budget, non-defense discretionary (NDD) programs are cut by $1.4 trillion, including cuts to Medicare and Medicaid, while defense spending is slated to increase by $750 billion over ten years.

- The budget would reduce funding for SNAP by $220 billion or 22 percent.

- Like the phony budget submitted last, the President's FY2020 budget again requests only $200 billion for the Administration's $1 trillion infrastructure proposal and forces cash-strapped state and local government to provide the remaining $800 million in funding.

- The budget requests Congress to approve spending $8.6 billion of the taxpayers' money to build an unnecessary, ineffective, and immoral wall along the southern border that the President boasted and assured Americans that would be paid for solely by Mexico.

- The budget would reduce funding for the State Department and international programs by more than 30 percent, eviscerating America's soft-power comparative advantage in international affairs.

- Let me blunt: the President should be embarrassed and ashamed to present this budget and expect it to be taken seriously by the American people's representatives in Congress.

- Let me tell you why.

- The President's budget sinks the nation into deficits exceeding $1 trillion a year while showering the top 1 percent with tax breaks.

- In contrast, last month the IRS reported that the average tax refund check is down 8 percent ($170) this year compared to last and the number of people receiving a refund so far has dropped by almost a quarter.

- The Government Accountability Office warned last summer that the IRS estimated that about 4.6 million fewer filers would receive refunds this tax filing season and another 4.6 million filers were likely to owe money who previously had not owed any money.

- The President's budget undermines the nation's future through reckless cuts to investments and programs needed to boost jobs and innovation, revitalize communities, and generate broad-based prosperity.

- The President's budget piles more hardships on Americans struggling to get by with $327 billion in cuts to direct spending programs that safeguard basic living standards for working families and people struggling to get by.

- The President's budget pursues deep Medicaid cuts and other destructive health care policies and it cuts Medicare funding by $845 billion.

- The President's budget continues the Republican obsession with dismantling and destabilizing health care for millions of Americans by making yet another attempt to "repeal and replace" the Affordable Care Act with an inferior plan that will leave millions more people without meaningful health insurance coverage, weaken protections for people with pre-existing conditions, and result in a net $1.5 trillion cut to health care.

- As part of this attack on health coverage, the President's budget cuts $1.4 trillion from Medicaid over ten years, jeopardizing care for seniors in nursing homes, children with disabilities, and low-income families.

- The President's budget fails to make necessary investments in infrastructure.

- The President's budget relies on extremely optimistic assumption of 3% annual economic growth, notwithstanding the fact that the nation's leading private forecasters, as well as the Congressional Budget Office, forecast average annual growth of less than 2 percent.

- There is much wisdom in the adage that "the President proposes, the Congress disposes."

- Mr. Chairman, this budget should be declared DOA and Congress should get to work on fashioning a budget that reflects the priorities and addresses the real challenges facing the American people.

- Thank you; I yield the remainder of my time.

Chairman John Yarmuth
U.S. House Committee on the Budget
Hearing on the Department of Health and Human Services FY 2020 Budget
March 26, 2019

The Administration's proposal to expand prior authorization to inpatient rehabilitation facilities (IRFs) may result in patients being diverted away from hospital-level rehabilitation care into less intensive settings. What safeguards are necessary for any prior authorization program to ensure that appropriate care is not delayed for patients? What safeguards are necessary to ensure appropriate access to IRFs? How would the Administration prevent a prior authorization requirement from interfering with patient care, particularly for patients transitioning from one site of care to another?

Rep. George Holding [NC-02]
House Committee on the Budget
Hearing on Department of Health and Human Services FY 2020 Budget
March 26, 2019

The Honorable Eric D. Hargan
Deputy Secretary, Department of Health and Human Services

PAMA offered the opportunity to reframe Medicare's static payment system for laboratory diagnostic tests under the Clinical Laboratory Fee Schedule (CLFS) to a market-based system by linking Medicare payment rates to the rates paid by private payers in the commercial sector. While I appreciate the work that the agency has done to implement PAMA, in gathering private-payer data to set the physician lab fee schedule, CMS did not include data from most hospital outreach laboratories and physician office laboratories in setting new payment rates. This resulted in an analysis of data that was not representative of the market as a whole.

1. What steps is CMS taking to collect private-payer data from all laboratories required to report under PAMA in order to ensure an appropriate lab fee schedule?

2. How is CMS planning to ensure representative data collection efforts, particularly as it relates to hospital outreach laboratories and physician office laboratories?

Pre. Jason Smith [MO-8]
Hearing on the President's Budget Proposal – HHS
House Committee on the Budget
March 26, 2019

I am greatly concerned about the opioid epidemic that continues to ravage our country. The scale of this crisis requires a coordinated response from all levels of government, and I am pleased to hear it remains a priority of your Department. I was particularly encouraged to learn that the Centers for Medicare and Medicaid Services (CMS) was contemplating adjusting payment for evidence-based non-opioid non-pharmacologic therapies in its CY2019 OPPS proposed rule, in order to ensure beneficiaries can access pain management treatments that can reduce the risk of opioid addiction. In the proposed rule, CMS stated its interest in hearing from stakeholders about "whether CMS should consider separate payment for such items and services for which payment is currently packaged under the OPPS and ASC payment system that are effective non-opioid alternatives as well as evidence that demonstrates such items and services lead to a decrease in prescription opioid use during or after an outpatient visit or procedure in order to determine whether separate payment may be warranted." CMS went on to state it would "examine the evidence submitted to determine whether to adopt a final policy that incentivizes use of non-opioid alternative items and services that have evidence to demonstrate an associated decrease in prescription opioid use and addiction following an outpatient visit or procedure," and specifically cited "studies published in peer-reviewed literature that such product aids in the management of acute or chronic pain and is an evidence-based non-opioid alternative for acute and/or chronic pain management" and "evidence relating to products that have shown clinical improvement over other alternatives, such as a device that has been shown to provide a substantial clinical benefit over the standard of care for pain management" as criteria that would be considered. However, I was disappointed to learn that CMS declined to make any adjustments to payments for non-opioid alternatives in its final CY2019 OPPS rule, even though I am aware of at least one therapy – high frequency spinal cord stimulation – that meets both of these criteria. Why did CMS choose to forego any payment adjustments for evidence-based non-opioid devices, even for those devices with prospective, long-term, peer-reviewed published evidence demonstrating a reduction in opioid use while maintaining clinical efficacy? Does CMS plan to revisit its payment policy for evidence-based non-opioid devices in its CY2020 OPPS rule?

Rep. Chip Roy [TX-21]

Hearing on the President's Budget Proposal – HHS

House Committee on the Budget

March 26, 2019

Questions for the Record

1) What states have expanded Medicaid?
2) What states have partially expanded Medicaid?
3) Under what mechanism or authority are states able to expand or partially expand?
4) For states that have already expanded Medicaid and move to partially expand, what percentage (or expected percentage) of people will sign up for an exchange plan?
    a. What percentage of individuals drop coverage (or can be expected to drop coverage)?
5) What impact does expansion and partial expansion have on federal government spending in contrast to states that choose not to expand at all?
    a. What are the overall budgetary impacts of Medicaid expansion and partial expansion?
    b. Does Medicaid expansion and/or partial expansion increase overall federal spending?
6) Has HHS in any way encouraged states to expand or partially expand Medicaid?

Questions for the Record
Congressman William Timmons (SC-04)
Department of Health and Human Services FY 2020 Budget
March 26, 2019

Question #1

On January 11, 2017, nine days before President Trump's inauguration, the Obama Department of Health and Human Services (HHS) finalized a regulation which amended the non-discrimination clause in Title IV-E of the Social Security Act to include religion and sexual orientation. This rule, 45 C.F.R. § 75.300 (c) and (d), has negatively impacted the religious liberty of faith-based Child Placing Agencies in my state of South Carolina and across the country. In January of this year, HHS granted a waiver to this regulation to South Carolina at the request of Governor McMaster. While South Carolina is longer forced to comply with this onerous Obama regulation, the rest of the country still does.

Is your Department considering repealing this regulation in its entirety?

Question #2

In addition to a strong history of providing high-quality and innovative patient care, particularly in rural and underserved areas across the country, doctors of osteopathic medicine (DOs) conduct clinical and basic science research to help advance the frontiers of medicine and to demonstrate the effectiveness of the osteopathic approach to patient care. However, compared to their MD counterparts, DOs participate in, and receive less money from, federal research programs.

How can the Department of Health and Human Services work with osteopathic medical schools to ensure that DOs are further included in federal research projects and are recipients of federal grant funding, particularly as it relates to their contributions to research and primary care?

Question #3

As you know, our nation faces a physician shortage of between 40,800 and 104,900 physicians in 2030. The President's Fiscal Year 2020 Budget request outlines a proposal to consolidate graduate medical education programs – including Medicare, Medicaid, and Children's Hospitals – into a new capped federal grant program. While I agree that GME training should support training physicians to deliver care in non-hospital settings, which claims to be the reasoning behind this consolidation, I am concerned that this proposal will only worsen physician workforce shortages. Can you please further explain in detail how this proposal will ensure we are training an ample number of physicians to eradicate this shortage?

Will this proposal lift the 1997 caps on Medicare-supported training positions?

How will this proposal ensure we are training an adequate number of specialists? For instance, pediatricians who previously benefited from their own program – the Children's Hospital Graduate Medical Education Program?

House Budget Committee FY2020 Budget Hearing QFRs
Deputy Secretary Eric Hargan
Hearing Date: March 26, 2019

Chairman John Yarmuth

The Administration's proposal to expand prior authorization to inpatient rehabilitation facilities (IRFs) may result in patients being diverted away from hospital-level rehabilitation care into less intensive settings.

1. What safeguards are necessary for any prior authorization program to ensure that appropriate care is not delayed for patients? What safeguards are necessary to ensure appropriate access to IRFs? How would the Administration prevent a prior authorization requirement from interfering with patient care, particularly for patients transitioning from one site of care to another?

Response: While prior authorization can be an effective tool for health care payers to support payment accuracy and reduce unnecessary utilization, current law restricts Medicare's ability to use this tool on all but a few fee-for-service items and services. The President's FY 2020 Budget includes a proposal that would extend the narrow existing authority to all Medicare fee-for-service items and services, specifically those that are at high risk for fraud and abuse. This proposal includes inpatient rehabilitation services because of the high and increasing improper payment rate for this service area. The FY 2018 Medicare improper payment rate for inpatient rehabilitation services is 41.6 percent, up from the FY 2017 error rate of 39.7 percent. Additionally, the Department of Health and Human Services Office of Inspector General has raised concerns regarding situations where "medical record documentation did not support that inpatient rehabilitation facility (IRF) care was reasonable and necessary in accordance with Medicare's requirements," most recently in a 2018 report.[1]

CMS does not believe this proposal would limit or delay beneficiary access to care. Prior authorization policies are commonly used throughout the private sector. Additionally, there have been promising results from a model conducted by CMS's Center for Medicare and Medicaid Innovation (CMMI), testing prior authorization of repetitive, scheduled non-emergent ambulance transport that found no quantitative evidence of a negative impact on quality of care and access to coverage. Additionally, under a prior authorization payment structure, providers would be largely assured that they would receive the correct payment for the correct items or services and not be subject to post-payment reviews, with the exception of reviews for suspected fraud or improper payment rate measurement. From other prior authorization efforts, CMS has heard that suppliers appreciate that prior authorization offers a predictable payment process without being subject to most future audits. Finally, beneficiaries can be assured that prior authorization will reduce unnecessary medical services, which would yield cost-sharing savings and preserve the beneficiary's ability to receive quality items and services.

[1] https://oig.hhs.gov/oas/reports/region1/11500500.pdf

Rep. George Holding

PAMA offered the opportunity to reframe Medicare's static payment system for laboratory diagnostic tests under the Clinical Laboratory Fee Schedule (CLFS) to a market-based system by linking Medicare payment rates to the rates paid by private payers in the commercial sector. While I appreciate the work that the agency has done to implement PAMA, in gathering private-payer data to set the physician lab fee schedule, CMS did not include data from most hospital outreach laboratories and physician office laboratories in setting new payment rates. This resulted in an analysis of data that was not representative of the market as a whole.

1. What steps is CMS taking to collect private-payer data from all laboratories required to report under PAMA in order to ensure an appropriate lab fee schedule?
2. How is CMS planning to ensure representative data collection efforts, particularly as it relates to hospital outreach laboratories and physician office laboratories?

Response to 1-2: Prior to implementing these new Medicare rates, CMS was required to collect certain private payor rate data from applicable laboratories to inform the rate setting process. Through notice and comment rulemaking, CMS considered stakeholder input in establishing parameters for the collection of the applicable information. In addition to rulemaking, CMS posted press releases and fact sheets on the CMS website describing the changes required by section 2 l 6(a) of PAMA and its progress in implementing the law. CMS held three national provider calls focused on data reporting and the data collection system.

As a result of these efforts, the data reported to CMS during the initial data reporting period captured more than 96 percent of laboratory tests on the CLFS, representing over 96 percent of Medicare's spending on CLFS tests in calendar year 2016. Laboratories from every state, the District of Columbia, and Puerto Rico reported applicable information. To determine if CMS could improve the 96 percent reporting rate without creating significant further burden for laboratories, particularly small laboratories, CMS modeled three additional reporting scenarios to estimate the impact of increasing data reporting. Based on this analysis, CMS determined that additional reporting requirements were not likely to result in a significant change to payment amounts, irrespective of how many additional laboratories reported. However, CMS noted that it would continue to analyze the effect of additional data when setting Medicare payment rates in the future.

In preparation for the next data collection period for most tests that runs from January 1, 2019, through June 30, 2019, CMS made two changes to the definition of applicable laboratory in the Medicare Physician Fee Schedule Calendar Year 2019 final rule (83 FR 59671, 60033 and 60074), which CMS believes will lead to an even more robust data collection from which to calculate payment rates for the next CLFS update, as more laboratories may be required to report data. First, the final rule excludes Medicare Advantage plan payments from the total Medicare revenues, the denominator of the Medicare revenues threshold, which CMS believes will result in more types of laboratories qualifying as an applicable laboratory. CMS believes that its previous interpretation of total Medicare revenues, which included Medicare Advantage revenues, may have had the effect of excluding certain laboratories from meeting the majority of

Medicare revenues threshold criterion and, therefore, from qualifying as applicable laboratories. In addition, CMS amended the definition to include hospital outreach laboratories that bill Medicare Part Busing the CMS-1450 14x Type of Bill. CMS is continuing to evaluate ways to increase data reporting, including targeted outreach and auditing of laboratories that may meet the definition of an applicable laboratory.

Rep. Jason Smith

I am greatly concerned about the opioid epidemic that continues to ravage our country. The scale of this crisis requires a coordinated response from all levels of government, and I am pleased to hear it remains a priority of your Department. I was particularly encouraged to learn that the Centers for Medicare and Medicaid Services (CMS) was contemplating adjusting payment for evidence-based non-opioid non-pharmacologic therapies in its CY2019 OPPS proposed rule, in order to ensure beneficiaries can access pain management treatments that can reduce the risk of opioid addiction. In the proposed rule, CMS stated its interest in hearing from stakeholders about "whether CMS should consider separate payment for such items and services for which payment is currently packaged under the OPPS and ASC payment system that are effective non-opioid alternatives as well as evidence that demonstrates such items and services lead to a decrease in prescription opioid use during or after an outpatient visit or procedure in order to determine whether separate payment may be warranted." CMS went on to state it would "examine the evidence submitted to determine whether to adopt a final policy that incentivizes use of non-opioid alternative items and services that have evidence to demonstrate an associated decrease in prescription opioid use and addiction following an outpatient visit or procedure," and specifically cited "studies published in peer-reviewed literature that such product aids in the management of acute or chronic pain and is an evidence-based non-opioid alternative for acute and/or chronic pain management" and "evidence relating to products that have shown clinical improvement over other alternatives, such as a device that has been shown to provide a substantial clinical benefit over the standard of care for pain management" as criteria that would be considered. However, I was disappointed to learn that CMS declined to make any adjustments to payments for non-opioid alternatives in its final CY2019 OPPS rule, even though I am aware of at least one therapy – high frequency spinal cord stimulation – that meets both of these criteria.

1. Why did CMS choose to forego any payment adjustments for evidence-based non-opioid devices, even for those devices with prospective, long-term, peer-reviewed published evidence demonstrating a reduction in opioid use while maintaining clinical efficacy? Does CMS plan to revisit its payment policy for evidence-based non-opioid devices in its CY2020 OPPS rule?

Response: CMS sought feedback in the CY 2019 OPPS proposed rule on whether other non-opioid alternatives for acute or chronic pain have evidence demonstrating that they lead to a decrease in opioid prescriptions and addiction and may, therefore, warrant separate payment under the OPPS and ASC payment systems. CMS received a number of comments on this issue.

CMS will continue to analyze this issue as the agency implements section 6082 of the SUPPORT for Patients and Communities Act which requires review and adjustment of payments under the OPPS and ASC payment systems to avoid financial incentives to use opioids instead of non-opioid alternative treatments.

Rep. Chip Roy

1. What states have expanded Medicaid?
2. What states have partially expanded Medicaid?
3. Under what mechanism or authority are states able to expand or partially expand?
4. For states that have already expanded Medicaid and move to partially expand, what percentage (or expected percentage) of people will sign up for an exchange plan?
    a. What percentage of individuals drop coverage (or can be expected to drop coverage)?
5. What impact does expansion and partial expansion have on federal government spending in contrast to states that choose not to expand at all?
    a. What are the overall budgetary impacts of Medicaid expansion and partial expansion?
    b. Does Medicaid expansion and/or partial expansion increase overall federal spending?
6. Has HHS in any way encouraged states to expand or partially expand Medicaid?

Response to 1-6: The Patient Protection and Affordable Care Act (PPACA) significantly expanded Medicaid eligibility, allowing states to enroll childless, non-disabled adults with incomes below 138 percent of the poverty level. It also provided states with an enhanced Federal contribution toward this newly eligible expansion population, covering 100 percent of these costs from 2014 through 2016. Starting in 2017, the matching rate declines slightly each year until it reaches 90 percent in 2020 and remains there; for 2019, the matching rate for the expansion population is 93 percent. As of March 26, 2019, 37 states including D.C. have adopted the expansion and 9 states have obtained approval through section 1115 waivers to implement Medicaid expansion.

Medicaid spending has increased rapidly in the last decade, due in part to Medicaid expansion. In 2017, an estimated 12.2 million newly eligible adult enrollees were covered under the expanded Medicaid eligibility, and, from 2017 through 2026, Medicaid expenditures for adults newly eligible under the PPACA are projected to amount to $938 billion ($855 billion paid by the Federal government).

This Administration is committed to refocusing Medicaid on the nation's most vulnerable populations to provide a more robust level of care and a strengthened program overall. The President's FY 2020 Budget includes numerous proposals—including a proposal to repeal the PPACA's Medicaid expansion—that would reform Medicaid financing to empower states to design state-based solutions that prioritize Medicaid dollars for traditional Medicaid population and support innovation.

Rep. William Timmons

1. On January 11, 2017, nine days before President Trump's inauguration, the Obama Department of Health and Human Services (HHS) finalized a regulation which amended the non-discrimination clause in Title IV-E of the Social Security Act to include religion and sexual orientation. This rule, 45 C.F.R. § 75.300 (c) and (d), has negatively impacted the religious liberty of faith-based Child Placing Agencies in my state of South Carolina and across the country. In January of this year, HHS granted a waiver to this regulation to South Carolina at the request of Governor McMaster. While South Carolina is longer forced to comply with this onerous Obama regulation, the rest of the country still does. Is your Department considering repealing this regulation in its entirety?

   Response: In light of the request from Governor McMaster, the Department granted the State of South Carolina an exception to the religious nondiscrimination provision in 45 CFR § 75.300(c). We determined that requiring Miracle Hill Ministries to abandon its use of religious criteria as a condition of receiving Title IV-E funds would substantially burden its free exercise of religion in violation of Religious Freedom Restoration Act, 42 U.S.C. § 2000bb, *et seq*. (RFRA). Our decision to grant an exception was also guided by programmatic considerations: Miracle Hill Ministries is responsible for up to 15 percent of the total number of foster care placements in South Carolina. If it were to cease providing services, the State's foster care program would have been substantially burdened.

   HHS continually reviews its regulations to determine whether changes are warranted to better enhance our mission of protecting the health and well-being of all Americans. We are limited in what we can say on this subject because it is subject to ongoing litigation. Any rulemaking would be subject to similar restrictions under the Administrative Procedure Act and long-standing Executive Branch policy.

2. In addition to a strong history of providing high-quality and innovative patient care, particularly in rural and underserved areas across the country, doctors of osteopathic medicine (DOs) conduct clinical and basic science research to help advance the frontiers of medicine and to demonstrate the effectiveness of the osteopathic approach to patient care. However, compared to their MD counterparts, DOs participate in, and receive less money from, federal research programs.

   - How can the Department of Health and Human Services work with osteopathic medical schools to ensure that DOs are further included in federal research projects and are recipients of federal grant funding, particularly as it relates to their contributions to research and primary care?

   Response: NIH is dedicated to strengthening and diversifying the biomedical research workforce. This includes fostering opportunities for physician-scientists with osteopathic medical degrees, a group of researchers NIH recognizes is underrepresented in the biomedical research workforce.

NIH continues to address recommendations described in a 2014 report focused on the physician-scientist workforce from the NIH Advisory Committee to the Director.[2] As the report notes and NIH agrees with, "findings which lead to advances in practice are driven largely by the work of investigators with a variety of degrees [including Doctors of Osteopathy]', of whom those with clinical training contribute essential knowledge and skills."

NIH has been engaged in conversation with professional societies. For example, on April 10, 2019, NIH leadership, including the Director and Deputy Director of the National Center for Complementary and Integrative Health (NCCIH) and the NIH Deputy Director for Extramural Research, held a meeting with representatives from the Edward Via College of Osteopathic Medicine to discuss ways in which the osteopathic community can work with NIH to develop D.O. clinician-scientists to drive research and to increase their numbers of grant applications. NIH will continue conversations with these D.O. professional societies.

As part of its attempts to strengthen the research workforce, NIH supports Mentored Clinical Scientist Research Career Development Awards. These programs prepare clinically-trained individuals, including Doctors of Osteopathy, for careers that have a significant impact on the health-related research needs of the Nation. This program provides support and protected time for an intensive, supervised research career development experience in the fields of biomedical, behavioral, or clinical research, including for translational studies.

Through the KL2 career development award program, NCCIH partners with the NIH's National Center for Advancing Translational Sciences (NCATS) to provide a new research career development pathway for complementary and integrative health clinician-scientists. Through this career development funding opportunity, NCCIH will support the appointment of scholars with doctoral-level clinical complementary and integrative health degrees, including individuals with a D.O. degree, to NCATS Clinical and Translational Science Award KL2 Institutional Career Development programs for a minimum of 2 years of research training.

NCCIH also supports the CAM Practitioner Research Project.[3] This initiative focuses on training osteopathic medical students, faculty, interns and residents, and practicing physicians in evidence-based medicine concepts. The project seeks to increase the quality and quantity of evidence-based medicine tools that support critical scientific thinking and self-directed lifelong learning.

NIH recently changed the eligibility criteria for the Academic Research Enhancement Award (R15) program (NOT-OD-19-015).[4] With these changes, NIH will provide R15 research enhancement opportunities for health professional and graduate schools under separate funding opportunity announcements. Accredited osteopathic medical schools

[2] https://acd.od.nih.gov/documents/reports/PSW_Report_ACD_06042014.pdf
[3] https://nccih.nih.gov/node/4557
[4] https://grants.nih.gov/grants/guide/notice-files/NOT-OD-19-015.html

would be eligible to apply if they: (1) grant baccalaureate or advanced degrees in health professions or biomedical and behavioral sciences as well as (2) did not receive NIH research support totaling more than $6 million per federal fiscal year in 4 of the last 7 fiscal years.

3. As you know, our nation faces a physician shortage of between 40,800 and 104,900 physicians in 2030. The President's Fiscal Year 2020 Budget request outlines a proposal to consolidate graduate medical education programs – including Medicare, Medicaid, and Children's Hospitals – into a new capped federal grant program. While I agree that GME training should support training physicians to deliver care in non-hospital settings, which claims to be the reasoning behind this consolidation, I am concerned that this proposal will only worsen physician workforce shortages. Can you please further explain in detail how this proposal will ensure we are training an ample number of physicians to eradicate this shortage?
    a. Will this proposal lift the 1997 caps on Medicare-supported training positions?
    b. How will this proposal ensure we are training an adequate number of specialists? For instance, pediatricians who previously benefited from their own program – the Children's Hospital Graduate Medical Education Program?

Response to a-b: Funding for Graduate Medical Education (GME) comes from multiple fragmented funding streams, and HHS's GME financing system does not target training to the types of physicians needed in the United States. The President's FY 2020 Budget includes a proposal that would consolidate federal graduate medical education spending from Medicare, Medicaid, and the Children's Hospital Graduate Medical Education Program into a single grant program for teaching hospitals, and direct funding toward physician specialty and geographic shortages areas.

Payments would be distributed to hospitals based on the number of residents at a hospital (up to its existing cap) and the portion of the hospital's inpatient days accounted for by Medicare and Medicaid patients. The Secretary would have authority to modify the amounts distributed based on the proportion of residents training in priority specialties or programs (e.g., primary care, geriatrics) and based on other criteria identified by the Secretary, including addressing health care professional shortages and educational priorities. These changes modernize graduate medical education funding, making it better targeted, transparent, accountable, and more sustainable. The program would not impact the 1997 caps on Medicare-supported training positions. The new grant program would be jointly operated by the Administrators of CMS and the Health Resources and Services Administration.

Children's teaching hospitals will continue to receive funding from the new consolidated block grant. This proposal works to bring transparency and accountability to payments that only indirectly relate to Medicare's health insurance role by financing them outside the Medicare Trust Funds. Currently, GME funding recipients are generally not held accountable for effectively producing a physician workforce that matches national healthcare needs. HHS currently has little-to-no discretion in disbursing GME funds to address geographic and specialty

workforce shortages. The vast majority of Federal funding for GME comes from mandatory CMS budget items (Medicare and the Federal Medicaid match) based on payment formulas to teaching hospitals – without any obligation for programs to help meet national workforce needs. GME costs are insufficiently transparent and poorly match the estimated costs associated with residency training. Federal GME payments are not primarily based on standardized, comprehensive cost data and bear little resemblance to hospitals' actual residency-related costs today.